



**Health Systems Funding Platform (HSFP)**

**Health Systems Strengthening (HSS) Support**

**COMMON PROPOSAL FORM**

This common proposal form is for use by applicants seeking to request Health Systems Strengthening (HSS) Support from GAVI and/or the Global Fund.

**HSS Funding requests to the Global Fund using the Common Proposal Form and Guidelines can only be made when the application materials are launched on 15 August 2011**

This form is structured in three parts:

* Part A - Summary of Support Requested and Applicant Information
* Part B - Applicant Eligibility
* Part C - Proposal Details

All applicants are required to read and follow the accompanying guidelines in order to correctly fill out this form.

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| **Part A - Summary of Support Requested and Applicant Information** | | | | |
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| **Applicant:** | **Ministry of Health, Government of Lesotho** | | | |
| **Country:** | **Lesotho** | | | |
| **WHO region:** | **Afro Region** | | | |
| **Proposal title:** | **Strengthening Health Systems for Improved Immunisation Services Delivery in Lesotho** | | | |
| **Proposed start date:** | **Jan 2014** | | | |
| **Duration of support requested:** | **December 2017** | | | |
| **Funding request:** | **Amount requested from GAVI:** |  | **Amount requested from Global Fund:** |  |
| **Currency:** | **2,721,235.36** | |  | |

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| **Executive Summary**  *→ Please provide an executive summary of the proposal.*  Lesotho’s immunization coverage is currently estimated at 83% (UNICEF JRF Report 2011). Six out of ten districts have the immunization coverage below 80 %( cMYP 2012/2016).The major Health Systems challenges which contribute to low immunisation coverage are: shortage of human resource for health, inadequate managerial supervisory skills, shortage of medical equipment and infrastructure, inadequate transport, and inadequate financial resources at household and national level. There are large populations of unimmunised children (53,792) especially in hard to reach mountainous areas of Lesotho that can be reached only through outreach services. These include sites which can only be reached using helicopters. The country is only able to offer outreach services to about a third of existing sites due to the challenges mentioned above  This proposal is mainly aimed at strengthening the conduct of outreach services through implementing interventions such as the purchase of 4X4 vehicles for District Health Management Teams (DHMTs), conduct of outreach clinics through use of helicopters, the introduction of mobile clinics and ensuring that immunisation services are conducted every day at health facilities. The ongoing training of personnel in the RED approach government funding will ensure that appropriate skills and knowledge are imparted which will ensure that all populations are reached with immunisation services. With support from GAVI supportive supervision will be conducted at all levels which will ensure that quality services are being provided including in remote rural areas of Lesotho. The conduct of outreaches including mobile services will be done in an integrated manner and all Maternal and Child Health and other health services will be provided. The proposal is aligned with the National Strategic Development Plan 2011/12-2015/16, the National Health Policy approved in 2012[[1]](#footnote-2), the revised comprehensive Multi Year Plan (cMYP**)** for the period of 2012-2016 for the National Immunization Program. The Health Sector Strategic Plan is still being drafted and will be ready in 2013.  The **goal** of this proposal is to contribute towards the country’s aim of reducing infant and under-five child mortality from 91 deaths per 1,000 live births to 24 deaths per 1000 live births and 117 deaths per 1,000 live births to 37 deaths per 1,000 live births, respectively by 2016[[2]](#footnote-3) through investments in health systems strengthening. This proposal has 4 objectives and under each objective there is a list of activities that will be implemented to achieve desired immunisation.  **General Objective:** To reduce morbidity and mortality due to vaccine preventable diseases through increasing immunization coverage from 83% to 90% by 2016.   1. **To strengthen cold chain and associated logistics by making available requisite equipment and infrastructure:** The key activities under this objectives are (1) Procurement of fridges for the immunisation program; (ii) Purchase of fridge tags; (iii) Construction of vaccine storage space at district level; (iv) Purchase of vaccine carriers for the private sector.(v) Purchase of cold boxes for CHAL and the Private sector 2. **To improve health sector capacity of providing vaccination, MCH and other health services by equipping health workers with requisite skills and knowledge:** The key activities are as follows: (i) Training of cold chain assistants; (ii) Training DHMT/ health centre staff in vaccine management. (iii) Training Health Centre personnel on planning outreach services. 3. **To strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho:** The activities under this objective are as follows: (i) Provision of vaccination services in all health facilities using a supermarket approach; (ii) Carrying outreach services for hard to reach areas and under-served populations; (iii) Launching of the mobile immunisation teams in low performing districts; (iv) Construction of health posts ; (v) Purchase 4X4 vehicles for the low performing districts and headquarters; (vi) Provide MCH services (antenatal care, PMTCT, Post natal care, growth monitoring, health education, Family Planning) in hard to reach helicopter sites; and (vii) Supportive supervision at all levels. 4. **To contribute to strengthening monitoring and evaluation of health sector interventions:** The activities under these objectives are as follows: (i) Purchase of cell phones for VHW; and (ii) Carrying out the impact assessment of GAVI HSS interventions.   The proposed budget for this proposal is US$2,721,235.36 over a 4 year period. The MoH, CHAL and Lesotho Red Cross Society (LRCS) will be responsible for the implementation of activities as detailed in this proposal and the existing M and E frameworks will be used to monitor progress. Specifically the following indicators will be used to measure progress: DPT-HebB-Hib 3 coverage; Dropout rate for DPT-HepB-Hib; and number of districts with DPT-HebB-Hib 3 and measles 1 coverage above 80%. |

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| ***TWO PAGES MAXIMUM***  **Goal of the proposal**  The **goal** of this proposal is to contribute towards the National Strategic Development Plan aim of reducing infant and under-five child mortality from 91 deaths per 1,000 live births to 24 deaths per 1,000 live births and 117 deaths per 1,000 deaths to 37 deaths per 1000 live births, respectively by 2016 through investments in health systems strengthening.  **General Objective:** To reduce morbidity and mortality due to vaccine preventable diseases through increasing immunization (DPT containing vaccine) coverage from 83% to 90% by 2016.  **Objectives of the proposal**  **Objective 1: To strengthen cold chain and associated logistics by making available requisite equipment and infrastructure:** According to EVM assessment 2011 and Cold Chain Inventory 2012, 213 fridges needed to be replaced as they were not in good working condition. In 2012 Government purchased fridges for 100 health facilities to address areas which were worse off. The remaining 113 would be replaced to ensure that all 213 health facilities have functional fridges**.** GAVI is requested to fund 100 fridges while government will budget for the remaining 13. Vaccines will be kept safe and efficacious and the temperature at which they are kept is effectively monitored by use of fridge tags. Therefore 100 fridge tags will be purchased for the newly acquired fridges. Out of the 213 facilities providing immunization 163 have sufficient number of vaccine carriers while 50 do not. This comprises private surgeries and CHAL facilities. Vaccine carriers will be distributed among 20 private sector surgeries and 30 CHAL facilities, currently delivering immunisations services but do not have these carriers. Vaccine storage capacity in all the 10 districts is inadequate because expansion of services and addition of new vaccines were not taken into consideration when they were constructed. In order to meet the demand half way the proposal is to ensure that at least 2 districts with larger population density should be supported to rehabilitate and expand the existing space to cater for high storage demand. These activities will ensure that vaccines are always available at health facilities and that services can be delivered everyday which is currently a major problem.  **Objective 2: To improve health sector capacity of providing immunization, MCH and other health services by equipping health workers with requisite skills and knowledge:** Government of Lesotho is currently training 24 cold chain technicians (4 national level technicians plus 2 trainees per district already in the service) to ensure proper maintenance of cold chain equipment for MoH, LRCS, CHAL and private for profit facilities. GAVI support is being requested for refresher training for these technicians after three years. Other training that will be conducted with support from GAVI will include vaccine management for members of the DHMT and health centre staff. GOL and UNICEF are conducting Reaching Every District (RED) training for 6 districts with the highest number of unimmunized children targeting community councils, chiefs and VHWs and health facility staff. . The RED strategy training will provide health workers and local leaders with the skills to better plan, manage and monitor all the interventions offered during the outreach. The RED strategy orientation for health workers and local leaders has proved effective in improving vaccination coverage. Studies such as the EVM assessment have also shown that there are managerial difficulties as far as vaccine management is concerned especially at district and lower levels; hence this training will ensure that health workers are knowledgeable about how vaccines are supposed to be kept. This will ensure that vaccines are kept safe and efficacious. Ten members (per district) of DHMT, Health Centre staff and the private sector will be trained in Vaccine Management. Health facilities currently provide antenatal care, prevention of mother to child transmission of HIV, family planning, growth monitoring and promotion, in an integrated manner when they carry out outreach services. However, these integrated outreach services are not well-planned.  **Objective 3: To strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho:** Immunisation coverage in Lesotho is low mainly because these services are not offered everyday at health facilities, outreaches are either infrequent or unavailable and that there exist some places in Lesotho especially in the mountains which cannot be reached. On average each district operate with 3 vehicles which are shared among all the disciplines/programs represented at the district level and running of various errands between the Head quarter and the district thus compromising delivery of service in the outreaches. Additional vehicle per district dedicated to outreaches is required to overcome this problem. Hard to reach services are currently delivered through Flying Doctor Services in 9 Health Centres which are accessible by Airstrips while the helicopter sites are visited only on National Immunization Days and other special occasions. It is the intention therefore of the Ministry from 2013 onwards to undertake 4 visits to the helicopter sites per year (3 of which will be sponsored by GAVI). This objective therefore aims at revitalising outreaches and reaching the hard to reach areas of Lesotho using different approaches including use of helicopters and 4X4 vehicles. For hard to reach areas it is difficult to attract Nursing Assistants who provide the bulk of vaccinations. Government has started implementing the Retention Strategy piecemeal starting with the hard to reach areas. It is already paying allowances to all nurses serving in the remote areas and has started paying a retention package for 46 hard to reach areas. The payment of incentives will help to attract nurses to remote rural areas who will provide services on an everyday basis including ensuring that outreaches are conducted. To incentify the Nurses at this level while government is preparing to take over the full package GAVI is requested to complement by paying allowances which will cater for eating and sleeping out while in the outreach.  **Objective 4: To contribute to strengthening monitoring and evaluation of health sector interventions:** There are challenges with regard to management of HMIS data at all levels of the health system brought about by shortage of personnel to effectively manage the system, data completeness, timeliness of reporting and lack of feedback to health centres and DHMTs. The Ministry of Health has therefore undertaken to do its internal assessments through routine Data Quality Surveys (DQS) which periodically receive external audit. The last independent Data Quality Assessment (DQA) was done in 2007. It is the intention of Government to undertake another assessment during the lifetime of the GAVI program this will assist in getting the impact of GAVI and other on-going initiatives.This proposal aims at strengthening community collection systems. The 2012 DQS has indicated that there are still challenges in maintaining the village data registers. The orientation on the RED strategy for the chiefs and councillors will also be on the use of the village register which is an important data collection initiative. This initiative is already underway and being funded by the GoL. The emphasis will be on the need to ensure that these registers are filled and information is used at village level for making health decisions at that level and that such data is submitted to health facilities to which the VHWs are attached. VHWs reside at community level and they have the ability to collect data for example on the number of immunised children but transmission of data to health facilities to which they are attached is problematic; hence the need for facilitating the means through which they can send data using cell phones wherever possible. The Health Centres to which they are attached to have already been provided with Cell phones to communicate with the hospitals and the Central Programs.    This objective aims at contributing to improvement of M and E activities within Lesotho’s health sector through carrying out an impact assessment of GAVI funded HSS interventions and making cell phones available to VHWs to submit data to health facilities and report emergencies. |

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| **Part B - Applicant Eligibility** |

If this application includes a request to the Global Fund, please fill out the eligibility and other requirements section available [here](http://www.theglobalfund.org/en/application/materials/documents/#HSS).

If this application includes a request to GAVI, please click [here](http://www.gavialliance.org/support/apply/countries-eligible-for-support/) to verify the applicant’s eligibility for GAVI support.

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| **Part C - Proposal Details** |
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| **1. Process of developing the proposal** |
| * 1. Summary of the proposal development process   *→ Please indicate the roles of the HSCC and CCM in the proposal development process. Also describe the supporting roles of other stakeholder groups, including civil society, the private sector, key populations and currently unreached, marginalised or otherwise disadvantaged populations. Describe the leadership, management, co-ordination, and oversight of the proposal development process.* |
| The process of developing a proposal in the Ministry of Health is always coordinated in the Health Planning and Statistics Department which coordinates and facilitate all activities in formulating project proposals. WHO, UNICEF, GAVI and other Technical Partners provide technical advice and information on opportunities as and when they arise. The Management Team of the MoH gives a go ahead to undertake the exercise and will in turn oversee and provide policy guidance throughout the whole process of its development. The ICC and other supreme bodies in the respective programs review and endorse the document once it is completed.  The process of developing Lesotho’s proposal to GAVI Alliance started in 2009 when the ICC made a decision for the Department of Planning and Statistics in MoH and stakeholders to go ahead with the development of the GAVI HSS proposal preparation. This application was however not successful. When the health systems strengthening (HSS) funding window opened again in 2012 WHO country office advised the MoH and stakeholders to revisit the 2009 proposal and submit a fresh proposal in 2012. The Ministry of Health of the Government of Lesotho agreed to submit a proposal. UNICEF and WHO provided funds for technical support for the development of this proposal. The approach to the development of the Lesotho GAVI proposal was as follows:   1. Review of relevant documents such as the 2009 Lesotho HSS application, the cMYP, the 2010 Lesotho Health System Assessment (HSA), the National Health Policy and the draft Health Sector Strategic Plan, Monitoring and Evaluation 2008/9-2010/11 MTEF, Lesotho National Development Plan 2011/12-2015/16, DQS by IST Presentation 04/04/20111, Lesotho PIE Report 2010, First Draft EVM Report September 2011. 2. A stakeholders’ meeting was convened during which the following issues were discussed: the health system challenges experienced within Lesotho’s health sector, initiatives being implemented to address these challenges and the HSS support that Lesotho should request from GAVI. The participants in this meeting were drawn from the MoH’s Department of Planning and Statistics and the EPI Unit in the Family Health Division; Public Health Nurses from the DHMTs; Christian Health Association in Lesotho (CHAL); UNICEF; World Health Organisation (WHO); the private for profit sector (represented by Beatitudes and Lahlakeng Surgeries) and civil society organisations (CSOs) namely LRCS and Human Resources Alliance for Africa (HRAA). This meeting took place in the morning of 5th July 2012 at the United Nations offices meeting room in Maseru. 3. An EPI Technical Working Group was convened in the afternoon of 5th July 2012 which discussed in details the issues discussed earlier that morning in the meeting with various stakeholders at the UN conference room. On 6th July 2012 further consultations were made with the EPI staff and Department of Planning and Statistics on the proposed interventions and this meeting was aimed at coming up with immunisation specific systems bottlenecks and their relevant systems strengthening activities. 4. This was followed by discussions with the private sector. In the meeting the representatives from the private sector reiterated that they also deliver immunisation services. Some of the private facilities report their immunisation activities to the EPI while others do not because they are not facilitated by the MoH in the delivery of these services. They therefore appealed that there was a need for them to be assisted in the delivery of these services. A decision was therefore made to include the private sector in requesting for support for example to purchase cold boxes and vaccine carriers for them. These pieces of equipment will target the private facilities that already provide immunisation services to at least 500 children a month and those that submit data. 5. Between 5th July 2012 and 21st July 2012 various consultations were made with individual stakeholders to get more details on the health system challenges Lesotho is experiencing, what is happening to address these challenges and what needs to be done to strengthen the health system? The stakeholders consulted included the Global Fund, the Millennium Challenge Account (MCA)-HSS and a representative of the private sector. The Department of Planning and EPI program further provided information on the interventions suggested by stakeholders. 6. The Director General (DG), Director of Primary Health Care, Director of Nursing Services, Director of Clinical Services and Head of Family Health Division were further consulted. They agreed with most of the interventions that were suggested by different stakeholders but had reservations with the use of Village Health Workers (VHWs) as providers of vaccination services. They suggested that there should be incentives given to nursing assistants who, among other functions, are already responsible for vaccinating under-five children. They also suggested that the proposal should focus on how best hard to reach under-five children can be reached. 7. Another stakeholder meeting was held at the Convention Centre in Maseru where further discussions about the suggested interventions were discussed. 8. When the first draft of the Lesotho GAVI proposal was completed it was shared with stakeholders including the WHO Regional Office in Harare, Zimbabwe. The proposal was subjected to peer review at the peer review workshop which took place in Harare from 6th August to 9th August 2012. These comments were further discussed with the EPI and Department of Planning and Statistics and later with stakeholders at a meeting held in the MoH on 30th November 2012. Stakeholders who attended the meeting included CHAL, UNICEF, WHO, LRCS and MoH including a representative of DHMTs. 9. The Department of Planning and Statistics coordinated the process of developing this proposal and there was active participation of the EPI Unit, the Department of Nursing and other Departments in MoH. 10. In terms of stakeholders’ role in the development of this proposal, they were instrumental in the identification of health system challenges, the initiatives that were being implemented by different stakeholders to address health system challenges and the gaps that existed for which support should be requested from GAVI. For example it was during the stakeholders’ meeting that MCA-HSS, PEPFAR, Irish Aid and the Global Fund were mentioned as playing a role in addressing specific health system challenges. Consultations were further made with individual stakeholders in order to further get information on what they were doing with regard to strengthening the health system. After the identification of interventions for which support was to be requested from GAVI these were then presented to senior management in the MoH which endorsed the interventions after suggesting changes as described above. Individual members of the ICC such as the DG and other Directors in the MoH, Program managers(such as EPI), CHAL, LRCS, UNICEF and WHO were consulted and did not have any major difficulties with the suggested interventions. An ICC meeting was called which supported the interventions and requested a number of modifications (that the presence of the Irish support in the hard to reach be recognized and reconciled with GAVI proposal and that the assistance to erect outreach posts should be participatory to instil ownership and cut down on the costs..The proposal was finally endorsed by ICC as contained in the attached minutes (see attachment 13). |
| 1.2 Summary of the decision-making process  *→ Please summarise how key decisions were reached for the proposal development.* |
| During the process of developing this proposal the Technical Working Group, selected specifically for this proposal, has been instrumental in providing technical guidance to the Writing Team (consultants). The Senior Management on the other hand provided policy clearance on specific issues when consulted while the ICC reviewed and looked out for areas of duplication and finally endorsed the document before it could be submitted to the donor. A number of stakeholders were consulted as described above. As has been described in Section 1.1 the process started with the stakeholders’ meeting and participants described the broader health systems challenges that were being experienced in the health sector and suggested interventions for which the Government of Lesotho (GoL) wants support from GAVI. During the meeting with the TWG and the EPI staff, participants were able to articulate the wider health system challenges that impact on the delivery of immunisation services and suggested further interventions necessary to address these wider challenges. There were also discussions about the capacity of the EPI to deliver services and the support that is anticipated in future in order to avoid duplication. A long list of interventions was made during these stakeholder meetings and this list was subjected to further scrutiny by stakeholders and they were able to prioritise the interventions that were critical for Lesotho. The reduction of the list of interventions was necessary in order to be within the budget allocated for such activities by GAVI.  This list of interventions was also presented to top management in the MoH who also helped to reduce the number of these interventions after looking at what other stakeholders such as MCA-HSS, Global Fund and President's Emergency Plan for AIDS Relief (PEPFAR) were funding. Top management in the MoH also offered explanations for choosing certain interventions over others. While stakeholders made suggestions on the interventions that the GoL needs support from GAVI, there were also other interventions that required endorsement from top management in the MoH as these were policy issues. For example currently the immunisation of children at health facilities is done by nurses and nursing assistants. However, there is a gross shortage of these cadres in Lesotho’s health sector such that the provision of immunisation services is done on scheduled days. As part of proposal development process discussions were held around the possibility of village health workers (VHWs) to be trained to provide vaccination services as evidence from other countries has demonstrated that the involvement of community-based health workers employed by Ministries of Health has helped to expand and sustain the delivery of health services including immunisation. The use of VHWs has been done in some districts in Lesotho by CHAL and such an approach was proved effective in reaching many children including those in hard to reach areas. While participants in the stakeholder meetings supported this, the question was, however, whether the current EPI Policy and the Lesotho Health Policy allowed for this. This suggestion, as far as it was appealing to stakeholders, was dropped because the existing policies did not provide for this.  In making decisions about the interventions for which support was required from GAVI, cost was another consideration. For example the stakeholders made a decision to use funds from GAVI to construct Health Post using prefabrications instead of using bricks, sand and iron sheets which would have been very expensive. Initially a suggestion was made to purchase tents for each district. After discussions, this was abandoned because of the problems of erecting the tents in the field and also durability. During the ICC meeting it was suggested that the proposal should take cognizance of the principle of ownership of these facilities by Communities by letting communities to collect and use local material where possible while GAVI provides other materials whose estimate has been made in the proposal. Some interventions such as the use of helicopters were chosen because that was the only way of reaching the large pool of unimmunised children in Lesotho’s hard to reach sites described as ‘***helicopter sites***’. Each district has several of these and they are only reached during National Immunisation Days (NIDs) when with support from development partners helicopters are hired from the Lesotho Defence Forces for this service. Decisions were, therefore, also made based on the most appropriate way of reaching hard to reach unimmunised populations of children, despite the fact that such an intervention would cost a lot of money.  The discussion in the stakeholders’ meetings on challenges experienced by the health sector in Lesotho was guided by WHO’s health systems building blocks. Under each building block challenges were identified, current initiatives to address the challenges were highlighted and interventions requiring support from GAVI suggested. Objectives were therefore formulated by the writing team around the building blocks and these were also informed by priorities of the National Health Policy and the cMYP. These objectives were also discussed with the stakeholders including individual members of the ICC and MoH management and they were agreeable to the suggestions made by the writing team. These objectives address the following issues: cold chain equipment, monitoring and evaluation, training of health workers and how best hard to reach populations can be reached which are also the priorities in the cMYP and the National Health Policy. |

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| **2. National Health System Context** | |
| * 1. a) National Health Sector   *→ Please provide a concise overview of the national health sector, covering both the public and private sectors at the national, sub-national and community levels.*   * 1. b) National Health Strategy or Plan   *→ Please highlight the goals and objectives of the National Health Strategy or Plan.*  2.1 c) Health Systems Strengthening Policies and Strategies  → Please describe policies or strategies that focus on strengthening specific components of the health system that are relevant to this proposal (e.g. human resources for health, procurement and supply management systems, health infrastructure development, health management information systems, health financing, donor coordination, community systems strengthening, etc.) | |
| ***FOUR PAGES MAXIMUM*** **2.1a. Lesotho’s National Health Sector** Lesotho is a small and land-locked country completely surrounded by South Africa and its population is estimated at 2,2M[[3]](#footnote-4) people with 51% of these being females. Twenty three percent (23%) of the population lives in urban areas and the rest live in rural and remote mountainous areas such as shown in Figure 1 below which makes service delivery and access quite difficult.  **Figure 1: Lesotho’s mountainous terrain makes it difficult to access and provide services**  Immunisation 003  Most of Lesotho’s 30,355 square kilometres is mountainous. The country is divided into 10 districts. The four largest districts of Maseru, Leribe, Berea and Mafeteng hold 62.2% of Lesotho’s population. The health statistics are generally worse off compared to other countries within the SADC region. Refer table 1.    Table 1: Country Statistics   |  |  |  | | --- | --- | --- | | **Indicator** | **Value** |  | | Country size (area) | 30,000 sq km |  | | Population size | 2.2M |  | | Under-five population | 12.6% |  | | GNI | US$ 1220[[4]](#footnote-5) |  | | Adult literacy rate | 82% |  | | Percent of the population possess a radio | 78% |  | | Population own TV sets | 19% (46% urban 10.8% rural) |  | | Life expectancy rate | 41 years |  | | Under five mortality rate | 117 deaths per 1000 live births |  | | Child mortality | 28 deaths per 1000 live births |  | | Fertility rate | 3.3 |  | | Maternal mortality ratio | 1155 deaths per 100,000 live births |  | | Pregnant women delivering with the assistance of a skilled birth attendant | 55% |  |   The MoH is the line GoL Ministry which coordinates the provision of health services in Lesotho. It has structures at central, district and community levels. The central MoH is largely responsible for the development of policies, strategic planning, resource mobilization, supervision, monitoring and evaluation (M&E) and providing a legal framework. The District Medical Officer (DMO) heads the district hospital and reports to MoH Headquarters. The delivery of health services is being decentralized and decision making authority will be at district level with the District Health Management Team (DHMT) focal person managing health services delivery at health centres and community level.  The delivery of health services is done at three levels namely primary, secondary and tertiary levels. There are 372 health facilities in Lesotho: 1 referral hospital, 2 specialty hospitals, 18 district hospitals, 3 filter clinics, 188 health centres, 48 private surgeries, 66 nurse clinics and 46 pharmacies. All filter clinics are public while all nurse clinics and pharmacies are private. In total 213 of these facilities belong to CHAL and MoH. 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[[5]](#footnote-6). About 90% of the private for profit health facilities are situated in Maseru, Berea, Mafeteng, and Leribe. GoL, LRCS and CHAL health centres now provide services free of charge after the abolition of fees in 2008. This has led to a huge increase in utilization of health services. CHAL is the largest partner of the MoH: it provides services to at least 30% of the population and most of these people live in remote rural areas where coverage by public facilities is limited. There is a Memorandum of Understanding between CHAL and MoH which aims at harmonizing service provision, provide salaries and user fees and the need for GoL to register and certify CHAL facilities[[6]](#footnote-7). The GoL has also entered into a purchase-provider partnership with Lesotho Red Cross Society (LRCS) for provision of a defined Essential Health Package (EHP). The current Health facility or service coverage map was done in 2005. Over the last 7 years a lot of health facilities have been established; hence the need for a new health facility map.  In addition to health centres there are health posts at community level which are manned by VHWs who are volunteers receiving an incentive of M300 from GoL and they provide promotive, preventive and rehabilitative care at community level. Nurses at health centres have the mandate to supervise and train VHWs. They also organize health education gatherings and immunization efforts. The VHWs include, among others, traditional birth attendants and community-based condom distributors. The link between community and health centres provided by VHWs has remained informal despite their huge contribution. At the national level, this program is coordinated by a Community-Based Health Care Manager based in the Division of Family Health[[7]](#footnote-8). Inadequate funding and acute shortage of health personnel to adequately train and supervise VHWs has hampered the growth of this community initiative[[8]](#footnote-9). VHWs are the first point of care at community level and they refer cases to health centres. Health centers are the first point of professional care and these are manned by nurse clinicians who posses skills in preventive and curative care including the dispensing of medications. Health centres refer cases to the district hospital and then to national level hospitals. If this does not work then patients are referred to South Africa for quaternary care through the national tertiary referral hospital. With regard to delivery of immunization services this is mainly done at static clinics by CHAL, LRCS and public facilities. Outreach immunization services are very limited. The MoH also arranges NIDs depending on availability of financial resources and the last one was conducted in 2010. The 2012 DQS observed the declining trends in immunization coverage as can be seen in Figure 1 below:    This is a worrying trend and needs to be reversed.  In terms of Human Resource for Health, there are 8,600 personnel working in the health sector: 44% work in the formal sector comprised of GOL, CHAL, NGOs (such as LRCS), and the private health  sector[[9]](#footnote-10); 75% work in government, 22% in CHAL, and 3% in NGOs and the private-for-profit sector. A third of MoH labour force consists of support staff. Nurses constitute 73.3% of the workforce in MoH followed by physicians at 6% with other health cadres constituting a low percentage of the workforce. The ratio of doctors to population is at 0.5 per 10,000 while that of nurses is at 6.2 per 10,000 population. Both ratios are far below the WHO Afro region of 2.4 and 10.9, respectively[[10]](#footnote-11). On average, Lesotho’s total health workforce is equivalent to a third of the African average (.850/1000 versus 2.626/1000). There is misdistribution of the health workforce: less than 20% of the health workforce is employed at PHC level even though 60% of health care are delivered at that level; 46% of the formal sector labour force is employed at the secondary level and 24% at the tertiary level. District and lower level facilities are severely understaffed: for example at district hospital level only 50% of their nursing requirement is filled. This generally demonstrates that there is gross shortage of HRH in Lesotho especially at district and lower levels.  Lesotho allocates adequate funds for the provision of the essential health package. Between 2004/05 the GoL spent 7.7% of its GDP on health and this is above WHO Afro region average of 5.6% in 2006. Over the same period GoL spent US$54.6 per capita per annum which was also above the US$34 per capita per annum recommended by WHO for providing a minimum package of cost effective interventions. With such levels of funding GoL therefore has the capacity to provide quality health care services to its people. Over the period 2004/05-2009 the GoL expenditure on health as a percentage of total GoL expenditure averaged 9.6% and this reached 14% in 2010/2011 which demonstrates that Lesotho is one of the countries which has made a lot of progress towards reaching the 15% Abuja target. The GoL is a major source of health financing contributing 60.7% of total health spending between 2004/5 and 2008/9. This is followed by private sources namely households and companies at 25.1% and donors ranked third at 14.2%. Currently Lesotho does not have a Medium Term Expenditure Framework (MTEF) as the last one expired in 2011. The GoL plans to develop another MTEF in the 2013/2014 financial year. While resources in the health sector appear to be adequate for provision of a basic package the last MTEF showed that there was a funding gap of M5 billion (about US$59 million); hence support from donors is required.  **2.1b. National Strategic Development Plan, Health Sector Strategic Plan, the National Health Policy and the Comprehensive Multi Year Plan (cMYP) for Immunization**  The National Strategic Development Plan (2011/12-2015/16) is an overarching document that guides the implementation of development interventions. The vision as stated in the plan is “*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 health and well developed human resources base. Its economy will be strong, its environment well managed and its technology well developed”*. With regard to health, the plan focuses on improving the health of the people of Lesotho particularly that of under-five children and mothers. In order to achieve this the key strategies that will be implemented include improvement of coverage of health facilities, their management and quality of care; improve quality and coverage of health prevention and education including the use of ICT among other interventions. The Plan specifically mentions the development of cost effective health interventions including immunization in order to reduce infant and child mortality. With regard to human resources for health the Plan also talks about the improvement of skills of the health workers through capacity building and provision of appropriate incentives to retain skilled health workers. These are also the focus of the Lesotho proposal to GAVI.  In 2012 the MoH developed the Lesotho Health Policy whose vision is “The Nation will have access to affordable and equitable quality health care irrespective of geographical location”. The goal of the National Health Policy is to have significantly reduced mortality and morbidity and thus contribute to attainment of improved health status among the people of Lesotho. There are three policy objectives and these are (i) To reduce morbidity and mortality among the Basotho; (ii) To reduce inequalities in access to health services; and (iii) To strengthen the pillars of health system. This goal of the GAVI HSS proposal has been derived from the National Health Policy. The policy recognizes that Lesotho has high infant and under five mortality rate mainly due to preventable diseases. In order to address this, among other strategies, the MoH provides quality children health services to reduce child morbidity and mortality and ensure eradication of vaccine preventable childhood diseases. The policy also aims at reaching the herd immunity for routine immunizable childhood diseases. These activities will be complimented by improvements in human resources for health and the implementation of comprehensive social mobilization campaigns aimed at creating awareness.  It should be mentioned that while the National Health Policy has been developed, the MoH has also started the process of developing the Health Sector Strategic Plan[[11]](#footnote-12) whose goal is to contribute to the attainment of improved health status and quality of life for socio-economic development. The purpose of the plan is to consolidate the health systems that guarantee quality health care to all citizens including the poor, vulnerable and disadvantaged.  The strategic plan highlights the persisting health concerns in Lesotho and these include high maternal mortality ratio, increasing trends in under-five and infant mortality rates, declining immunization coverage, high HIV prevalence and the emerging problem of non-communicable diseases. The plan further highlights some of the broad strategies, including strengthening of health systems that will be implemented in order to address the challenges in the health sector and improve the health status of the people of Lesotho. The process of developing the strategic plan has not yet been finalized and has involved CSO. as well. The last MTEF for Lesotho was for the period 2008/9-2010/11 and the next one will be developed in 2013/2014 and by that time the Health Sector Strategic Plan will have been developed including the costing of its implementation.  In addition to the Lesotho Health Policy and the National Health Strategic Plan, the GoL also developed a comprehensive Multiyear Plan for immunization (cMYP) for the period 2012-2016. The cMYP aims at improving and sustaining immunization coverage in Lesotho by ensuring that the large pools of unimmunized children are reached. The cMYP also highlights the strategies that will be used in order to improve vaccination coverage and these include training of various cadres (including VHWs) for example in the RED strategy, vaccine management and cold chain management; implementation of the RED strategy after training appropriate people; implementing a supermarket approach to delivery of immunization services and other MCH services delivery; and conducting outreach clinics using helicopters, horses and 4X4 vehicles. Specific indicators have been included in the cMYP to monitor performance. .  **2.1c Health systems strengthening policies and strategies**  This proposal looks at strengthening specific components of the health system and these are human resources for health (HRH), health infrastructure development, health management information system and community systems strengthening. With regard to human recourse, the GoL has a *Human Resource Development and Strategic Plan* (HRDSP) for the period 2005-2025 which has detailed information on how Lesotho will address the HRH over the period up to 2025. It will address for example the shortage of nurses and health educators at district and health centre levels that are critical in the provision of immunisation services. It will also ensure that nurses in hard to reach areas are paid incentives as stipulated in the retention strategy. The posts of health educators are established but GoL is yet to find resources to pay salaries for this cadre. The human resource strategy also provides for short term training workshops to equip nurses and other health workers with appropriate skills. The *cMYP* is another plan that deals with human resource issues particularly emphasising on strengthening managerial skills of personnel involved in immunisation activities and the provision of training workshops for health personnel (nurses and nursing assistants and health educators) involved in immunisation activities among others. These training workshops will be in areas such as the RED strategy; stock management; cold chain maintenance; data collection, analysis and utilisation; and orientation of staff in areas such as new forms developed as a result of the anticipated introduction of new vaccines.  There are high levels of attrition within the health sector in Lesotho and GoL, with support from MCA-HSS, has developed a *Retention Strategy for the Health Workforce.* The overall objective of this strategy is to contribute towards attaining a full staff compliment at health institutions. It is also aimed at reducing the number of health professionals leaving the service by improving motivation and job satisfaction among key workers such as nursing staff. The full implementation of the Retention Strategy will help to address the high attrition rate in the health sector including ensuring that health workers serve in the remote rural areas of Lesotho. This will ensure that adequate staffing levels are available at the health facilities to provide health services including immunisation using a supermarket approach[[12]](#footnote-13). During stakeholder consultations it was also reported that nurses do not take up posts in hard to reach areas because there is no incentive to make them stay in such areas. This is why as part of the Retention Strategy for the Health Workforce GoL requests funding for a package to help in attracting these nurses to hard to reach areas and differentiate them from those working in Maseru and other district capital towns. The positions are advertised, and people attend interviews but they do not take up the offers because of the absence of incentives. The suggestions that have been made are therefore in line with the HRDSP and cMYP. The Irish Aid has pioneered providing assistance to implement the Retention Strategy on human resource for 46 hard to reach health facilities and Government has promised to take over in 2014 when the assistance phases out.. With regard to infrastructure, the *Lesotho Health Policy* recognises that facility requirements are changing hence the need to respond to these changes. The policy objective with regard to infrastructure is to ensure that health physical infrastructure is appropriately designed and constructed and requisite equipment is provided, installed and maintained in accordance with set standards. Cold Chain assessment has been conducted in anticipation for introduction of new vaccines. All health facilities do not have adequate storage space as consideration for expansion of services and possibilities of introduction of new vaccines were not made when they were constructed. Due to lack of resources it is prudent that densely populated districts be addressed first to serve the high demand that will be created in these areas and to bring vaccines closer to the other districts with relatively low populations. As part of this proposal there is a need therefore to construct storage space for vaccines in these districts. Shortly Lesotho will be introducing new vaccines and if adequate space is not provided for, the country will have problems in storing these vaccines and other immunisation supplies. The policy also provides for appropriate equipment to be put in the health facilities. In order to provide effective service delivery in the hard to reach areas it is recommended that each district in the 6 low performing districts selects 5 health centres to erect health posts which will be central to serve as many outreaches as possible. The request to is to support construction of Health posts which will be used to provide integrated services during outreaches and accommodate nurses to stay overnight or for whatever time that may be required. GoL is asking for the purchase of fridges to be put in 113 more facilities which operate with old and poor performing fridges. Purchase of equipment such as fridges and motor vehicles are in line with cMYP. The GoL has developed a *PHC Revitalization Plan for the period 2011-2017* demonstrating its commitment to PHC in line with the 2008 Ouagadougou Declaration on PHC. The Plan looks at practical consideration for revitalization of PHC in Lesotho and defines the roles of various levels of the health system starting with MoH headquarters which is essentially for policy making and ensuring adequate funding for PHC activities. The health facilities have the responsibility of training and supervision of VHWs while health centre committees, which represent a cross section of society, advise health centre management. The plan aims at strengthening community health systems through training of VHWs and other members of the community. The GoL has already started sensitizing the community councils, VHWs, chiefs and health centre staff and the promotion of use of village health registers. This proposal also aims at utilizing VHWs to strengthen data collection at community level through use of cell phones. Improving data collection systems at community level is a major focus for the national health policy. | |
| 2.2 Key Health Systems Constraints  *→ Please describe key health systems constraints at national, sub-national and community levels preventing your country from reaching the three health MDGs (4, 5 and 6) and from improving immunisation, and from improving outcomes in reducing the burden of (two or more of) HIV/AIDS, tuberculosis and malaria. Include constraints particular to key populations and other unreached, marginalised, or otherwise disadvantaged populations (including gender related barriers).* | |
| ***TWO PAGES MAXIMUM***   * 1. **Key health systems constraints in Lesotho**   The National Strategic Development Plan (2011/12-2015/16 highlights some of the constraints being experienced within the Lesotho health system and these include shortage of HR, weak procurement system, lack of efficiency in the utilisation of financial resources and lack of infrastructure and equipment among others. We describe some of these constraints in details below.  **2.2.1 Mountainous terrains and long distances to health facilities**  The mountainous terrain of Lesotho makes delivery of and accessibility to social services including health care services quite difficult. Some of these areas can only be reached with the use of helicopters. Figure 2 and 3 shows helicopters dropping bricks and other materials for construction of a health facility in some locations in the mountains:  **Figure 2: Helicopters dropping bricks and other materials**  **Sekolopata 026**  The distances in some of the hard to reach areas are quite long making it difficult for people to walk to the health centres. In other countries within the region outreach clinics conducted by the MoH have been institutionalised and this is not the case in Lesotho. In Lesotho there are certain sites which are hardly reached by routine health services delivery including immunisation services. These are only reached for example during NIDs and using helicopters. These populations which can only be reached by helicopters have challenges in terms of seeking health care as facilities are far or they cannot access them. The EPI estimates that there are 133 hard to reach areas in Lesotho, areas that can only be reached by helicopters. Other hard to reach areas can, however, be reached using horses and 4X4 vehicles.  **Figure 3: Nurses on their way to deliver immunisation services by helicopter on a very cold day**  Immunisation 021  **2.2.2 Critical shortage of human resources for health**  As has been discussed earlier there is a critical shortage of skilled human resources for health in Lesotho. The problem is particularly acute at district and lower levels. It is however gratifying to note that the hard to reach areas are receiving special attention with the intention of meeting the minimum required staff complement of 5 Nurses per Health Centre. The Ministry is currently recruiting nurses to man at least 46 hard to reach Health Centres to ensure that full staff complement is attained in these facilities. The employment conditions for these new recruits include the newly set retention package for hard to reach areas. Inadequate incentives have made it difficult for health workers to serve in very hard to reach mountainous areas. With a renewed focus on PHC following the 2008 Ouagadougou Conference, VHWs will play a critical role in mobilising communities including delivery of PHC services at community level. However, a significant proportion of VHWs remain untrained to effectively deliver services and these VHWs are actually being under-utilised. While community councils, health centre committees (HCCs) and village health committees (VHCs) have just been established as part of the decentralisation process, they are yet to be trained on health issues to effectively support the VHWs in the work they do.  **2.2.3 Lack of managerial and supervisory skills at all levels**  Inadequate managerial and supervisory skills at all levels and the limited conduct of supportive supervision have also affected the delivery of health services including immunisation services. The PIE report for HIB highlights the inadequate supportive supervision and attributes this to the shortage of staff at district level who are busy with other duties to effectively supervise delivery of vaccination services. Stock-outs of some essential medicines in Lesotho have been reported and this is partly due to inadequate skills in forecasting and stock management. The EVM assessment also found that there was a lack of trained cold chain technicians who can perform preventive maintenance. There is a need therefore to build managerial and supervisory skills at all levels of the health system.  **2.2.4 Shortage of medical and related equipment and infrastructure**  The shortage of important medical and related equipment especially at district and lower levels has been observed and been detailed for example in the 2012 DQS as well as in the 2010 Lesotho HSA. Challenges experienced in supply of medicines include inadequate financial allocation for medicines, absence of a national policy on drug donations, inadequate management system in the medicines supply chain and inadequate and inequitable distribution of pharmaceutical HR. Because of this there have been cases of stock out of medicines at facility level. In term of equipment, this is in short supply and the problem is exacerbated by lack of personnel to perform preventive maintenance and the non-availability of definitive sector equipment replacement plan and strategies. In some cases even if working equipment is available, it is not being used because the users have not been trained.  New vaccines are being introduced in Lesotho and the EVM assessment observed the general lack of cold chain storage at the central level where there is a need to increase cold chain volume. At the central level the EVM also identified the lack of dry stores which can be used to store diluents and syringes and safety boxes. Cold chain capacity at district level was also found severely lacking. Other challenges at the district level included lack of complete sets of temperature charts, no planned maintenance of equipment including cold chain, the lack of computerised stock management software[[13]](#footnote-14). The private sector lacks vaccine carriers and cold boxes which can be used to carry vaccines from public health facilities where they source them. The shortage of equipment especially cold chain has affected the delivery of immunisation services.  **2.2.5 Shortage of transport**  At district and lower levels there is a shortage of 4X4 vehicles for carrying out outreach services not only for immunisation but for other MCH activities and supportive supervision by the DHMT to the Health Centres as well. The 2010 Lesotho HSA reports that accessing vehicles for referral at district level is a major challenge even for obstetric cases. The PIE report also identified inadequate transport mainly to transport vaccines from the national level to lower level facilities. As of now each district has at least 10 Health Centres which provide static services. On average each Health Centre has 3 Outreach sites (i.e. a total of 30 outreach sites per district). The current transport capacity is able to offer services in about a third of these outreach sites. In this proposal GOL is requesting that each district be provided with one 4x4 vehicle to offer services in the remaining estimated 20 outreach sites which are going to be covered by paying one visit per month.  **2.2.6 Poor data management including non-use at source**  There are challenges with regard to management of HMIS data at all levels of the health system. While the HMIS is functional, there are still challenges such as shortage of personnel to effectively manage the system, data completeness and timeliness of reporting is a challenge and the lack of feedback to health centres and DHMTs by MoH headquarters is a concern. The 2012 DQS has also reported the lack of under five registers and that in some contexts health facilities are using improvised forms. There is also insufficient knowledge of a proper way of tallying among health workers[[14]](#footnote-15). The other challenges include lack of capacity at all levels to analyse and utilise data for decision making and the existence of parallel data collection systems for example within the MoH the EPI program collects its own data and so do the Tuberculosis and HIV/AIDS programs. The existence of parallel data collection system tends to put a lot of pressure on already thin human resource within Lesotho’s health sector. Lastly, VHWs reside at community level and they have the ability to collect data for example on number of immunised children but transmission of data to health facilities to which they are attached is problematic; hence the need for facilitating the means through which they can send data. Only two out of 10 districts are currently using the District Vaccine Data Management Tool (DVDMT) with the rest managing data using a paper-based system just as is the case with health centres.  **2.2.7 Lack of financial resources at household and national level**  While the payment of user fees at CHAL and GoL health centres has been removed in order to allow even poor people to access health services; challenges still exist. Poor families still struggle to meet transport and medication costs involved in the process of seeking care. The lack of funds for transport is the primary reason across the population for not seeking relevant health services at the appropriate time. It has been mentioned earlier that the GoL is a major source of health expenditure followed by private sources and that the country is very close to achieving the Abuja target with respect to government expenditure on health as a percentage of total government expenditure. While it seems that there are adequate resources within the GoL to adequately provide the minimum health care package the last MTEF demonstrated that there was a significant shortfall in resources required to effectively deliver health service; hence the continued need for support from development partners[[15]](#footnote-16). | |
| 2.3 Current HSS Efforts  *→ Please describe current HSS efforts in the country, supported by local and/or external resources, aimed at addressing the key health systems constraints.* | |
| ***THREE PAGES MAXIMUM***  **Current HSS efforts in Lesotho**  The GoL with assistance from development partners as well as stakeholders is implementing interventions aimed at addressing the HSS challenges that it faces. The investments in health system interventions is particularly critical now as evidence from national surveys demonstrates that health and other social indicators have been going down and this is especially with regard to maternal, newborn and child health. The progress towards achieving MDGs in this area is off track. The GoL is already implementing a wide range of initiatives in order to address the prevailing HSS challenges: together with CHAL it is responsible for the training of health workers and the recruitment and payment of salaries, purchase of equipment and pharmaceuticals, financing the health sector and monitoring and evaluation of the performance of the wider sector. With regard to immunisation, the GoL has embarked on the following activities:   * The training of cold chain assistants all over the country. * The training of health workers and community members in the RED strategy in 6 poorly performing districts. * Mobilisation of communities for immunisation through the use of TVs and Radios. * Training of VHWs. * Purchased adequate cold boxes and vaccine carriers for the public sector. * The conduct of a DQS in 2012.   In addition to this Government has bought fridges for 100 out of 213 health facilities offering immunizations. It can be seen that GoL with support from in-country partners are doing quite a lot as far as immunisation is concerned. While GoL is a major source of health expenditure, there are gaps including in health systems strengthening where it requires financial and technical support from partners. As far as HSS is concerned there are three major partners involved in the implementation of HSS interventions in Lesotho and these are the Global Fund, PEPFAR and MCA-HSS. Furthermore Irish Aid is assisting in fulfilling the implementation of the Human Resource Strategic Plan (Retention Strategy). This section describes the health system interventions which are being implemented by these partners.  **2.3.1 The Global Fund**  The GoL is currently implementing a Round 8 grant from the Global Fund which has been and is being used to fund salaries for key personnel within the health sector and procurement of vehicles and other pieces of equipment for the MoH. The Global Fund has been paying salaries for health educators at district level up to June 2012. This cadre has been useful in the MoH but since the funding from the Global Fund stopped in June 2012 the health educators stopped working and have since left their positions as GoL was still processing their re-engagement and was not ready to take up their salaries. The implementation of the child survival strategy will be critical to re-engage health educators at district level mobilisation of communities to participate in health initiatives.  The Global Fund has also helped in the payment of salary top ups for medical doctors, nurses, clinicians, pharmacists, laboratory personnel, human resource officers, accounting personnel and lay, basic and professional counsellors. These counsellors are mainly stationed at ART clinics throughout the country. The Global Fund is further supporting the salaries of 89 data entry clerks working on the HMIS at health centre level through provision of an incentive of M300 per month per VHW. A total of 2000 VHWs are being supported by Global Fund. It has also trained VHWs especially in PMTCT issues.  The Global Fund has supported the renovation of some STI Clinics and Radiology Units but this was discontinued because of inadequate funding. In terms of equipment the Global Fund has purchased some equipment for STI clinics as well as the Radiology Departments in hospitals. It also purchased 10 vehicles, one for each district, to address the transport challenges that were being experienced at district level and supported the salaries of drivers for these vehicles. Lastly, the Global Fund also purchased 2 vehicles and requisite accessories which are being used to provide mobiles dental clinics by the Division of Dental Services in the MoH. EPI will explore the possibility of mobile vehicles being used for dental services by the Division of Dental Services.  **2.3.2 MCA-HSS**  The MCA-HSS is mainly working in 4 broad areas namely human resource, HMIS, decentralisation and research. These activities are being implemented by MoH with support from the National Institute of Health and Social Welfare in Finland and runs up to 2013.  **2.3.2.1 Human resources**  This component of the MCA-HSS aims at strengthening the human resources base of the MoH. The activities are planned and owned by the Ministry but works side by side with MCA-HSS staff to assess and build the capacity of MoH. So far the MCA-HSS has helped the MoH to develop the Continuing Education Strategy and its Implementation Plan and the Retention Strategy for the Health Workforce in Lesotho which defines a package which will help in retaining health workers especially in the rural remote hard to reach areas. The MCA-HSS together with the MoH identifies training programs that should be conducted for people in the health sector and MCA supports such courses and these are mainly in the areas of health management and budgeting. The MCA-HSS has also helped in terms of developing guidelines in the health sector for example treatment guidelines. It is also focussing on training of health workers in health care waste management at national and district levels. MCA is therefore playing a critical role in terms of identifying continuing education training requirements, developing resource materials as well as conducting these training programs. It is also playing a role in the recruitment and supporting of tutors for health training institutions.  **2.3.2.2 Decentralisation**  The process of decentralisation is ongoing in the MoH. The DHMTs are now in place but they need capacity building in order for them to work effectively in managing health services delivery at district level. The MCA-HSS is therefore supporting the MoH at district level in developing systems and other capacities needed to manage health services at district and health centre levels. The MCA-HSS is providing technical assistance to strengthen DHMTs through expanding their skills and capacities for leadership and oversight. There is a mentorship program in which MCA staff visits the DHMTs after the trainings in order to find out the challenges they are experiencing and help them to address these challenges on the job.  **2.3.2.3 HMIS**  A lot of challenges have been highlighted with regard to the HMIS. The MCA-HSS project is assisting the MoH to transform HMIS and central reporting systems to a field-based system that reports performance and needed health data for decision making at all levels of health care. The HMIS was initially paper-based but MCA-HSS is helping in transforming this into an electronic system. It has also embarked on integrating the existing parallel data collection processes so that at the end of the day there is only one functional HMIS which captures all data from the health sector. Currently the electronic medical records system is being piloted in Motebang Hospital and the intention is to have all patients’ records electronically.  **2.3.2.4 Research**  The MCA-HSS is helping the MoH to define the role and strengthen the capacity of the MoH Research Unit. Particularly this project aims at strengthening research governance through the establishment of research ethics committees which are vibrant and capable of reviewing research proposals. Where there is need, the MCA-HSS project will provide the necessary trainings to review boards to make them functional.  **2.3.3 PEPFAR**  PEPFAR is another major organisation that is working with the GoL to implement interventions aimed at strengthening health systems and it supports organisations that are implementing interventions namely JHPIEGO, Nursing Education Partnership Initiative (NEPI) and the Human Resources Alliance for Africa. With regard to systems strengthening PEPFAR is working on HRH, supply chain management, laboratories and infrastructure. It is also looking at health financing and there is no specific objective in the current partnership framework on health financing but GoL can ask for technical assistance in this area. Since MCA is implementing a lot of infrastructural interventions, PEPFAR has stopped implementing similar interventions.  With regard to HRH PEPFAR is supporting the GoL in building capacity of institutions that are responsible for training of health workers. The HRH support that PEPFAR is providing to the GoL has a huge bias towards nurses and, among other reasons; this is because nurses constitute a cadre that can easily be retained. PEPFAR is working towards how the training of nurses can be sustained and, through the NEPI, it is supporting activities such as providing scholarships for nurses, revising curricula for nursing education, equipping clinical skills laboratory for nurses; and renovation of student housing at health institutions. PEPFAR through NEPI is also working with professional regulatory bodies. Other interventions that are being supported by PEPFAR include continuous credentialing of nurses, strengthening of Human Resources Information System, expansion of training institutions such as NHTC and Scott. PEPFAR, through Management Sciences for Health, is also supporting the MoH in the area of supply chain management. Despite producing about 40 graduates in pharmacy there is a huge vacancy rate in the public sector. Among other things PEPFAR will support the placement of TAs at different levels to support strengthening supply chain management within the MoH. Lastly, MCA-HSS will be phasing out its programs in 2013. One of the interventions, strengthening HMIS will be taken over by PEPFAR to ensure that there is capacity at district to manage data.  **2.3.4 Ireland Aid**  Assists the GOL to attain minimum staffing requirements in 46 remotest Health Centres across the country at the recommended allocation of 5 Nurses per Health Centre. The chosen Health Centres are considered less attractive to nurses since there has been a high attrition rate experienced by the nursing cadre in these areas. The program is expected to provide funding for the salaries and retention costs for 166 nurses based at 32 government health centres, 12 CHAL and 2 from Lesotho Red Cross as stipulated in the Retention Strategy. The retention package will include once off basic furniture, airtime, provision for monthly visits transport or bus fare and monthly hardship allowance increment from M275 to M600.The intention is to have retention package details incorporated into the Nurses Terms and Conditions. The Government of Lesotho has committed itself to absorb salary and retention costs by the end of project which ends in March 2014. | |
| **3. Health Systems Strengthening Objectives** |
| * 1. HSS objectives addressed in this proposal   *→ Please describe the HSS objectives to be addressed by this proposal and explain how they relate to, and flow from, the information provided in section 2 (National Health System Context). Please demonstrate how the objectives proposed to GAVI will improve health outcomes related to immunisation, and how the objectives proposed to the Global Fund will improve health outcomes for (two or more of) HIV/AIDS, tuberculosis and malaria.* |
| ***TWO PAGES MAXIMUM***  Infant and under five mortality rates in Lesotho are quite high and the trends demonstrate these indicators have been worsening. Infant mortality rate increased from 72 deaths per 1,000 live births in 2004 to 91 deaths per 1,000 live births in 2009. Under-5 mortality also increased from 113 to 117 deaths per 1,000 live births over the same time period. The DHS suggests that these increases may be due to factors such as poverty, malnutrition and the impact of the AIDS epidemic. These increases are worrying and investments in child survival interventions are required in order to reverse this situation. This proposal, therefore, aims at contributing to the reduction in infant and under five child mortality rates by assisting the rural poor to gain access to immunizations and other services such as maternal health, HIV AIDS preventive and control programs, nutrition education and others through integrated outreach services.  **3.1 Goal of the proposal**  The **goal** of this proposal is to contribute towards the reduction of infant and under-five child mortality from 91 deaths per 1,000 live births to 24 and 117 deaths per 1,000 deaths to 37, respectively by 2016 through investments in health systems to improve and sustain immunisation coverage in Lesotho.  **3. 2 Objectives of the proposal**  This proposal has five objectives and under each objective an explanation has been provided on how these objectives will help to achieve immunisation outcomes.  **3. 2.1 To strengthen cold chain and associated logistics by making available requisite equipment and infrastructure**  As part of this proposal, 100 fridges, 100 cold boxes and 100 vaccine carriers will be purchased. With an exception of the fridges that GoL has purchased in 2012 the remaining ones are old and they breakdown quite frequently; hence GoL has planned complete overhaul of the cold chain system by 2014. The availability of functional and well maintained fridges will ensure that vaccines remain efficacious and available all the time to ensure that vaccination services are offered on an everyday basis at health facilities and during outreaches.  **3. 2.2 To improve health sector capacity of providing vaccination and other MCH services by equipping health workers with requisite skills and knowledge.**  The training of health workers at different levels will equip them with the requisite skills for them to effectively deliver immunisation services. For example the training in RED is critical if GoL will reach the large pool of unimmunised children in hard to reach sites in Lesotho. The training in cold chain maintenance is also critical as it will ensure that fridges are in working order all the time. The planned trainings are requirements by WHO.  **3. 2.3 To strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho**  The strengthening of outreach clinics conducted by the DHMTs and health centre staff and the use of helicopters to reach what are called hard to reach helicopter sites will help to reach children who are not normally reached by the routine immunisation services. Four by four vehicles will also be used to reach hard to reach populations. Reaching these hard to reach populations will help in increasing immunisation coverage and so will the payment of incentives to nurses serving hard to reach areas.  **3. 2.4 To contribute to strengthening monitoring and evaluation of health sector interventions.**  While other partners are helping to improve the HMIS, in this proposal the activities namely the distribution of cell phones to VHWs and the carrying out of an impact assessment of GAVI HSS interventions) that have been proposed are aimed at contributing to availability of quality data for the health sector which is important for program planning and decision making processes. The use of cell phones will improve submission of data to health facilities to which they are attached.  It is evident from the above discussion that each of these objectives and associated activities being proposed to GAVI address some of the major health systems constraints that have been identified in this proposal. |
| * 1. a) Narrative description of programmatic activities   → Please provide a narrative description of the goals, objectives, Service Delivery Areas (SDAs) and key activities of this proposal.   * 1. b) Logframe   *→ Please present a logframe for this proposal as Attachment 2.*   * 1. c) Evidence base and/or lessons learned   *→ Please summarise the evidence base and/or lessons learned related to the proposed activities. Please provide details of previous experience of implementing similar activities where available.* |
| **3.2 Narrative description of programmatic activities**  This proposal aims at improving the capacity of the health sector in Lesotho to effectively provide immunisation services to improve and sustain high coverage. The context in which immunisation services are provided is challenging. The terrain in Lesotho is mountainous hence very difficult to reach some of the hard to reach mountainous areas even with the utilisation of 4X4 vehicles and horses. Only about a quarter of the children targeted by the EPI in the hard to reach areas are reached with routine immunisation services; the rest of the targeted children are only reached during NIDs and outreach clinics. The health sector now operates scheduled immunisation services implying that health facilities have particular days when they offer these services. In most cases this is conducted only once a week. Many missed opportunities to vaccinate eligible children exist. The number of outreach clinics conducted by health facilities is quite limited due to shortage of health workers as available nurses have to provide other services as well. With support from GAVI this proposal will help the GoL to strengthen its health system and improve the conduct of immunisation and other MCH services to ensure that immunisation services are conducted every day, all the health facilities conduct outreach services and that helicopters and 4X4 vehicles will be available. The GoL will also ensure that appropriate human resource is available at all levels to provide these services.  **Human resources implications:** This proposal to GAVI does not aim at introducing new cadres in the health sector and this is for purposes of sustainability of the interventions being proposed. The aim is to use existing human resources in order to implement the interventions. This proposal also explores the need to support training of health workers and provide incentives and attract them to serve in hard to reach areas. The cold chain assistants will not be recruited but existing staff of the MoH at district level will be trained as cold chain assistants. At the same time the GoL is implementing a Human Resource Development and Strategic Plan which among other things aims at ensuring that there is adequate HRH at all levels of the health system and that the Retention Strategy package is implemented. Following the extensive refurbishment of all Health Centres in the country efforts are being made to provide these facilities with prescribed staff compliments.  The following sections describe the interventions that have been proposed for support from GAVI. These have been described by objective.  **Objective 3.2.1: To strengthen cold chain and associated logistics by making available requisite equipment and infrastructure**  **3.2.1.1 Procurement of fridges for the immunization program**  Health facilities which do not have fridges either do not offer immunisation services or have to carry vaccines from other health facilities. In some health facilities vaccines have been moved to the district hospital because of unavailability of fridges. There is a need to provide fridges for the immunisation program in all the health facilities that are currently providing immunisation services. The Ministry has embarked on a nationwide program of renovating the cold chain in Lesotho. In 2012 GoL purchased 100 fridges and distributed them to health facilities across the country including health facilities belonging to CHAL and LRCS. This means that in order to fill the gap in public health facilities there will be a need to purchase an additional 100 fridges. Support is therefore being requested from GAVI to purchase about 100 fridges to feel the gap in the equipping all health facilities providing immunisation in Lesotho. The purchase of these fridges will ensure that each facility has a fridge for storing vaccines. The lack of fridges for storing vaccines is one of the major factors that make it impossible for the health facilities in Lesotho to provide vaccination services every day. The purchasing of these fridges will also ensure that the vaccines are kept in good condition.  **3.2.1.2 Purchase fridge tags**  There will be a need to purchase 100 fridge tags for the fridges that will be bought with support from GAVI. This will ensure that vaccines are kept according to required temperature as recommended by WHO.  **3.2.1.3** **Rehabilitate vaccine storage structures at district level**  The renovation of district stores to improve capacity is critical because the GoL is planning the introduction of new vaccines namely pneumococcal vaccine in 2013 and rotavirus in 2014. As GoL is planning for the introduction of new vaccines within the next two years with support from GAVI and in order to improve the current scenarios where storerooms are crowded, there is a need for renovations of existing storage space. Instead of renovating storerooms in all the districts, GoL is seeking funding from GAVI to renovate storage facilities in at least 2 large districts namely Leribe and, Mohale’s Hoek because this is where there will be large impact. These districts also have a large number of health facilities and are strategically placed to serve other districts hence there will be a need to have large storerooms that will be able to keep stock for three months. The construction of vaccine storage space will also help in managing stock levels in the selected huge districts.  **3.2.1.4 Purchase of vaccine careers and cold boxes for the private sector**  As a contingency for power cuts and transportation of vaccines a request is being made to GAVI to purchase cold boxes for CHAL, LRCS and the private for profit sector which can be used to carry vaccines from the private facilities to public facilities for safe storage in case of power outages and ensuring that the potency of the vaccines is maintained. These cold boxes will also be used to order vaccines from public facilities. In addition to cold boxes it is also proposed that vaccine carriers be purchased for them to use when they are conducting vaccinations. This will ensure that vaccines, which are quite expensive, remain effective and potent.  A total of 100 cold boxes and 100 vaccine carriers will be purchased with support from GAVI and distributed to 50 private facilities which meet the criteria for producing the reports and to 30 CHAL and 20 to LRCS for undertaking outreach services. The distribution of vaccine carriers will ensure that the private for profit sector comply with regulations from the MoH for example reporting on immunisation data. It has been difficult to get data on immunisation and other services provided by the private sector because they have argued that it is their data and that they do not get any support from the public sector. The implementation of this activity will help foster collaboration with the private sector and create ownership of the program by both the private and public sectors.  **Objective 3.2.2 To improve health sector capacity of providing immunization and other MCH services by equipping health workers with requisite skills and knowledge**  **3.2.2.1 Training of cold chain assistants**  The 2012 DQS reaffirms the absence of cold chain assistants at the district level. There will be a need to train cold chain assistants at this level who will be responsible for the maintenance of fridges not only in public and CHAL facilities but also in the private for profit sector and CSOs. GoL has already embarked on the training of cold chain assistants in all the districts. There will however be a need for them to be reoriented in 2016 at the end of the GAVI HSS support in order to ensure that staff is available who can maintain fridges. The training will target MoH personnel such as drivers, health assistants and health educators at the DHMT level who will then provide support to all the health centres in the districts. The training of cold chain assistants will take one week and this training will be outsourced. A total of 24 cold chain assistants will be trained in the fourth year: two from each district and 3 from the 4 large districts of Maseru, Leribe, Mohale’s Hoek and Berea  **3.2.2.2 Training in vaccine management**  In order to avoid stock outs and ensure that vaccines are available throughout the year, two persons will be trained on vaccine management which includes planning, forecasting and managing vaccine supplies and logistics. The training in vaccine management will target 100 public health nurses at district and health centre level (10 per district) in Year 2 of support from GAVI HSS support. Those trained will have the responsibility of training other health workers at health centres.  **Objective 3.2.3 To strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho**  **3.2.3.1 Provide vaccination services in health facilities in Lesotho using a supermarket approach I**n line with the EPI Policy the MoH will introduce a supermarket way of providing services implying that MCH services will be provided on a daily basis in an integrated manner. The GoL plans to have two Nursing Assistants at health centre level one of whom will be dedicated to vaccination of children. Mothers who come from very far with their sick children will be able to access immunisation services and there will be no missed opportunities. There will be no cost attached to this as this will constitute routine provision of services.  **3.2.3.2 Carry out outreach services for hard to reach and under-served populations**  Over the period of support from GAVI, the GoL will institutionalise the conduct of outreach clinics by providing logistical support to staff from health facilities to do this. Six districts with low vaccination coverage will be targeted with this intervention. In each district the DHMT will identify 5 health facilities where vaccination coverage is low. Health centre staff will be supported in terms of allowances and fuel for them to be able to conduct outreach clinics. Outreaches will be carried out once a month by districts in the selected 5 low performing health facilities in each district using 4X4s.  **3.2.3.3 Launch the mobile immunisation teams in low performing districts**  In 3.2.3.2 6 districts which are performing poorly with regard to immunisation coverage have been targeted with intensification of MCH outreach services including immunisation. In addition to outreach clinics the MoH will also launch the provision of MCH services including immunisation through the use of mobile teams to supplement routine and outreach services. The mobile teams have been extensively used during the NIDs and the turn up of mothers has been quite high. These mobile teams will be from the district level and will be the responsibility of the DHMT. The mobile team in each district will go out once a week to provide services to communities. In this proposal funding is being requested from GAVI to support the allowances for these mobile teams as well as provision of fuel for the vehicles. This activity will help to improve immunization services in low performing districts. Where possible they will move from house to house and will target the areas within the districts where coverage is low. In each of the 6 target districts mobile immunisation teams will go out once a month to provide services.  **3.2.3.4 Construct Health Posts using low cost materials**  There are a number of health posts that have been either constructed by the communities with support from development partners such as the Canadian International Immunisation Program where among other things immunisation services are being provided. Immunisation and other MCH services are also offered at community level using roundavels provided by the chief or other community members. These roundavels are usually small. Considering the massive social mobilisation that has been embarked on by the EPI with funding from GoL the turn up of mothers with under five children, these roundavels will be small and not accommodate the large numbers of people expected and the wide range of services that will be offered. These outreach clinics will generally offer all the MCH services including immunisation. The PHC revitalisation encourages involvement of communities in health care. The model health post as recommended by the MoH is that it should have a room where MCH services will be delivered and 2 other rooms where nurses providing services can stay. They can stay there overnight or even a week in order to ensure that all children are vaccinated. Members of the community will be mobilised to provide sand, bricks and other local building materials that they can provide. The funding from GAVI will be used to purchase iron sheets, paints, cement, planks, nails and other building materials requiring money. In addition to this funding will be used to pay labour charges for persons who will be hired to construct the health post. Three health posts will be constructed in each of the 6 districts where vaccination coverage is low.  **3.2.3.5 Purchase of 4X4 vehicles for the districts and headquarters**  The Lesotho Health Policy, the EPI Policy and the cMYP all call for resuscitation of outreach services. The introduction of regular MCH outreach services at district level managed by the DHMT will overstretch activities at that level and the available transport will not be adequate. With funding from GAVI a vehicle will be purchased for each district to cater for increased level of services; hence a total of 6 4X4 vehicles will be purchased for the 6 districts with low immunisation coverage. Additional vehicle will be purchased for the national EPI office s to enable the conduct of supportive supervision to lower level facilities.  **3.2.3.6 Provide MCH services in hard to reach helicopter populations**  Lesotho is a mountainous country and there are sites in each district including in Maseru District which cannot be reached by 4X4 vehicles or horses but only by helicopter as shown in this photograph in Figure 5.  **Figure 5: A helicopter about to land in a hard to reach area**  Sekolopata 049  There are approximately 133 hard to reach helicopter sites in Lesotho: namely those sites that can only be reached by helicopter and not any other means of transport. These helicopter sites are as follows: Buthe-buthe (4), Mokhotlong (17), Leribe (10), St. James (19), Qacha's Nek (40), St. Josephs (11), Tebellong (4), Berea (2), Maseru (16) and Paray (10). The helicopter sites are only reached during the supplementary immunisation activities (SIAs). The routine immunisation services only reach 25% of the population. The payment of allowances for staff involved in this initiative will be borne by the GoL and in-country partners. These helicopter sites will be visited 4 times a year. GAVI is requested to sponsor 3 visits per year for 4 years while GoL and in-country partners will provide resources for one quarter per year.  **3.2.3.7. Conduct supportive supervision at district, health centre and community levels**  Currently there are challenges with regard to conducting supportive supervision at all levels as highlighted in the Hib Post Introduction Evaluation report[[16]](#footnote-17). While the central level conducts some supportive visits to the districts these are not conducted frequently. It is important that the central level conducts integrated supportive supervision to the districts and at the same time mentor members of the DHMT to adequately support health centre and community initiatives. The infrequent supervision of district and lower level facilities is mainly due to lack of funding for these initiatives. Funding is therefore being requested from GAVI to support the conduct of supportive supervision to the districts for a period of 4 years of support from GAVI. This will be evaluated in order to determine the impact on service delivery and coverage and GoL and in-country stakeholders will be encouraged to sustain this initiative.  **3.2.4 To contribute to strengthening monitoring and evaluation of health sector performance**  **3.2.4.1 Purchase cell phones for village health workers**  VHWs deal with a wide range of issues at community level that need to be communicated to health facilities to which they are attached. Most of the VHWs are resident in remote rural areas. They need to report outbreaks of notifiable diseases such as measles; report on emergencies (e.g. pregnancy complications) and timely reporting of community level data (such as numbers of unimmunised children). The health facilities also need to get in touch with the VHWs for example for them to tell patients to report to the facility immediately. The coverage of mobile phones network is quite good in Lesotho and there is a need to utilise such technology for communication. About 80% of the Health Centres have already been provided with cell phones. It is suggested that, with support from GAVI, cell phones will be purchased for 1,000 VHWs to report any challenges they are encountering in the community to the health facility timely. VHWs also experience difficulties in accessing the facilities to which they are attached; hence they can use the cell phones to report community level data which should be integrated with facility data. The 2010 Lesotho HSA reports that inadequate access to transportation and communication infrastructure impedes VHW’s ability to transmit data timely to health facility. Airtime for these village health workers will not be given as they will be connected to a toll free number at the DHMT’s office.  **3.2.4.2 Impact assessment of GAVI funded HSS interventions**  GAVI will be investing a substantial amount of resources to improve health systems that will impact on immunisation coverage. In 2016 there will be a need to do a comprehensive evaluation of the impact of these interventions on immunisation coverage and the wider health services delivery in Lesotho. The data generated through this impact study will be used to inform GoL on future health system investments. GAVI will also know the effectiveness of the interventions it supported.  **3.2b. Logframe**  The logframe is attached.  **3.2c. Evidence-base for the interventions**   * **Objective 1:** This objective aims at ensuring that within the health system including the private sector there is adequate cold chain equipment such as fridges, cold boxes, vaccine carriers and storage space for vaccines. Vaccines are very sensitive to heat and freezing and therefore they must be kept cold from the time they are manufactured to the time they are used. This is well documented by WHO[[17]](#footnote-18). In Lesotho there is a shortage of fridges, because the fridges that are available now are old and need to be replaced in order to ensure availability of an effective cold chain. The rehabilitation of district EPI storage will ensure availability of adequate space for storing vaccines. For fridges to work well there is a need for them to be maintained properly by someone who has been trained to do so and this is a recommended international practice. Currently the EPI program in Lesotho is training cold chain assistants who will need to be reoriented towards the end of the GAVI HSS grant in 2016. * **Objective 2**: This objective aims at providing the necessary knowledge and skills to health workers for them to effectively deliver services. The trainings in vaccine management and the cold chain assistants are all recommended by WHO as necessary to improve immunisation coverage. WHO designed these courses based on evidence and other countries in the region which have conducted these trainings of for their health workers in the RED strategy have improved and sustained their immunisation coverage. As has been mentioned earlier there has been a lack of training for cold chain assistants in Lesotho and it is only now that GoL is funding such trainings. After 3 years there will be a need for reorientation of cold chain assistants. * **Objective 3:** This objective is on how populations which are hard to reach can best be reached. There is evidence that the low immunisation coverage in Lesotho is partly due to the fact that immunisation services are scheduled and outreaches are very limited and that some sites are unreachable with even 4X4 vehicles. The helicopters, even though expensive, are the only way of reaching the hard to reach helicopter site populations. Lesotho has at times used these helicopters and managed to reach these populations[[18]](#footnote-19). WHO recommends use of outreach clinics in order to bring services closer to the people and the interventions suggested under this objective have been proved effective. Since there are more than 133 helicopter sites in Lesotho visiting these sites using a helicopter at least four times a year is recommended even in the Global Immunisation Vision and Strategy 2006-2015[[19]](#footnote-20). This objective also looks at strengthening supportive supervision as studies have generally demonstrated that this helps in improving vaccination coverage. For example in a study by Babu 2011 et al it has been demonstrated that supportive supervision improves immunization coverage and also serves as an efficient tool to strengthen the local health system[[20]](#footnote-21). Conducting a DQS is also recommended by WHO as a tool for improving data quality[[21]](#footnote-22). * .**Objective 4:** This objective is about monitoring and evaluation. Among other things this objective will contribute in strengthening the monitoring and evaluation system in Lesotho through making available cell phones to VHWs and conducting an impact assessment of the GAVI funded HSS interventions in Lesotho. VHWs have the potential of systematically collecting community level data including on immunisation. They however require a supportive environment. Some of the VHWs have not been trained and they will be trained using resources from elsewhere but with support from GAVI they will be given cell phones for data reporting. |
| * 1. Main Beneficiaries   *→ Please describe how the proposed activities under each objective contribute to equity (e.g., gender, geographic, economic), reach the unreached, underserved and marginalised populations with health services, and benefit the poorest and other disadvantaged populations, including any measures to reduce stigma and discrimination that these populations may face.* |
| ***TWO PAGES MAXIMUM***  The main beneficiaries of the interventions that will be supported by GAVI are children under the age of 5 years, pregnant women and other segments of the population since this proposal aims at integration[[22]](#footnote-23) of service delivery. Secondary beneficiaries will be MoH headquarters, District hospitals and health centre staff.  **To strengthen cold chain and associated logistics by making available requisite equipment and infrastructure**  Thisobjective isabout making available cold chain equipment in both public and private health facilities and providing training to cold chain assistants. The activities under this objective are all important because they will ensure the availability of well maintained and serviced cold chain equipment which will ensure that efficacious vaccines are available in all health facilities belonging to the MoH and CHAL facilities and some selected private for profit facilities. This objective also involves the rehabilitation of district storage space for vaccines which will ensure that there is adequate space for vaccines especially with the planned introduction of new vaccines in 2013 and 2014. The provision of cold chain equipment and its maintenance and the rehabilitation of district storage capacity will ensure that all children regardless of *socio-economic status* and *gender* will be able to access MCH services including immunisation. Geographical equity will also be ensured because all facilities including those in very hard to reach sites will be provided with requisite equipment including ensuring that there are cold chain assistants maintaining the fridges. All population groups such as the poor, unreached and underserved (such as those residing in mountainous areas) will be reached with these interventions.   1. **To improve health sector capacity of providing vaccination and other MCH services by equipping health workers with requisite skills and knowledge.**   This will ensure there are adequate knowledge and skills which can effectively provide MCH services including immunisation with a special focus on outreaches and reaching hard to reach sites such as in mountainous areas. Such trainings as suggested in this proposal are also recommended by the WHO. While some interventions will be implemented nationwide others will be restricted to specific districts for example to 6 districts which have low immunisation coverage. This will ensure that among other beneficiaries they also reach hard to reach populations. The major beneficiaries will be health workers who will be trained.   1. **To strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho**   The major challenge in Lesotho is that the country is mountainous and there are certain sites that cannot be reached even with the use of 4X4 vehicles. Some of the sites are reached using horses while others are reached with the use of helicopters. The conduct of outreach services is limited. Under this objective several interventions have been proposed to reach hard to reach populations which normally do not receive routine immunisation services. This is why a suggestion has been made to purchase 4x4 vehicles for supportive supervision and conducting outreach services. The use of helicopters has also been suggested because that is the only way of reaching the 133 sites which cannot be reached by any other means but helicopters. The major beneficiaries of this intervention will be the hard to reach populations of Lesotho.   1. **To contribute to strengthening monitoring and evaluation of health sector interventions.**   Under this objective the aim is to ensure that, among other things, quality data is available for making decisions at point of source. The data at both national and district level will be used to monitor trends in immunisation coverage and where immunisation coverage is low decisions will have to be made on innovative approaches that can be used to reach a higher number of children. The DQS will be used to monitor data quality. This objective is to strengthening community systems of data collection and analysis particularly promoting the use of cell phones among VHWs to submit community level data. The major beneficiaries for this proposal are the health workers at all levels of the health system as data will be available to guide interventions. |
| **4. Performance Monitoring and Evaluation** |
| 4.1 National Monitoring and Evaluation (M&E) Plan and Performance Framework  *→ Please present your National M&E Plan as Attachment 3, and the Performance Framework for this proposal (using prescribed te3mplate) as Attachment 4.* |
| 4.2 a) M&E arrangements  *→ Please describe how the Performance Framework in this proposal uses existing national indicators, data collection tools and reporting systems.*  4.2 b) Strengthening M&E systems  *→ Please describe the M&E systems strengthening activities to be funded through this proposal.* |
| ***THREE PAGES MAXIMUM***  **4.1a. National Monitoring and Evaluation (M&E) Plan and Performance Framework**  The National Monitoring and Evaluation Plan for the health sector covers the period 2013-2017 and it is attached to this proposal.  **4.2a. M & E arrangements**  Currently the EPI program has a parallel system for data collection just like the national Tuberculosis and HIV and AIDS programs. The program has always been verticalised and it is only now that initiatives are being discussed to integrate monitoring and evaluation systems. In all the service delivery points the EPI has made available tally sheets. These tally sheets are filled as children are being vaccinated. At the end of each month the officer in charge of a health facility compiles a summary report for the health centre. This summary report also contains other MCH data as well. This report has 5 sheets and one is kept at the health centre while the rest are distributed as follows: EPI headquarters, DHMT and CHAL. At EPI headquarters the data is entered and analysed using software provided by WHO. This system will be used until efforts to have an HMIS system that addresses the needs of the health system have been finalised.  A Health Management Information System is also functional in Lesotho. Data is collected at health facility level and sent to the districts where it is aggregated by the DHMT and sent to MoH headquarters. While data from the districts is electronically transmitted the data from the health centres to the districts is still paper based and the process of making this electronic is underway with support from MCA. There are challenges with regard to the effectiveness of the HMIS: data quality is compromised by lack of timeliness and completeness. At district level quarterly reflection meetings are held to discuss their quarterly report and a copy of this is sent to MoH. The M and E Unit in the MoH headquarters, based on reports from the districts and HMIS data, produces a report and organises a quarterly meeting for all stakeholders to discuss the national quarterly report. Every year there is an annual joint review meeting during which progress over the year is discussed by all stakeholders. For support from GAVI the existing M&E system will be followed. Until the data collection and analysis processes are integrated, all immunisation specific activities will be captured using the EPI system as described above. All the indicators to be used in this support from GAVI will be in line with the M&E framework. All data will be disaggregated.  **4.2b. Strengthening M & E systems**  Efforts are already underway to strengthen the M&E system in the health sector by MCA-HSS and when this project phases out, PEPFAR plans to take over some aspects of the work that MCA-HSS has been doing. This proposal aims at strengthening community data collection systems. At community level there are structures such as chiefs, community and municipal councillors and VHWs. Chiefs and municipal councils are non-health and hence they need to be oriented into the field of health, they will be oriented especially on issues relating to the RED strategy. In addition to this the emphasis during these sensitisation meetings will be for these structures to support VHWs. In addition to the orientation on the RED strategy the chiefs and councillors will also be sensitised on the use of the village register which is an important data collection initiative. This initiative is already underway and being funded by the GoL. The emphasis will be on the need to ensure that these registers are filled and how these data are useful at village level for making health decisions at that level and that such data should be submitted to health facilities to which the VHWs are attached using cell phones wherever possible. |

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| **5. Gap Analysis, Detailed Work Plan And Budget** |
| 5.1 Detailed work plan and budget  *→ Please present a detailed work plan and budget as Attachment 5.* |
| 5.2 Financial gap analysis  *→ Please present a financial gap analysis (and counterpart financing table for Global Fund applicants).* |
| 5.3 Supporting information to explain and justify the proposed budget  *→ Please include additional information on the following:*   * *Efforts to ensure Value For Money* * *Major expenditure items* * *Human Resources costs and other significant institutional costs* |
| ***TWO PAGES MAXIMUM***  **5.1 Detailed workplan and budget**  The detailed workplan and budget has been attached.  **5.2 Financial gap analysis**  This is only required for Global Fund proposals as per guidelines. There is however a comprehensive financial gap analysis in the cMYP for Lesotho. |

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| **6. Implementation Arrangements, Capacities, and Programme Oversight** |
| **6.1 a) Lead Implementers (LI)**  *-> For each LI, please list the objectives they will be for responsible to implement. Please describe what lead to their selection, including their technical, managerial and financial capacities to manage and oversee implementation of objectives, including previous experience managing Global Fund and/or GAVI grants. Describe any challenges that could affect performance (refer to any current assessments of capacity if available) as well as mitigation strategies to address this.*  *🡪 Please copy and paste the tables below if there are more than two Lead Implementers (LI). Where a LI will act for more than one objective, list all objectives*. |

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| **Lead Implementer:** | Ministry of Health, Government of Lesotho |
| **Objective(s):** | 1. To strengthen cold chain and associated logistics by making available requisite equipment and infrastructure. 2. To improve health sector capacity of providing vaccination and other MCH services by equipping health workers with requisite skills and knowledge. 3. To strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho. 4. To contribute to strengthening monitoring and evaluation of health sector interventions. |
| *🡪 Description of the Lead Implementer’s technical, managerial and financial capabilities.* | |
| ***HALF-PAGE MAXIMUM***  The lead implementer of this proposal is the MoH of the GoL and within the Ministry the Department of Planning and Statistics will be responsible for leading the implementation process. The EPI Unit within the Family Health Division has the technical capacity to implement immunisation specific activities such as the training of health workers in vaccine management. Specific units or departments within the MoH such as Department of Human Resource, Procurement Unit and the PAU will perform specific responsibilities related to this proposal. Technical departments and managerial capacity exist in the MoH to implement this. As will be discussed later there is also financial management capacity within the Ministry to implement this proposal. The MoH Finance Department has handled funds in excess of US$100,000,000. In terms of auditing the GAVI funds the GoL Auditor General will be responsible for auditing the accounts as is the case with other government departments and Ministries. | |

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| **Lead Implementer:** | CHAL |
| **Objective(s):** | 1. To strengthen cold chain and associated logistics by making available requisite equipment and infrastructure. 2. To improve health sector capacity of providing vaccination and other MCH services by equipping health workers with requisite skills and knowledge. 3. To strengthen MCH interventions aimed at reaching hard to reach populations in Lesotho. 4. To contribute to strengthening monitoring and evaluation of health sector interventions. |
| *🡪 Description of the Lead Implementer’s technical, managerial and financial capabilities.* | |
| ***HALF-PAGE MAXIMUM***  CHAL is a major partner of the MoH in health services delivery and its facilities are mostly found in remote rural areas of Lesotho. It owns about a third of the health facilities in Lesotho. Just like the MoH it has the capacity to effectively deliver immunisation and other health services. There is an MoU with the GoL on health services delivery as has been described earlier. While the funds will be managed by MoH CHAL will benefit in terms of getting the fridges, the vaccine carriers and cold boxes as well as fuel and allowances for the hard to reach areas. Its staff will also participate in all the trainings that have been planned. The activities as contained in this proposal will be aimed at smooth delivery of immunisation services by all providers of these services. | |

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| **6.1 b) Coordination between and among implementers** |
| *🡪 Please describe how coordination will be achieved (a) between multiple Lead Implementers, if there is more than one nominated for the proposal; and (b) between each nominated Lead Implementer for the proposal and its respective Sub-Implementers.* |
| ***ONE PAGE MAXIMUM***  There is a MoU between CHAL and MoH and then another MoU between MoH and LRCS. Both the LRCS and CHAL get subvention from GoL to enable them provide services (including immunisation) free of charge at health centre level. The MoUs also enable them to access funds from MoH Projects Accounting Unit (PAU) to implement defined workplans. When GAVI funds are made available the existing procedures will be followed in disbursement of funds to LRCS and CHAL. In addition to these MoUs, CHAL, LRCS and MoH are members of the EPI Technical Working Group. Progress in the implementation of the GAVI funded HSS interventions will be shared within the TWG which will report to the ICC. At the national level, the ICC will oversee the implementation of the GAVI HSS interventions. As has been said the ICC meets quarterly and special meetings of this committee can always be called to deliberate on special issues on immunisation. The ICC is an advisory committee to the MoH and to EPI on policy issues and its specific responsibilities have been highlighted earlier on. Therefore with regard to coordination, mechanisms already exist: the MoUs, the TWG and the ICC. |

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| **6.1 c) Sub-Implementers *(Not Applicable for GAVI applicants)*** | |
| 1. Will other departments, institutions or bodies be involved in implementation as Sub-Implementers? | *🡪 go to section 6.1 c) (iii) and 6.1 c) (iv)* |
| *🡪 go to section 6.1 c) (ii)* |
| (ii) If no, why not? | |
| ***HALF-PAGE MAXIMUM*** | |
| (iii) List the identified Sub-Implementers and, for each Sub-Implementer, describe:   * The roles and responsibilities to be fulfilled; * Past implementation experience; * Geographic coverage and a summary of the technical scope; * Challenges that could affect performance and mitigation strategies to address these challenges. | |
| ***TWO PAGES MAXIMUM*** | |
| iv) If the private sector and/or civil society are not involved as Sub-Implementers or only involved in a limited way, explain why. | |
| ***HALF-PAGE MAXIMUM***  The thrust of this proposal is to ensure that outreach services are conducted and that hard to reach populations especially the mountainous populations of Lesotho are reached with MCH services. The private for profit sector in most of these remote rural areas is not available as they are mostly in urban areas. The only way the private for profit sector will be involved in the implementation of this proposal is that they will be given vaccine carriers and cold boxes and they will continue getting the vaccines from public health services. They will be expected to submit data to MoH. On the other hand the involvement of CSOs in immunisation services delivery is somehow limited. LRCS has 4 facilities and just like CHAL will benefit from the trainings and they will be expected to continue delivering immunisation services. | |

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| **6.1 d)** **Strengthening implementation capacity**  (a) Applicants are encouraged to include a funding request for technical assistance to achieve strengthened capacity and high quality services, supported by a summary of a technical assistance (TA) plan. In the table below, please provide a summary of the TA plan.  *🡪 Please refer to the* [*Strengthening Implementation Capacity information note for further background and detail*](http://www.theglobalfund.org/en/application/infonotes/). | | | | |
| Management and/or technical assistance **objective** | Management and/or technical assistance **activity** | **Intended beneficiary** of management and/or technical assistance | Estimated timeline | Estimated cost  *🡪 same as proposal currency* |
| To improve data collection, analysis and utilisation at all levels of health care. | Recruitment of Technical Assistant with an M & E background | The MoH will be the major beneficiary of this technical assistance as data collection, analysis and utilisation will be improved. The continued mentoring of data entry clerks and health workers at health centre and district level will significantly improve data quality as well. | This intervention will be implemented over a period of 24 months. By that time persons involved in data management at all levels would have been capacitated. | The cost of the TA has been estimated at .017% of the total cost of implementing the interventions as detailed in this proposal. |
| To improve supply chain management at all levels | Recruitment of TA in supply chain management | The MoH will be the major beneficiary. The MoH experiences quite a lot of challenges in terms of quantification, forecasting and management of pharmaceuticals including vaccines.recasting and management of pharmaceuticals including vaccinesllenges in terms of quantification, f improve data quality as wel | This intervention will be implemented over a period of 24 months. By that time persons involved in quantification, forecasting and management of pharmaceuticals at all levels would have been capacitated |
| (b) Describe the process used to identify the assistance needs listed in the above table. | | | | |
| ***HALF-PAGE MAXIMUM***  A lot of investments have been made to improve Lesotho’s HMIS as well as supply chain management. Development partners such as the MCA- HSS project have assisted in the recruitment and deployment of staff to manage the HMIS at different levels. There have been limited achievements in terms of improving data quality as well as managing stock levels of pharmaceuticals and related products. As part of this project a private firm (TA) will be hired for a period of two years to mentor health workforce particularly that which handles data in their respective workplaces to appreciate the importance of data and the need to use it for purposes of decision making at the point of source. The same things will be done regarding pharmaceuticals. This mentorship program carried out at the workplace will be aimed at ensuring that people acquire knowledge, skills and interest in data management as well as management of pharmaceutical and related products. Stakeholders identified the need for such assistance. | | | | |
| (c) If no request for technical assistance is included in the proposal, provide a justification below. | | | | |
| ***HALF-PAGE MAXIMUM*** | | | | |

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| **6.2 Financial management arrangements**   * *Please describe:*  1. *The proposed financial management mechanism for this proposal;* 2. *The proposed processes and systems for ensuring effective financial management of this proposal, including the organisation and capacity of the finance department and the proposed arrangements for planning and budgeting, treasury (fund management and disbursement), accounting and financial reporting, internal control and internal audit, procurement, asset management and external audit.* 3. *Technical Assistance (TA) proposed to strengthen the financial management capacities in order to fulfil the above functions.* |
| ***TWO PAGES MAXIMUM***  **6.2a. Proposed financial management mechanisms for this proposal**  Once this proposal is approved by the GAVI, an MoU will be signed between GAVI and GoL. This MoU will state the conditions of implementing the proposal. The Ministry of Finance (MoF) will open a foreign denominated account (FCDA) at the Central Bank of Lesotho as is the case with all donor funds. The MoF will also open another account for the MoH at one of the commercial banks in Lesotho. The funds in the FCDA will be transferred to the local account held in Maloti (Lesotho Currency) at the local bank when need arises. The Project Accounting Unit (PAU) at the MoH will be responsible for managing the GAVI funds at both the Central Bank and the local bank. All the transactions pertaining to these accounts will be done by PAU.  **6.2b. Proposed processes and systems to ensure effective financial management**  As has been mentioned above the GAVI funds meant for this proposal will be managed by the PAU which is within the MoH. It has the capacity of managing large amounts of funds to the tune of more than US$100 million per annum. The accounting staffs in this Unit are employed on a temporary basis and that over the years the Unit has been managing funds from different donors. Some of these projects have come to an end and accounting staff have been laid off. In order to manage the GAVI funds effectively there will be a need to recruit an Accountant who will not only work on the managing GAVI funds but will also be involved in all accounting work in the Unit including the production of financial reports. He or she will be the focal person for issues to do with GAVI funds. The Accountant will cost about US$2000 per month inclusive of gratuity.  The account at the commercial bank will be used for all transactions concerning the GAVI funded HSS project. The authorisation of any expenditure on this project will be done by the Director of Planning and Statistics and the Head of Family Health Division. Once the payments have been authorised they will be sent to PAU for payments None of the members of the PAU is a signatory on the account: signatories on this account, as is the case with all other MoH accounts, will be senior officials in the MoH namely the Principal Secretary, the Director General, The Director of Planning and Statistics, the Director of PHC and Director of Finance. The PAU will be accountable for all the funds. In accordance with financial regulations in the GoL each donor is provided a financial report at the end of the financial year. In addition to providing this to GAVI there will also be a consolidated financial report covering all the funds handled by the PAU.  The Auditor General of the GoL shall arrange the auditing of the GAVI funds and normally this exercise is done by private auditors hired by the Auditor General. The private auditors hired have the responsibility of producing audit reports which will be shared with GAVI. The internal auditing of accounts is only being introduced now in the public sector. Once these become fully functional internal audit reports will also be shared with GAVI. In terms of procurement the Procurement Unit handles all the procurement activities in the MoH following established governments rules and regulations. However there is also flexibility in case donors would want to add procedures of their own. It should be mentioned however that while PAU is currently managing these funds in the MoH and other government Ministries and Departments, currently GoL has introduced the position of Finance Managers who will be responsible for managing these funds. Government procedures take long and these GAVI funds will be managed by PAU until such a time when the positions of Finance Managers become fully operational and fully integrated with PAU.  **6.2c. Technical assistance**  Currently there is adequate capacity to manage the funds that GAVI will provide to the MoH. This will not be the first time that the MoH has received funding from GAVI and the management of funds has always been done through the PAU. However, while the PAU has staff there will be a need to hire an additional member of staff to manage GAVI funds and this will be the focal person for all GAVI accounting activities. There will therefore be no need for technical assistance per se but an additional member of staff in the PAU. The person who will be recruited will eventually be taken over by the GoL as a full time employee. |
| **6.3 Governance and oversight arrangements**   * *Please describe:*  1. *The committee(s) responsible for the governance of the HSS support in the country (this should include the roles of the HSCC and the CCM, including how the roles of these bodies are aligned with Global Fund or GAVI requirements);* 2. *The mechanisms for coordinating the proposed HSS support with other health system strengthening activities and programs;* 3. *Plans (where appropriate) to strengthen governance and oversight;* 4. *Technical Assistance (TA) requirements to enhance the above governance processes.* |
| ***ONE PAGE MAXIMUM***  **6.3a. Committee responsible for Governance of HSS support in Lesotho**  The HSCC has not yet been established in Lesotho and the highest level where immunisation is discussed is the ICC. The ICC was established in Lesotho in 1996 and is a standalone committee headed by the Minister of Health. Membership of this committee is drawn from the Ministry of Health, Maseru City Council, Irish Aid, Rotary Club International, WHO, UNICEF, Lesotho Red Cross and CHAL. Most of the Departments from MoH are represented in this committee including PHC and Family Health Division under which EPI falls. This committee meets quarterly and special meetings of this committee can always be called to deliberate on special issues. The ICC is an advisory committee to the MoH as well as to EPI on policy issues and its specific responsibility are as follows: (i) To coordinate and foster partnerships which enhances or facilitates the sharing of resources and technical inputs; (ii) To advocate for EPI at higher political levels in Lesotho and at a global level with the aim of improving program performance; (iii) To review and endorse EPI plans and support the program by mobilising resources at national and internal level; (iv) To review and monitor program performance of the EPI through quarterly meetings and also ensure that routine reports are produced; (v) To review and monitor the use of funds and other resources together with the EPI Unit and provide feedback to donors and communities based on need.  **6.3b. Mechanisms for coordinating GAVI HSS support**  There are a number of organisations in Lesotho which are contributing to the strengthening of health systems and these include MCA-HSS, Global Fund Country Coordinating Office and PEPFAR. These are not members of the ICC. The MoH will broaden the membership of the ICC in order to include the major partners implementing or supporting HSS initiatives in Lesotho. All the partners will be required to provide progress in implementing their HSS interventions at the Joint MoH and donor quarterly meetings. It is also important to note that all these partners are working with the MoH and they were consulted during the process of developing this proposal. At a lower level than the ICC there is also an HSS TWG chaired by the Department of Planning and Statistics where HSS issues are also discussed. The overall implementation of the GAVI HSS support will be the responsibility of the Department of Planning and the day to day activities will be done by the EPI Unit and other relevant Departments in the MoH for example Department of Human Resources and the Department of Nursing. The Department of Planning and Statistics will be responsible for reporting of the GAVI funded activities together with other health sector interventions.  **6.3c. Plans to strengthen governance and oversight**  As has been mentioned in 6.3a the membership of ICC has been limited to those organisations that have a role to play directly in the delivery or financing of immunisation specific services. This proposal does not only look at the immunisation but the wider health systems interventions. Since the HSCC does not exist in Lesotho, the MoH plans to widen its membership to even include organisations that are implementing or funding HSS interventions such as the Global Fund Coordinating Office in Lesotho and PEPFFAR. Once this proposal is funded the ICC will be reconstituted and its ToRs modified to reflect broader membership.  **6.3d. Technical assistance requirements to enhance Governance**  The ICC is immunisation specific but its ToRs as has been mentioned will be modified in order to allow broader membership specifically targeting the organisations involved in HSS interventions in Lesotho. With changes in membership the ICC will be able to oversee the GAVI HSS interventions as contained in this proposal. However, there is still a need to establish a Health Sector Coordination Committee as is the case in other countries. Such a committee is high level and oversees the entire health sector and membership is quite wide. Technical assistance will be required to establish and operationalise the HSCC in Lesotho including the development of the ToRs. It will be critical to explain why this higher level committee is required. In country development partners particularly WHO and UNICEF will be requested to provide technical assistance in the creation and operationalisation of this committee within the period of GAVI support. At that time the HSCC will take over the overseeing of GAVI HSS interventions. |

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| **7. Risks and Unintended Consequences** | |
| **7.1 Major risks**   * *Please describe any major “internal” risks (within the control of those managing the implementation of the HSS support) and “external” risks (beyond the control of those managing the implementation of the HSS support) that might negatively affect the implementation and performance of the proposed activities.* | |
| **Risks** | **Mitigating strategies** |
| A weak health management information system including lack of utilisation of data at all levels | * MCA-HSS is addressing some of these problems. * A TA will be hired as part of this proposal to help address these issues |
| Shortage of human resources for health at all levels | * A Human resource development strategic plan has been developed and is being implemented. * A Retention Strategy for the Human Resources for Health in Lesotho has also been developed and its implementation has started with nursing personnel in hard to reach areas. |
| Stock-outs of pharmaceuticals and other products including vaccines | * A TA will be hired as part of this proposal to address issues to do with supply chain management. |
| Inadequate funding of the health sector | * GoL continues mobilising resources for the health sector. * Donors will continue supporting the GoL in addressing health systems challenges. |
| * 1. **Unintended consequences** * *Please describe any possible unintended consequences that might occur as a result of implementing the proposal and the strategies to mitigate these unintended consequences.* | |
| ***HALF-PAGE MAXIMUM***  One of the major challenges within Lesotho’s health sector is the shortage of human resource especially at health centre level to provide services. This is why services such as immunisation services are provided in a scheduled manner. The lack of human resources has also affected the conduct of outreach services. In this proposal a call is being made to intensify the provision of MCH services including immunisation services: that these services should be provided everyday and that health facilities should provide integrated outreach services. Carrying out these activities will have a big strain on available human resources. However GoL plans to recruit additional nurses for each health centre to attain the prescribed minimum requirement (of 5 per facility) in the nearest future and this will address the human resource constraints that the country has. In the mean time, to kick start the process, GOL will give priority to hard to reach areas. With the intensification of the provision of outreach services again there will be a strain on vehicles available in the districts. To address this issue one vehicle will be purchased for each district to address transport challenges that may arise. | |

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| **Mandatory Attachments**  *→ Please tick when the attachment is included* | | |
| *No.* | *Attachment* | ***✓*** |
| 1 | National health policy | ***✓*** |
| 2 | Logframe | ***✓*** |
| 3 | National M&E Plan | ***✓*** |
| 4 | Performance Framework | ***✓*** |
| 5 | Financial gap analysis, detailed work plan and detailed budget | ***✓*** |

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| **Optional Attachments**  *→ Please tick when the attachment is included* | | |
| *No.* | *Attachment* | ***✓*** |
| 6 | cMYP 2012 -2016 |  |
| 7 | Lesotho Health Systems Assessment 2010 |  |
| 8 | Lesotho National Strategic Development Plan 2011/12-2015/16 |  |
| 9 | Lesotho DQS |  |
| 10 | PIE Report 2010 |  |
| 11 | EVM Report September 2011 |  |
|  | PHC Revitalization Strategic Plan 2011-2017 |  |
|  | Lesotho Integrated Measles Campaign Report 2010 |  |
|  | ICC Minutes |  |
|  | Health Strategic Plan |  |
|  | HMIS Strategy |  |
|  | HRH Strategic Plan 2005-2025 |  |
|  | Retention Strategy |  |
|  | PHC Revitalization Plan |  |

1. This is a 10 year plan and expires in 2022. [↑](#footnote-ref-2)
2. These are targets for 2015 as detailed in the National Strategic Development Plan 2011/12-2015/2016.

   3. RED: a strategy aimed at planning, managing and monitoring health services that will improve immunization coverage and impact. [↑](#footnote-ref-3)
3. UN Population Division, Revision 2010 [↑](#footnote-ref-4)
4. [↑](#footnote-ref-5)
5. Ministry of Health and Social Welfare. (2010). *Lesotho health system assessment 2010.* Maseru: Ministry of Health and Social Welfare. [↑](#footnote-ref-6)
6. Ministry of Health and Social Welfare. (2010). *Lesotho health system assessment 2010.* Maseru: Ministry of Health and Social Welfare. [↑](#footnote-ref-7)
7. Ministry of Health (2011). *National health policy*. Maseru: Ministry of Health and Social Welfare [↑](#footnote-ref-8)
8. Ministry of Health and Social Welfare. (2010). *Lesotho health system assessment 2010.* Maseru: Ministry of Health and Social Welfare. [↑](#footnote-ref-9)
9. Ministry of Health. (2005). *Human resource strategic plan 2005-2025*. Maseru: Ministry of Health. [↑](#footnote-ref-10)
10. Ministry of Health. (2012). *National Strategic Development Plan 2011/12-2015/16*. Maseru: Ministry of Health. [↑](#footnote-ref-11)
11. The strategic plan is still in draft form but it was felt that it was important to highlight the contents of the Draft Plan as it is about to be finalised. [↑](#footnote-ref-12)
12. Supermarket Approach: providing integrated services on daily basis including immunizations to avoid missed opportunities [↑](#footnote-ref-13)
13. Ministry of Health. (2011) *Effective vaccine management: assessments, recommendations and improvement plans*: Maseru: Ministry of Health. [↑](#footnote-ref-14)
14. Ministry of Health. (2012). *Lesotho in-country RED DQS training and DQS 19th March-3rd April 2012.* Maseru: Ministry of Health. [↑](#footnote-ref-15)
15. Ministry of Health and Social Welfare. (2010). *Lesotho health system assessment 2010.* Maseru: Ministry of Health and Social Welfare. [↑](#footnote-ref-16)
16. Ministry of Health. (2010). *Report on Hib post introduction evaluation in Lesotho*. Maseru: Ministry of Health. [↑](#footnote-ref-17)
17. See WHO. (1999). *Module 3: the cold chain*. Geneva: WHO. [↑](#footnote-ref-18)
18. See also NIDs reports for Lesotho. [↑](#footnote-ref-19)
19. WHO and UNICEF. (2005). Global *immunisation strategy and vision 2006-2015*. Geneva: WHO and UNICEF: New York. [↑](#footnote-ref-20)
20. Babu, G.R. 2011, V.V. Singh, S. Nandy, S. Jana, S. TN, S. SM: Supportive Supervision And Immunization Coverage: Evidence From India. *The Internet Journal of Epidemiology*. 2011 Volume 9 Number 2. DOI: 10.5580/1437 [↑](#footnote-ref-21)
21. WHO. (2005). *the immunisation data quality self assessment tool.* Geneva: WHO.

    23. Integrated services mean antenatal care, immunizations, HIV, nutrition, TB etc. [↑](#footnote-ref-22)
22. Integrated Services means antenatal care, immunizations, IMCI, HIV, Nutrition, TB, Health Education, Family Planning [↑](#footnote-ref-23)