LESOTHO

MDG ACCELERATION FRAMEWORK

IMPROVING MATERNAL HEALTH

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Improving Maternal Health

October 2013

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WHO

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ACRONYMS AND ABBREVIATIONS

AIDS	ACQUIRED IMMUNE DEFICIENCY SYNDROME
AJR	ANNUAL JOINT REVIEW
ANC	ANTENATAL CARE
ART	ANTI-RETROVIRAL TREATMENT
BEMONC	BASIC EMERGENCY OBSTETRIC AND NEONATAL CARE
BOS	BUREAU OF STATISTICS
CBD	COMMUNITY BASED DISTRIBUTORS
CEMONC	COMPREHENSIVE EMERGENCY OBSTETRIC AND NEONATAL CARE
CHAL	CHRISTIAN HEALTH ASSOCIATION OF LESOTHO
DHMT	DISTRICT HEALTH MANAGEMENT TEAM
DHS	DEMOGRAPHIC HEALTH SURVEY
EMONC	EMERGENCY OBSTETRIC AND NEONATAL CARE
FP	FAMILY PLANNING
GOL	GOVERNMENT OF LESOTHO
HIV	HUMAN IMMUNODEFICIENCY VIRUS
HRH	HUMAN RESOURCES FOR HEALTH
M&E	MONITORING AND EVALUATION
MAF	MILLENNIUM DEVELOPMENT GOAL ACCELERATION FRAMEWORK
MCA	MILLENNIUM CHALLENGE ACCOUNT
MDGS	MILLENNIUM DEVELOPMENT GOALS
MMR	MATERNITY MORTALITY RATIO
MNCH	MATERNAL, NEWBORN AND CHILD HEALTH
MOA	MINISTRY OF AGRICULTURE
MOCST	MINISTRY OF COMMUNICATIONS, SCIENCE AND TECHNOLOGY
MOH	MINISTRY OF HEALTH
MOLGCA	MINISTRY OF LOCAL GOVERNMENT AND CHIEFTAINSHIP AFFAIRS
MOPS	MINISTRY OF PUBLIC SERVICE
MOPWT	MINISTRY OF PUBLIC WORKS AND TRANSPORT
NGOS	NON-GOVERNMENT ORGANIZATIONS
NSDP	NATIONAL STRATEGIC DEVELOPMENT PLAN
PIH	PARTNERS IN HEALTH
PMTCT	PREVENTION OF MOTHER TO CHILD TRANSMISSION
PNC	POSTNATAL CARE

SRH	SEXUAL AND REPRODUCTIVE HEALTH
UNDG	UNITED NATIONS DEVELOPMENT GROUP
UNDP	UNITED NATIONS DEVELOPMENT PROGRAMME
UNFPA	UNITED NATIONS POPULATION FUND
USAID	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
VHW	VILLAGE HEALTH WORKER
WFP	WORLD FOOD PROGRAMME
WHO	WORLD HEALTH ORGANIZATION
WB	WORLD BANK

FOREWORD

The Millennium Development Goals have provided the world with an unprecedented opportunity for advancing human development through improvements in health and education outcomes while also tackling the challenge of poverty. A major global review of progress towards the achievement of the MDGs carried out in 2010 found that results across the eight MDGs were mixed and that additional concerted efforts were required to meet global targets of the Millennium Declaration.

In Lesotho, the situation is no different as we note mixed progress in meeting the set targets. The health-related MDGs pose a particular challenge, with rising rates of maternal and child mortality. One of the MDGs most off track is MDG5 — improving maternal health. Efforts need to be redoubled to immediately reverse the trend of rising maternal mortality rates in the country. The MDG Acceleration Framework (MAF), endorsed by the United Nations Development Group, is an excellent tool to address this challenge systematically through a collaborative approach of the Government of Lesotho, its development partners, NGOs, civil society organizations and communities. The MAF adds value to and operationalizes the strategic interventions identified in the Roadmap for Acceleration of the Reduction of Maternal and Neonatal Mortality and Morbidity in the country (2007–2015) as well as the broader objectives enshrined in the National Health Policy and the National Strategic Development Plan (2012–2017). Over the next two or three years, we need to ensure that fewer women die due to pregnancy and childbirth, that we increase access to reproductive health services and also reduce rates of child mortality. As we do so, we also need to think beyond the 2015 deadline and ensure that the interventions proposed in the MAF process are locally grounded, that they take into consideration Lesotho's unique character and that they will be sustainable.

Whilst the MAF process was led by the Ministry of Health, other Government ministries and departments, civil society and non-governmental organizations, and development partners actively participated in and supported the process. The Government of Lesotho and the UN System in Lesotho look forward to this continued collaboration in the implementation of the priority action plan as we collectively facilitate high standards of maternal and child health care in the country.

Finally, the implementation of the prioritized actions is beyond the capacity of the Ministry of Health alone. This requires strong collaboration with other stakeholders including other ministries and government agencies, development partners and civil society organizations. Technical and financial support is needed from other actors to effectively implement the practised interventions. The financial outlay for implementing the MAF is $105,781,562 (M952,034,065). This is beyond the budgetary capacity of the Government of Lesotho, notwithstanding the Government's commitment to disbursing its own resources for the implementation of the MAF and to integrating its critical components into the annual budget. To effectively implement the priority action plan, we encourage private sector, development partners and civil society organizations to support us in bridging the technical and financial gaps.

We are confident that with strong partnership with other agencies of Government, the private sector, the UN System, other development partners, and civil society organizations, the overall goal of the MAF will be achieved in the country.

Hon. Dr. Pinkie Rosemary Manamoelela
Ministry of Health
Kingdom of Lesotho

Ms. Karla Robin Hersey
UN Resident Coordinator
and UNDP Resident Representative

ACKNOWLEDGEMENTS

The MDG Acceleration Framework (MAF) for Lesotho was formulated under the leadership of the Ministry of Health, with support from the United Nations Country Team. The desk review and consultations for the Situation Analysis and the Action Plan were carried out by Ms Regina Mamello Mpemi and Mr Morabo Morojele.

The MAF Task was coordinated by Dr Lugemba Budiaki, Director Primary Health Care, overseeing Family Health, Sexual and Reproductive Health in the Ministry of Health under the guidance of the office of Director General Health Services.

Guidance was provided by Dr Jacob Mufunda, World Health Organization (WHO) Representative, Ms Alka Bhatia, Economics Advisor, UNDP and Ms Mantsane Bolepo, WHO Sexual Reproductive Focal Person during the preparation of the MAF. The MAF Plan would not have been possible without the invaluable support and oversight provided by Ayodele Odusola and Renata Rubian, experts from UNDP in New York; Osten Chulu the UNDP Regional Service Centre, Johannesburg; and Kordzo Sedegah, National Economist UNDP Ghana. Thanks also to WHO staff Dr Atnafu Getachew, Dr Bucagu Maurice, and Dr Fleischer-Djoleto Charles who participated in MAF process. Acknowledgement also must be given to Institute for Health Measurement for their contribution and input throughout the process. In the same vein, the Ministry of Health appreciates the effort from the MAF Task Team and various stakeholders that contributed to the preparation of the Lesotho MAF Priority Action Plan.

EXECUTIVE SUMMARY

The Millennium Development Goals Acceleration Framework (MAF) for Lesotho seeks to step up the efforts of the Government of Lesotho and its development partners to accelerate progress on what is nationally considered to be the most off-track MDG target in Lesotho — reducing maternal mortality, in keeping with MDG 5, Improve Maternal Health.

The Kingdom of Lesotho, which is completely surrounded by South Africa, is a highly mountainous country of which less than 10 percent is arable. The country has a population of around 2 million people of which 76.2 percent resides in rural areas, a population growth rate of 1 percent and an average life expectancy of 41 years. In spite of the fact that Lesotho is a middle income country, it falls in the category of low human development countries, with an HDI value of 0.461 in 2012. Therefore, addressing maternal mortality still remains a serious challenge while the HIV prevalence rate among adults (15-49 years), at 23 percent the third highest in the world, has started to see slow progress.

Maternal mortality rates have increased from 419 per 100,000 live births in 2000, to 762 per 100,000 in 2004, to 1,155 per 100,000 in 2009. The lifetime risk of maternal death is estimated at 1:32, which indicates that one out of 32 women in Lesotho will die of pregnancy and childbirth-related conditions.

The Government of Lesotho's Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity (2007-2015) aims to accelerate strategies articulated in the various policy documents of the country. It aims to enhance the provision of skilled attendants during pregnancy, childbirth, and the postpartum period at all levels of the health care delivery system, and to strengthen the capacity of individuals, families and communities to improve maternal and newborn health. However, owing to gaps in design and implementation, the anticipated reduction in maternal mortality has not taken place. The high levels of maternal mortality in Lesotho are a result of the 'three delays':

1. **Delays in making decisions** on the part of pregnant women to access health care services, mainly as a result of sociocultural barriers. These include their lack of decision-making power, their low ability to command resources and their low societal status, as well as their failure to recognize complications during pregnancy;

2. **Delays in reaching health care** services on the part of women experiencing complications, poor accessibility of maternity homes in large part due to Lesotho's difficult and mountainous terrain, the lack of sufficient community and formal ambulatory transport, the limited hours of operation of health facilities and the weakness of the health referral system;

3. **Delays in receiving** adequate health care services due to insufficient human resources, particularly in health facilities hard to reach, and inadequate equipment and supplies and infrastructure including water and electricity.

The MAF seeks to provide solutions to these challenges that are implementable, impactful and sustainable in the long term. The MAF methodology is a four-step process that systematically undertakes the following:

Step 1: Prioritization of country-specific interventions;

Step 2: Identification and prioritization of bottlenecks to the effective implementation, at scale, of these prioritized interventions;

Step 3: Selection of feasible, multi-partner acceleration solutions to overcome the prioritized bottlenecks;

Step 4: Planning and monitoring of the implementation of the selected solutions.

Through participatory processes, the MAF has prioritized four key intervention areas and identified pertinent bottlenecks impinging on progress in each of these areas. Prioritized solutions have been associated with each of the strategic interventions as indicated below:

1. **Improve skilled delivery** by improving road access to health facilities; availing of community-based transport systems; providing food in Maternity Waiting Homes; incentivizing health care workers, particularly in facilities that are hard to reach; and by improving communications, including through the enhanced use of cellular technology;

2. **Strengthen the provision of Basic Emergency Obstetric And Neonatal Care** by providing ambulances for all District Health Management Teams (and some health centres); ensuring the supply and retention of adequate human resources for health; empowering health workers in emergency obstetric care skills; ensuring the availability of adequate emergency obstetric care equipment and supplies, including blood supplies; ensuring the improved monitoring of pregnant women during labour and delivery; and by exploring the use of low-cost technologies in maternal and neonatal health;

3. **Improve the quality of antenatal care and neonatal care** by making available postnatal wards at the health centre level; exploring the possibility of instituting free care in hospitals; by enhancing community outreach and using Village Health Workers (VHW) for maternal and neonatal care;

4. **Increase access to family planning services** by increased community outreach to advocate the establishment of male support groups and to change sociocultural attitudes to FP; training health workers (including community-based distributors of FP commodities) in customer care and the logistical management of commodities.

The total cost for the MAF action plan implementation is $9,520,340.65 (M952,034,065).[1] The MAF budget is distributed and allocated as indicated in table 1.

1. Lesotho's currency, the maloti, has an exchange rate of $1 to M10 at the time of this report.

TABLE 1: MAF BUDGET AND ALLOCATION

Cost	Investment/activity	2013	2014	2015	2016
Infrastructure and operating costs	IConstruction and refurbishment of Maternity Waiting Homes, purchase of ambulances and other vehicles, operating costs and equipment and supplies	76,429,010	58,244,756	42,176,476	176,850,242
Human resource costs	Salaries for additional staff benefits and incentives	161,394,889	163,567,844	165,843,975	490,806,708
Programme costs	Training and mentoring, training material costs and costs of social mobilization and outreach	20,631,121	14,431,433	6,202,721	41,265,275
Other supportive costs	Construction and upgrading of roads and establishment of keyhole gardens for health centres	81,037,280	81,037,280	81,037,280	243,111,840
Grand total		339,492,300	317,281,313	295,260,452	952,034,065

A number of these costs are already part of the Government of Lesotho's budget, particularly for the construction or upgrading of roads. Other costs will have to be sourced, either from government resources or from development partners and other funding agencies.

The Government has proposed to allocate overall responsibility for oversight and supervision of the MAF to a Cabinet Sub-Committee to be chaired by the Minister of Health, with the membership of ministers whose ministries have some responsibility in ensuring the achievement of MAF objectives, namely the Ministries of Finance; Development Planning; Public Service; Social Welfare; Public Works and Transport; Local Government and Chieftainship Affairs; Communications, Science and Technology; and Agriculture and Food Security; with ministers from additional ministries being requested to participate when required.

It is proposed that the Health Development Partners which include international organizations and health sector implementing partners should, in collaboration with the Ministry of Health, constitute a second oversight body, although this body will also have an implementation responsibility.

The day-to-day management and implementation of MAF processes will be carried out by the Family Health Division in the Ministry of Health, which will work in close collaboration with the District Health Management Teams. Monitoring and evaluation will be the responsibility of the Statistics and Monitoring and Evaluation Unit in the Ministry of Health.

I. MDG ACCELERATION FRAMEWORK AND MATERNAL HEALTH

Photo: WHO

1.1 RATIONALE OF THE MAF IN LESOTHO

According to the draft Lesotho MDG report (2013), Lesotho's progress on various MDGs is mixed: there is significant progress in only two MDGs, while some show slow progress and others, especially those related to health and poverty, are off track. Table 2 shows the progress of MDGs in Lesotho at a glance.

Safe motherhood remains an elusive goal for many developing countries, including Lesotho. The obstacles to progress in reducing avoidable maternal mortality and severe morbidity include both old and new challenges. Among the older challenges are barriers to public health such as dysfunctional health systems, poverty and the low status of women. Foremost among the new challenges in Lesotho are the effects of the Human Immunodeficiency Virus (HIV) and the Acquired Immune Deficiency Syndrome (AIDS).
Global recognition of the magnitude and implications of poor maternal health has led to the development of global, regional and national declarations, commitments and strategies geared towards reducing maternal morbidity and mortality. Lesotho is a signatory to most of these commitments and declarations which include delivery on the United Nations Millennium Development Goals (MDGs) adopted in 2000. This committed Lesotho to reducing maternal mortality (MDG5) by three quarters of the 1990 level and achieving universal access to reproductive health by 2015.

Presently, one out of 32 women in Lesotho die of pregnancy and childbirth-related conditions. Lesotho's maternal mortality ratio (MMR) is among the highest in the region, with an estimate of 1,155 deaths per 100,000 live births in 2009. The Government of Lesotho (GoL) has set a target to reduce maternal deaths to 300 deaths per 100,000 live births by 2015 but with the present trend this is highly unlikely to be achieved, unless accelerated measures are undertaken.

As a follow-up to the Maputo Plan of Action for reduction of maternal and neonatal mortality which was agreed to by the African Union Heads of States and Governments, the Government of Lesotho developed the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity (2007–2015). The Roadmap aims at accelerating strategies articulated in the various policy documents and to provide skilled attendants during pregnancy, childbirth and the post-partum period at all levels of the health care delivery system, and to strengthen the capacity of individuals, families and communities to improve maternal and newborn health. Yet, evidence points to gaps in implementation and design in the Roadmap as a result of which the decline in maternal mortality rates has not taken place.

Therefore, the GoL has decided to apply the MDG Acceleration Framework (MAF) to facilitate not only the systematic identification of bottlenecks impeding the successful reduction of maternal mortality, but also in prioritizing the solutions to address them. It is a useful and relevant tool in accelerating the achievement of maternal health, with the development of an action plan to operationalize the existing Roadmap for Maternal Health and bringing multi-stakeholder partners to support the Government.

TABLE 2: PROGRESS MADE ON THE MDGS IN LESOTHO

MDG	Goals	Target
MDG 1	Eradicate extreme poverty and hunger	Halve the proportion of people whose income is less than a dollar a day
MDG 2	Achieve universal primary education	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
MDG 3	Promote gender equality and empower women	Eliminate gender disparity
MDG 4	Reduce child mortality	Reduce by two thirds the under-five mortality rate (per 1,000 live births)
MDG 5	Improve maternal health	Reduce by three quarters the maternal mortality ratio
MDG 6	Combat HIV and AIDS, malaria and other diseases	Halt and begin to reverse spread of HIV/AIDS
MDG 7	Ensure environmental sustainability	Halve the proportion of people without access to safe drinking water and basic sanitation
MDG 8	Develop a global partnership for development	Availability of essential medicines

Source: Lesotho Draft MDG Report: 2013 UNDP/ GoL.
Note: DHS - Demographic Health Survey.

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2. Government of Lesotho: DHS, 2009.
3. Government of Lesotho, Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Lesotho (2007-2015).

	Baseline	Latest available data	Progress
	66.61 (1995)	57.3% people below the poverty line (HBS 2010/11)	Off track
	82 (2000)	81.8% net enrollment rate	On track
	101 (2000)	96.4% primary education (girls/100 boys)	On track
	113 (2001) 81/1000 (2001)	117/1000 live births 91/1000 (DHS,2009)	Off track
	370/100,000 (1990)	1,155/100,000 (DHS,2009)	Off track
	0.8%(1990)	23%	Slow progress
	80.6 (1995) and 24% (2001)	78.9% and 24%	Slow progress
	74% (2007)	77.7%	Uneven progress across indicators

with the present trend this is highly unlikely to be achieved, unless accelerated measures are undertaken.

As a follow-up to the Maputo Plan of Action for reduction of maternal and neonatal mortality which was agreed to by the African Union Heads of States and Governments, the Government of Lesotho developed the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity (2007-2015). The Roadmap aims at accelerating strategies articulated in the various policy documents and to provide skilled attendants during pregnancy, childbirth and the post-partum period at all levels of the health care delivery system, and to strengthen the capacity of individuals, families and communities to improve maternal and newborn health. Yet, evidence points to gaps in implementation and design in the Roadmap as a result of which the decline in maternal mortality rates has not taken place.

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1.2 OBJECTIVE OF THE MAF

The MAF was developed with the objective of accelerating progress on MDG targets that were off-track by focusing the otherwise fragmented efforts and resources of government ministries and departments, development partners and other stakeholders through concrete and targeted measures. The MAF is a systematic approach that has been used in other countries to determine priorities within existing strategies and plans, making use of existing studies, statistics, evaluations and lessons learned. It aims to break down the silos between sectors and MDGs in favour of a pragmatic, cross-sectoral, results-based approach that exploits synergies and leads to new types of collaboration and partnerships. The MAF helps to focus MDG efforts on addressing development gaps and disparities, by targeting population groups or geographical areas that may be lagging behind.

Accordingly, the objectives of the MAF in Lesotho are as follows:

- Review existing Government strategies (national and sectoral policies and plans), mid-term reviews and evaluations on progress made toward improving maternal health in Lesotho, with special emphasis on the Maternal and Child Road Map (2007-2015);
- Identify gaps in existing policies and interventions;
- Reprioritize the interventions that are required to achieve a significant reduction of the Maternity Mortality Ratio (MMR);
- Identify and prioritize bottlenecks to the interventions;
- Identify solutions to bottlenecks for effective implementation and acceleration of progress towards attaining MDG 5.

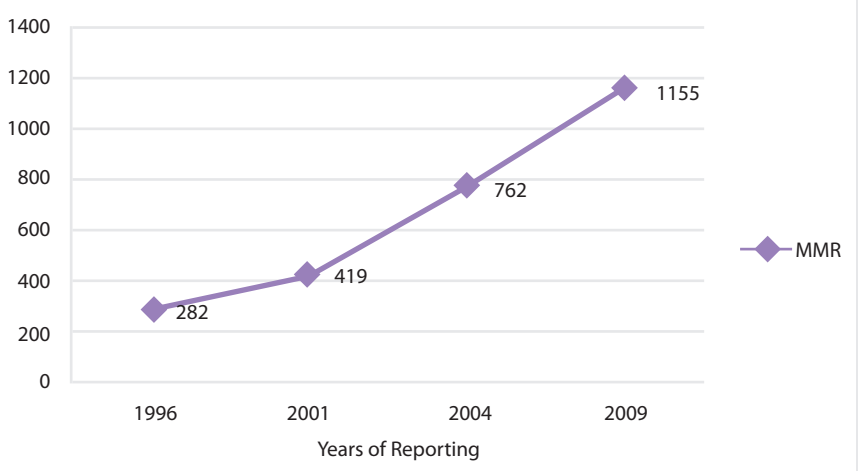
Lesotho's MMR is among the highest in the region. The rising trend of maternal mortality, estimated at 1,155/100,000 in 2009, up from 762/100,000 in 2004, shows that it is off track. It points to the unlikelihood of attaining a two-third reduction in maternal mortality by 2015 against the baseline of 1990.[4]

These trends in maternal mortality further show that the MoH alone cannot succeed in its effort of reducing MMR, without the collective efforts of other stakeholders. All stakeholders need to be actively involved to identify bottlenecks and implement needed interventions to achieve targets set in the Roadmap.

Further, the MAF employs evidence-based information about utilizing high-impact solutions to address the impediments to achievement of off-track MDGs. Therefore, in the Lesotho context, the value of the MAF would not only be to determine priorities within existing strategies but also to bring together fragmented efforts and resources of various partners and stakeholders to specifically accelerate maternal health achievements. The MAF will assist in reviewing the Maternal and Child Road Map (2007-2015) to identify gaps in existing policies and interventions and in reprioritizing the interventions required to achieve a significant reduction of MMR. It will help identify and prioritize bottlenecks and develop cost-effective solutions in an Action Plan.

4. World Health Organization (2009) Annual Report, Lesotho.

FIGURE 1: **NATIONAL TRENDS IN MATERNAL MORTALITY (DEATHS PER 100,000 LIVE BIRTHS)**



Source: LDHS (2009).

TABLE 3: MAF BUDGET AND ALLOCATION

Country	MMR	Survey year
Botswana	190	2009
Namibia	448	2007
Swaziland	589	2007
South Africa	625	2007
Lesotho	**1155**	**2009**

Source: DHS 2009, UNDP Botswana, Namibia, Swaziland and South Africa.

1.3 METHODOLOGY

The MAF methodology is a four-step process that systematically undertakes:

Step 1: Prioritization of country-specific interventions;
Step 2: Identification and prioritization of bottlenecks to the effective implementation, at scale, of these prioritized interventions;
Step 3: Selection of feasible, multi-partner acceleration solutions to overcome the prioritized bottlenecks;
Step 4: Planning and monitoring of the implementation of the selected solutions.

A number of methodological approaches were used for the development of the MAF:

1. A review of the extensive literature on the health and development sectors in Lesotho;[5]
2. Interviews with key officials of GoL, development partners, non-governmental organizations (NGOs) and civil society organizations and the private sector;[6]
3. Weekly meetings of the MAF Task Team under the leadership of the MoH;[7]
4. A MAF Methodological Workshop convened in January 2013 with extensive stakeholder participation;
5. The support of a number of external UNDP and World Health Organization (WHO) consultants, as well as the work of two local consultants contracted to drive the MAF process;
6. The development of a MAF budget based on local knowledge of the costs of both physical and non-physical planned investments and activities;
7. A number of other consultative processes, including a major meeting of stakeholders on 28 March 2013 that was aimed at accelerating the finalization of the MAF.

These processes resulted in an inclusive and highly participatory formulation of the MAF and its ownership by the GoL and local development and implementation partners. There were, however, a number of limitations to the formulation of the MAF. These included the paucity of data in some instances, delays in the submission of information particularly from the districts, the absence of evaluations of the main health-related programmes and interventions, and relationship management challenges.

5. See Annex3: List of references.
6. See Annex 2: MAF Methodological Workshop: Participants and officials consulted
7. See Annex 2: Members of the MAF Task Team.

1.4 IMPLEMENTATION

Following the GoL's agreement to engage in the MAF process in May 2012, UNDP and WHO commenced the MAF process by briefing key officials in the MoH on the process and securing the services of two local consultants, a health specialist and a development generalist to carry out the base work. The consultants engaged in extensive consultative processes and a detailed review of the literature to develop a draft situation analysis, which was then circulated amongst stakeholders for their review and comments.

The process also benefitted from the experience and training provided by UN officials from Ghana, Geneva and Johannesburg at various points in the process. A methodological workshop for all stakeholders took place in January 2013, which provided orientation for national stakeholders to systematically identify and prioritize bottlenecks and propose solutions. The entire process was conducted under the supervision of the Director of the Family Health Division of the MoH, who regularly convened the Task Force set-up to add detail and nuance to the identified interventions and solutions and to calculate the costs of the MAF. The Task Force had broad representation from the Government, the NGOs and the UN.

The MAF budgeting process was based on the quantification of physical and non-physical inputs required to achieve the objectives of the MAF. Physical costs included those required to upgrade rural roads to improve access to health facilities, construct and refurbish Maternity Waiting Homes, provide food to at these homes, and pay for ambulances and other vehicles as well as equipment and supplies. The costs of non-physical inputs were mainly for incentivizing health workers, providing security at health facilities and for training, mentoring and for various outreach activities.

Following ongoing and reiterative processes, a penultimate consultative process was convened to authenticate the MAF document. The MAF document was then approved by the GoL and submitted to the Cabinet by the Honourable Minister of Health for endorsement, after which it was printed and launched as a public document.

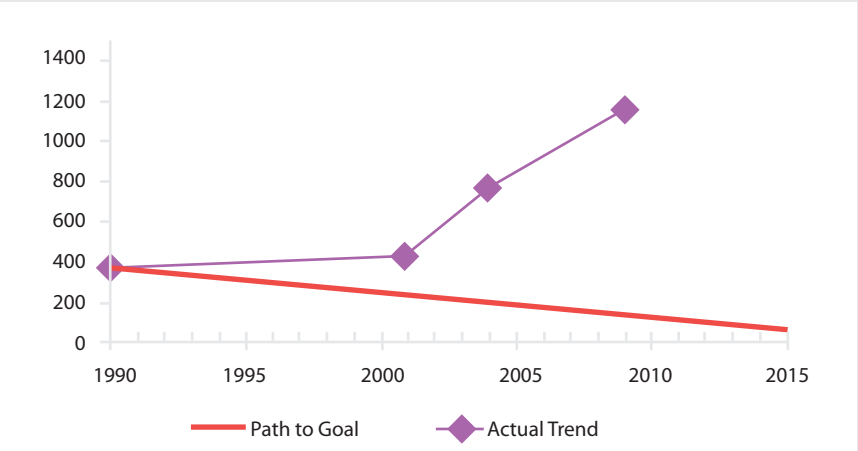
II. ASSESSMENT OF PROGRESS MADE TOWARDS MDG 5

Photo: WHO

2.1. MATERNAL MORTALITY

The MMR in Lesotho is increasing at an alarming pace (Fig. 2). This steady increase is not seen in other countries which are also off-track on MMR. According to the End of Decade Multiple Indicator Cluster Survey (EMICS) of 2000 and the Demographic and Health Surveys of 2004 and 2009,[8] the MMR increased from 419 per 100,000 live births in 2000 to 762 per 100,000 in 2004 and 1,155 per 100,000 in 2009. According to the Maternal Death Review report of 2010, 42.6 percent of deaths recorded among young, pregnant women aged 24 years were attributed to pregnancy-induced hypertension and haemorrhage. [9]

FIGURE 2: **MATERNAL MORTALITY RATIO (PER 100,000 LIVE BIRTHS)**



Source: LDHS (2009).

e births in 2000 to 762 per 100,000 in 2004 and 1,155 per 100,000 in 2009. According to the Maternal Death Review report of 2010, 42.6 While supportive policies and strategic programmes have been put in place to ensure universal access to reproductive health, most of the relevant indicators have shown only a modest improvement, and have been unable to reverse the trends for MMR in the country over the past decade. Lesotho therefore remains off-track on the target of reducing maternal mortality ratio, but is registering some progress on the target of ensuring universal access to reproductive health. The high rate of maternal deaths among young women is also an area of concern that needs to be addressed.

8. EMICS and LDHS used slightly different survey methodologies. EMICS includes women who had a birth in the year preceding the survey, whereas LDHS surveyed trends in the five-year period preceding the survey.
9. MoH Maternal Death Review Report 2010.

TABLE 4: GENERAL MATERNAL HEALTH TRENDS					
Indicator	**1990**	**2001**	**2004**	**2009**	**2015(target)**
Off Track					
Maternal mortality ratio (per 100,000 live births)	370[10]	419	762	1,155	300
Slow progress					
Proportion of births attended by skilled health personnel	-	60.0	55.0	61.7	80
Contraceptive prevalence rate, married women, 15-49	-	36.1	35.2	45.6	80
Total fertility rate	-	-	3.5	3.3	2.8
Adolescent (15-19) birth rate	-	-	20.2	19.6	-
ANC coverage (at least 1 visit)	-	85.2	90.0	92.0	100
ANC coverage (at least 4 visits)	-	-	69.6	70.4	-
Unmet need for FP	-	-	30.9	23.0	-

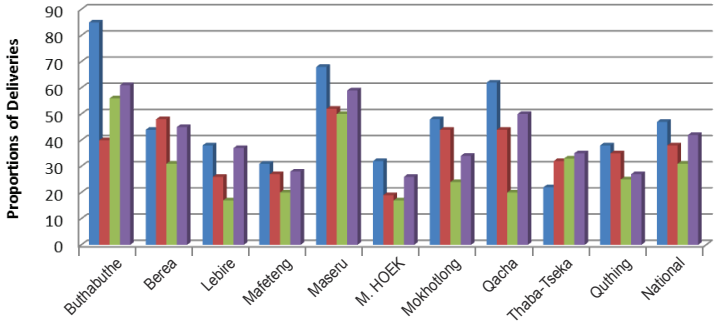
2.2. SKILLED ATTENDANTS AT DELIVERIES

Through the MoH,[11] the GoL adopted the WHO recommendation that all women should deliver in a health facility under the care and support of a health professional. Other than access to skilled care during labour, facility-based deliveries are expected to be conducted under hygienic conditions, to reduce the risks of infection and complications that may cause death or serious illnesses to the mother, baby or both.[12] Facility-based delivery hastens immediate care of both the labouring woman and the newborn, in the event intrapartum complications occur.

The deliveries attended to by skilled personnel (nurses 51 percent and doctors 10 percent) increased from 55 percent in 2004 to 62 percent in 2009. Most women who delivered in health facilities were from urban areas, lowlands and often from Maseru district. Although the proportion of women who delivered in health institutions increased in 2009 compared to 2004,[13] in general, the number of deliveries conducted in the institutions countrywide as a proportion of expected deliveries remains low (fig. 3).[14]

10. WHO/UNICEF/UNFPA/WB. Trends in Maternal Mortality: 1990-2008.
11. Previously the Ministry of Health and Social Welfare; two separate ministries were established in 2012.
12. MoHSW (2009:109) Lesotho DHS.
13. Lesotho DHS, 2009.
14. MoHSW (2011) Annual Joint Review.

FIGURE 3: **TRENDS IN PROPORTION OF DELIVERIES CONDUCTED IN HEALTH INSTITUTIONS BY DISTRICT**



2007	85	44	38	31	68	32	48	62	22	38	47
2008	40	48	26	27	52	19	44	44	32	35	38
2009	56	31	17	20	50	17	24	20	33	25	31
2010	61	45	37	28	59	26	34	50	35	27	42

Source: MoH (2011:87) Annual Joint Review.

2.3 CONTRACEPTIVE PREVALENCE RATE

The GoL road map target is to increase contraceptive prevalence rate from 37 percent in 2001 to 60 percent by 2015 and to reduce the fertility rate from 3.5 to 2.5 by 2015. The trend in contraceptive use has shown a steady increase over the years: 47 percent in 2009 which was about 10 percent higher than in 2004 (37.3 percent) among married women aged between 15 and 49 years.

The use of FP methods varied by geographic location. Individuals in urban areas (58 percent) were more likely to use contraceptives than those in the rural areas (42 percent).[15] Also, the use of contraceptives was affected by the level of education and wealth status. Access was also an important factor. It was noted that contraceptives were obtainable from government hospitals and health centres and Lesotho Planned Parenthood Association (LPPA) clinics.

Although overall fertility rates have declined in Lesotho and is recorded to be one of the lowest in the sub-Saharan region, it is still higher among the poorest and in rural areas. This may be associated with early marriage and childbearing which is a common phenomenon in these populations as well as the lesser educated.

15. DHS, 2009.

2.4. ANTENATAL CARE

Antenatal clinic attendance is an entry point into maternal and child health services. Lesotho has adopted WHO recommendations of a minimum of four antenatal visits during pregnancy. The first ANC visit should be during the first trimester. The recommended visitation schedule for Lesotho is as follows:

First visit	at less than 16 weeks
Second visit	between 16 and 28 weeks
Third visit	between 28 and 32 weeks
Fourth visit	at more than 32 weeks

There is a slight increase in the number of women making at least one visit, from 90 percent in 2004 to 92 percent in 2009. The MoH recommends that ANC attendance should be initiated during the first trimester (at less than 16 weeks). However, Demographic Health Survey (DHS) 2009 data shows that most women delay commencing ANC; 60.3 percent initiated ANC after the first trimester in 2004 and 59.3 percent in 2009. DHS 2009 data further show that there is slight improvement in the percentage of women who initiated ANC within the first trimester from 30.2 percent in 2004 to 32.5 percent in 2009.

The geographic differences in ANC utilization are also apparent, whereby fewer women in rural areas (28.4 percent in 2004 and 29.2 percent in 2009) initiated ANC during the first trimester, compared to 40.2 and 42.3 percent respectively from urban areas. It is recommended that women should at least have a minimum of four visits during their pregnancy, provided there are no complications. DHS 2009 shows that while the majority of women do have a minimum of four visits or more, there are still a sizeable number of women who do not do so (18 percent in 2004, 19.4 percent in 2009). When disaggregated geographically, the data reveals that more women in the urban areas (85.5 percent in 2004 and 82.5 percent in 2009) are likely to have had four or more visits as compared to those in the rural residences (67 and 66.3 percent for those respective years).

2.5 POSTNATAL CARE

The Roadmap aims to increase PNC attendance from 23 percent to 50 percent by 2015. According to LDHS, (2009), 42 percent of women reported that they did not obtain their first PNC visit within the first hour after birth. However, for their first check-up, 53 percent women were examined by health professionals while 5 percent were examined by community health workers and 1 percent by Traditional Birth Attendants.

2.6 TEENAGE PREGNANCY

Teenage pregnancy is a major health concern because it is associated with higher maternal and child mortality and morbidity and carries high risks such as pregnancy-induced hypertension, obstructed labour, prolonged labour and unsafe abortion. Younger mothers are also much less likely to receive ANC. Moreover, teen pregnancy adversely impacts long-term well-being, as young mothers are less likely to continue their education and find decent employment.[16] In Lesotho, 41 percent of women have had a baby or are pregnant with their first child by the age of 19, and 20 percent of teenagers (15-19 years) have had at least one birth or are pregnant with their first child.[17]

16. DHS, 2009.
17. Ibid.

2.7 NATIONAL AND HEALTH POLICIES

2.7.1 STRATEGIC INITIATIVES

A number of strategic initiatives have sought to drive Lesotho's economic and social development in recent years. Vision 2020 has developed a number of high-level, national socio-economic, governance, human development and environmental targets.

Vision 2020, Lesotho's key development planning framework, envisages that *"By the year 2020 Lesotho shall be a stable democracy, a united and prosperous nation at peace with itself and its neighbours. It shall have a healthy and well-developed human resource base. Its economy will be strong, its environment well managed and its technology well established."*

Vision 2020 has been given more precision through additional planning frameworks such as the Poverty Reduction Strategy (PRS, 2004–2007) and the current National Strategic Development Plan (NSDP) 2012-2017). The NSDP posits the following strategic objectives and actions to reduce maternal mortality:

- Deploy skilled birth attendants at health centres across the country;
- Increase access to emergency obstetric care services;
- Provide maternal health education to communities and develop specific programmes for males;
- Reintroduce antenatal shelters;
- Scale up Sexual and Reproductive Health (SRH) education and services for adolescents;
- Scale up education and roll-out of contraception;
- Increase coverage of Anti-Retroviral Treatment (ART) and find innovative ways to increase uptake and adherence;
- Establish comprehensive outreach health services;
- Increase awareness and improve facilities for cervical cancer testing;
- Scale up essential nutritional packages for pregnant and lactating women.

Other elements of the NSDP that could have positive impacts on maternal health include planned strategies and interventions in nutrition and food security, water and sanitation and access to health infrastructure.

2.7.2 GENDER POLICIES

Appropriate gender policies and strategies are crucial to the achievement of MDG 5 targets and indeed of national development goals. Historically, females have had higher rates of participation in education and dominate employment in the public service. In terms of political representation, whilst Lesotho had one of the highest proportions of female representation in parliament in the world, the results of the elections of 2012 saw this proportion decline, although female representation in local Community Councils remains high due to the implementation of a quota system. This is in large part due to the changes effected in the legal system of the country in recent years. However, these changes have not yet influenced social and cultural practices regarding female roles and sexual relationships.

Lesotho is a patriarchal society with women being regarded as minors, which perpetuates gender inequality and which in turn has a bearing on sexual and reproductive beliefs and practices. For example, women have to seek the permission of their husbands before seeking any

SRH services. This has been cited as one of the barriers to using SRH services, with 7 percent of women giving this as a reason.[18]

Sexual initiation of adolescent girls often takes place with older men, who have a high likelihood of being HIV positive. In Lesotho, intergenerational relationships are culturally entrenched, and are plagued with gender inequality, with women less able than men to exercise control over their bodies and negotiate safer sex practices.[19]

While a Gender Technical Committee has been established under the leadership of the Department of Gender in the Ministry of Gender, Youth, Sports and Recreation (MGYSR), the participation of the MoH in its activities has been limited. Increased collaboration between this Technical Committee, MoH and other stakeholders would enable synergistic Behavioural Change Communication for improved maternal health outcomes.

The NSDP also calls for enhanced training in SRH targeted at men and bo-Matsale (mothers-in-law). This is because of the influence that men and mothers-in-law have over health-seeking behaviour. Typically, mothers-in-law resort to the use of traditional remedies to treat pregnancy-related problems and invoke traditional beliefs to confine women at home, which at times causes delays in reaching medical facilities.

2.7.3 HEALTH SECTOR POLICIES

The key national policies that impact on maternal health are the Health Sector Policy (HSP) of 2011, the National Reproductive Health Policy of 2008, the National Adolescent Health Policy of 2006, the National HIV and AIDS Policy of 2006, the National Population Policy and the National Health and Social Welfare Research Policy of 2007. The HSP[20] presents the following health priorities:

1. Strengthen reproductive health care services;
2. Improve child survival and nutrition services;
3. Strengthen HIV and AIDS prevention, care and treatment;
4. Improve human resource management and development;
5. Improve prevention of non-communicable diseases.

The HSP seeks to institutionalize the modified structure of the MoH, with the central level focusing on policy, strategic planning and supervision, and the districts being responsible for budgeting, planning and implementation and for the supervision of health centres through the District Health Management Teams (DHMT). The policy also reaffirms Public-Private Partnership arrangements for the delivery of health services, primarily through memoranda of understanding with the Christian Health Association of Lesotho (CHAL), the Lesotho Red Cross Society (LRCS) and other implementing partners.

The policy identifies the following as the main constraints to the achievement of national health and well-being objectives, which bear considerable similarity to the challenges identified through the MAF process:

1. Human resource development: high levels of attrition, a reliance of external (non-Basotho) human resources and the reluctance of health workers to be deployed in areas that are hard to reach;
2. The inefficient and ineffective utilization of financial resources;
3. Weakness in management and procurement of pharmaceuticals and essential supplies;

18. DHS, 2009.
19. Ibid.
20. Government of Lesotho: National Health Policy: 2011.

4. Insufficient fiscal decentralization due to limited human resources, which undermines decentralized planning and management;
5. The slow establishment of functional DHMTs;
6. The inadequate maintenance of health infrastructure;
7. The inadequate sustenance of environmental health and hygiene standards at household and public levels;
8. The need for the improved harmonization of the Health Information System (HIS) and Monitoring and Evaluation (M&E).

Decentralization, a policy shift in user fees and the increasing use of Public-Private Partnerships for health service delivery remain the main challenges to the health system in Lesotho.

Of significance is that only 44 percent of the MoH's capital budget is funded by the GoL. The balance is funded by donors including Irish Aid, WHO, United Nations Children's Fund, Norwegian Aid (NORAD), the Global Fund, Millennium Challenge Corporation, the European Union, International Development Association, GAVI, United States Agency for International Development (USAID)and United Nations Population Fund. (Not accounted for other sources: the Clinton Foundation and the Global Fund). [21]

Given that more than half of the health budget is funded by international aid, effective aid coordination is of critical relevance for Lesotho in order to ensure the efficient delivery of resources and budget predictability for achieving development results.

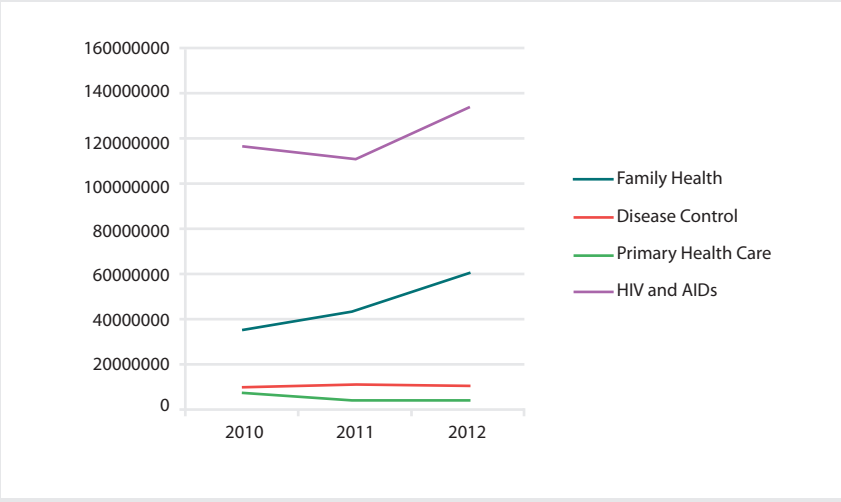
Capital budget allocations for reproductive health amount to M6,320,000, representing 1 percent of the total approved capital budget of M621,656,069. While minimal, this allocation does not account for other capital interventions with potential or actual benefits to reproductive health, because some interventions are systemwide and would benefit SRH as well as other health programme objectives. For example, the Millennium Challenge Account contributions of M260,000,000 to the Health Sector Reform Project will support the human resource retention strategy essential for achieving positive maternal health outcomes. In addition, other interventions such as for HIV and AIDS also contribute to maternal health. The multi-benefit nature of some of these interventions makes it difficult to isolate or ring-fence accruals to reproductive health.

The Family Health Division's Operational Plan for 2010/13 is a comprehensive list of activities, some of which have been budgeted for and some of which donors have indicated their support, but have not yet secured or approved funding.

Figure 4 illustrates trends in recurrent budget allocations to MoH centres between 2010 and 2012, and reveals that the highest and growing allocations are to HIV and AIDS, partly as a result of the cost of drugs, followed by the Family Health Division. Allocations to primary health care have been declining over the period. Yet, despite these increases, the MMR has been rising.

21. See Status of Funds Report, Capital Budget, 2011/12, February 2012.

FIGURE 4: **TRENDS IN RECURRENT BUDGET ALLOCATIONS TO MOH COST CENTRES FROM 2010 TO 2012 (LSL CURRENCY)**



Source: MoH, Recurrent Budget 20110 to 2012.

2.7.5 AID COORDINATION

Lesotho ratified the Paris Declaration on Aid Coordination in 2008 and endorsed the Accra Agenda for Action in 2008. Since then, aid coordination has been receiving increasing attention, with donors formulating strategic development frameworks more closely aligned to national development priorities. Nevertheless, there is considerable scope for improvement.

According to a 2011 survey carried out by the Ministry of Finance, only two out of the ten targets for which there were indicators were achieved. Constraints in achieving these targets included low government ownership of the coordination processes; unreliability of the public financial management system; the alignment of aid funds to national priorities and the use of common procedures; the paucity of joint analytical work between government and donors and the lack of joint missions on the part of donors; and the absence of results-oriented frameworks. Inadequate human and financial resources have also contributed to slow progress in achieving goals for aid coordination. This uncoordinated aid architecture greatly impacts maternal health delivery, as donors and other partners duplicate interventions, resulting in less than optimum achievements.

The main challenges to effective aid coordination have been identified as the following:[22]

- The absence of an aid coordination policy and action plan (which are, however, being developed and should be finalized by the end of the current calendar year);
- The need to enhance the harmonization of donor procedures;
- The need for improved programme-based aid allocation and management;
- The continued allocation of extra-budgetary donor assistance, which is not recorded and/or coordinated.

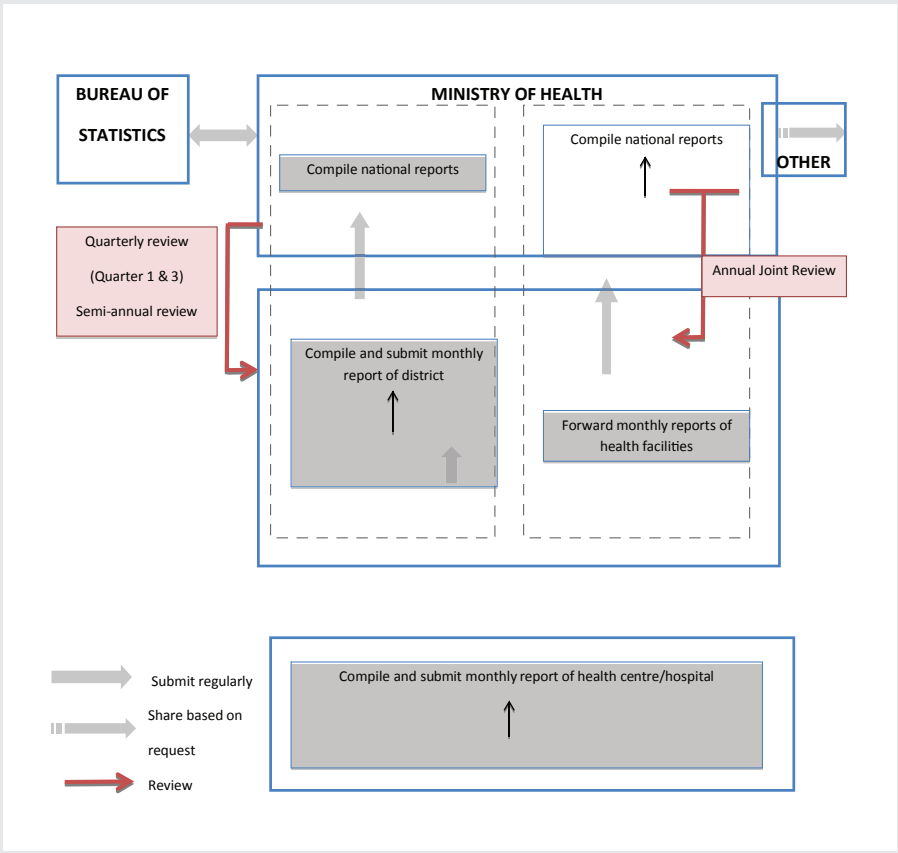
The last point is a major constraint to aid coordination. Donors commence projects within ministries or support government objectives and incur capital and recurrent expenditures which are not reported to the government. This is particularly the case with the health sector. The magnitude of these types of projects is not known and weakens aid coordination efforts. The Ministry of Finance is currently building its capacity for aid coordination, which is expected to contribute to the more efficient allocation and use of resources.

2.7.6 MONITORING AND EVALUATION

The MoH Health Information Management System utilizes a standardized data form for each programme. These forms, including registers are completed daily by health centres and hospital personnel. At the health facility level, the monthly reports are compiled and submitted to DHMTs. Depending on the programmes, DHMTS will process the data in the following ways: (1) For data within the categories of ANC, Delivery, Under 5, OPD, Inpatient, Mental, and Dental, the DHMTs will capture the monthly statistics of health facilities per programme and then compile the district monthly report to submit to the central MOH which then compiles the national reports; (2) For data on ART, HTC, TB, EPI, etc., DHMTs forward the monthly reports of health facilities to the central MOH which draws on these to compile national reports. Figure 5 shows how data flows from the health facilities to the national level.

22. Aid Effectiveness and related reports not available from the Aid Coordination Unit of MOF.

FIGURE 5: DATA FLOW FACILITY TO NATIONAL LEVEL



Source: MoH IHM chart submitted to USAID in June 2013.

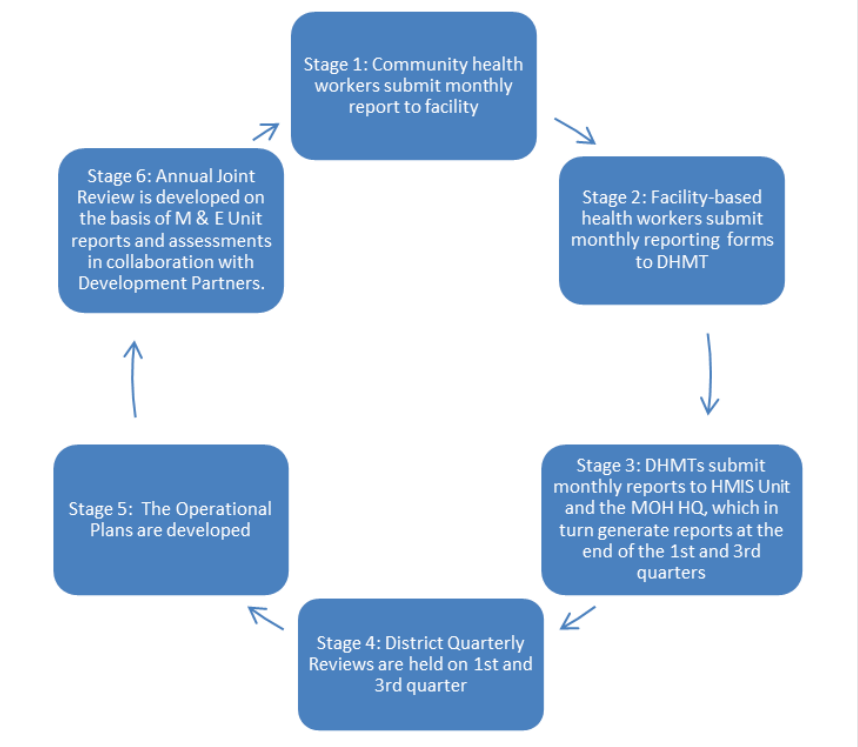
The M&E system used by the MoH has been tracking key indicators to monitor implementation and progress on key health outcomes. The MOH uses quarterly reviews to monitor progress on selected indicators at the district and central level, relaying a performance report at the end of each quarter (quarterly to the GoL financial year which starts in April). On an annual basis the MOH hosts a sectorwide review, the Annual Joint Review (AJR), which assesses and documents national and district performance throughout the year. Traditionally, the AJR report is published between May and June of every year.

Both the Health Information Management System and the M&E system are constrained by a number of factors, chiefly the incompleteness or inaccuracy of data and the insufficient timeliness of its submission by the various levels of the health system.

The major cause of these shortcomings is the inadequacy of qualified staff at many health facilities, with overworked health workers pressured to collect and produce the data as required. In response, the MoH has utilized Data Clerks, who assist facility-level health workers with the collection, checking and clearing of facility-level data and ensuring their timely submission. The Data Clerks are recruited and paid for by development partners under specific programmes, which raises the question of their sustained employment and availability. Currently, there is no formal provision for their permanent recruitment, although the MAF proposes a budget for their employment.

The MoH intends to survey the populations of health facility catchments, a practice used by some partners such as Partners in Health (PIH), and is developing criteria for the delineation of catchments. It is not clear when this process will be finalized. Detailed information on the health status of populations in health facility catchment areas, including, for example, the number of women of child bearing age and the number of pregnant women, would enable community health workers to facilitate ANC attendance and the monitoring of pregnant women.

FIGURE 6: **MINISTRY OF HEALTH: MONITORING AND EVALUATION CYCLE**



III. STRATEGIC INTERVENTIONS

Photo: WHO

INTRODUCTION

The global concern on maternal health has led to various global and regional declarations, aimed at eliciting commitments from governments and their health authorities to the development of strategies and plans of action geared towards reducing maternal and newborn morbidity and mortality by 2015.[23]

Lesotho is a signatory to many international declarations and conventions (box 1.1) that are aimed at improving access to and provision of quality health care services to the population, as well as reducing morbidities and mortalities, thus achieving the MDG on maternal health. To this effect, in 2006, Lesotho developed a Roadmap for action for the period 2007 to 2015, to accelerate progress on these goals.

Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity (2007-2015)

With the objective of increasing coverage and utilization of maternal and newborn health care services, the Roadmap focuses on providing an enabling environment for women through policies and strategies such as the following: increasing the availability of skilled attendants to provide maternal and newborn health care; strengthening of the referral system; integrating sexually transmitted infections and HIV and AIDS prevention and care with SRH, maternal and newborn health, and FP etc; making available more Maternity Waiting Homes; and strengthening the management of the health system. With a view to strengthening individual, family and community capacity to improve Maternal, Newborn and Child Health (MNCH) the Roadmap emphasizes the following:

Box 1.1: Regional and International Declarations and National Policies, Guidelines and Strategies for SRH

International Confederation on Population and Development (1994), 2000

Millennium Development Goals 2000

Gaborone Declarations (SRH Policy Framework) 2005

SADC SRH Strategic Plan 2006

MAPUTO Plan of Action 2006

Ouagadougou Declaration (OD) 2008

National Health Policy 2011

Gender and Development Policy 2003

National Adolescent Health Policy 2006

Roadmap for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality (2007-2015), 2006

Lesotho Blood Transfusion Service Policy 2006

National Reproductive Health Policy 2006

National Reproductive Health Policy Implementation Framework (draft) 2010

23. Lesotho Roadmap, p.20.

1. Strengthen the VHW programme;
2. Promote the household-to-health facility continuum of care;
3. Support the revival of community committees and the establishment of community emergency committees to mobilize essential emergency community services including transport and blood donors;
4. Empower communities for enhanced community response.

Despite this comprehensive and elaborate road map which was to be implemented in three phases, maternal health issues have not shown any appreciable progress; in fact, as discussed earlier, the MMR has only worsened. While no specific evaluation of the road map has been conducted, the general observation of stakeholders in government, NGOs and development partners is that there are serious gaps in implementation of the strategies, which are perhaps compounded by paucity of resources, both human and financial.

Given the strong political will to address SRH and MNCH issues and the existence of necessary plans and strategies, there is a felt need to adopt a fresh approach to implementing the strategies. There is also an acknowledgement of the need for other stakeholder involvement in MNCH issues, particularly the need for collaborating among and coordinating otherwise fragmented approaches.

Against this backdrop, the following interventions were identified and prioritized by stakeholders during the methodological workshop (January 2013). It was agreed that these interventions have the potential to accelerate the progress of MDG 5 in Lesotho.

- Improving skilled service delivery (deliveries attended by skilled personnel);
- Strengthening provision of Emergency Obstetric and Neonatal Care (EmONC);
- Improving quality of ANC and PNC;
- Increasing access to FP services.

The interventions were identified and ranked using the following MAF methodology criteria:
- Impact
- Sustainability
- Speed
- Coverage and available capacity
- Reported causes of maternal mortality

3.1 IMPROVED SKILLED SERVICE DELIVERY

One of the principal objectives of the health care system in the country is to provide skilled service delivery and enhance access to health facilities. Facility-based deliveries are expected to hasten immediate care of both the woman in labour and the newborn in the event complications occur. However, for facilities to be able to provide EmONC, they must meet specified criteria among which adequate human resources for health (HRH) is a priority.

The MoH has stipulated the number and professional specifications required for each level of facility.[24] However, this has not yet been attained as evidenced from the current staffing pattern at the health centres. There is an acute shortage of nurse clinicians and registered nurse midwives, with most health centres not having even the minimum complement of five nursing staff. The MoH (2010) acknowledges the fact that the shortage of skilled personnel compromises access to skilled service delivery.[25]

In addition, skilled services and well-equipped health facilities need to be accessible. This can

24. GoL, Human Resource Development Strategic Plan, 2005.
25. GoL and MoHSW (2010) Retention Strategy for Health Workforce.

be facilitated though provision of adequate and functional Maternity Waiting Homes, strengthening of referral systems and improvement in infrastructure such as roads and communication facilities, especially in the hard to reach health facilities. Presently, 46 out of a total of 181 facilities are classified as hard to reach because of absence of appropriate roads and inadequate communication systems, including ambulances and phones.

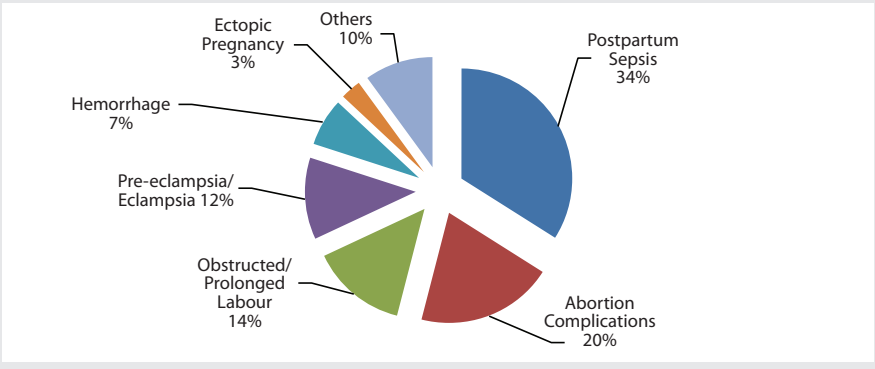
Therefore, the identified and prioritized interventions aimed at improving skilled service delivery include:

- Provision of adequate and functional Maternity Waiting Homes at both the health centre and hospital level;
- Provision of adequate HRH in both quantity and quality;
- Improvement of referral systems and development of protocols and guidelines for referrals;
- Improvement of health centre physical infrastructure and roads connecting health centres to hospitals, as well as other means of communication including cellular coverage.

3.2 IMPROVED AVAILABILITY OF EMERGENCY OBSTETRIC AND NEONATAL CARE

Although most obstetric complications are preventable with good quality ANC and PNC, they are hard to predict. Research and MoH documents have shown that women and newborn babies in Lesotho die from preventable causes. The four major causes of death are haemorrhage postpartum, infections, hypertensive disorders in pregnancy (eclampsia) and obstructed labour (figure 8). High rates of HIV especially among women (26.7 percent) are another important driver of maternal mortality in the country.[26] However, a strong Prevention of Mother to Child Transmission (PMTCT) programme is already addressing one aspect of this issue as evidenced from the increases in PMTCT coverage from 5.9 percent in 2005 to 88 percent in 2010. The uptake rate for HIV testing among pregnant women is estimated at 81 percent, with 92 percent of HIV-positive ANC clients receiving either ART or ARV prophylaxis for PMTCT.[27]

FIGURE 7: CAUSES OF MATERNAL MORTALITY IN LESOTHO



26. Strategic Plan for Elimination of Mother to Child Transmission of HIV and for Paediatric HIV Care and Treatment, MoHSW, 2011/12-2015/16.
27. Ibid.

Given that EmONC is available only at government health facilities, it is important for the Government to improve access. According to the 2009 Accreditation Survey,[28] 44 percent of hospitals and 47 percent of health centres did not meet the recommended minimum standards for the provision of emergency obstetric care.

While deliveries attended by skilled personnel have increased from 55 percent in 2004 to 62 percent in 2009, the progress towards achieving the target of 80 percent by 2015 is slow. The shortage of HRH in Lesotho is probably the main reason for this slow progress. For this reason, the identified key priority interventions for provision of EmONC include:

- Provision of adequate numbers of professional nurses and medical doctors and scaled-up training on BEmONC and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) signal functions, respectively;
- Improvement of referral and emergency transport systems;
- Improvement of the procurement and inventory management of BEmONC and CEmONC equipment and supplies;
- Establishment and equipping of regional blood bank stations with basic equipment, adequate and skilled human resources;
- Improvement in monitoring (use of the Lesotho Obstetric Record/partograph) during all stages of labour, newborn and postnatal.

3.3 BETTER QUALITY ANTENATAL AND POSTNATAL CARE

3.3.1 ANTENATAL CARE

Timely attendance and frequent visits for ANC are important for early diagnosis and management of obstetric complications and control of pre-existing medical conditions. During this time, the monitoring of foetal growth and development and the health of the pregnant woman are carried out. Lesotho has experienced an upward trend in antenatal coverage.

The proportion of women who have at least four antenatal care visits a year — the minimum under WHO guidelines — has also slightly increased from 69.6 percent in 2004 to 70.4 percent in 2009. With accelerated efforts in this area it may be possible to attain the target of 100 percent coverage by 2015. Moreover the challenge is to ensure that women meet the criteria of the minimum number of ANC visits. In addition, it is necessary to ensure that the needed equipment and adequate supplies are available in health facilities for ANC services.

3.3.2 POSTNATAL CARE

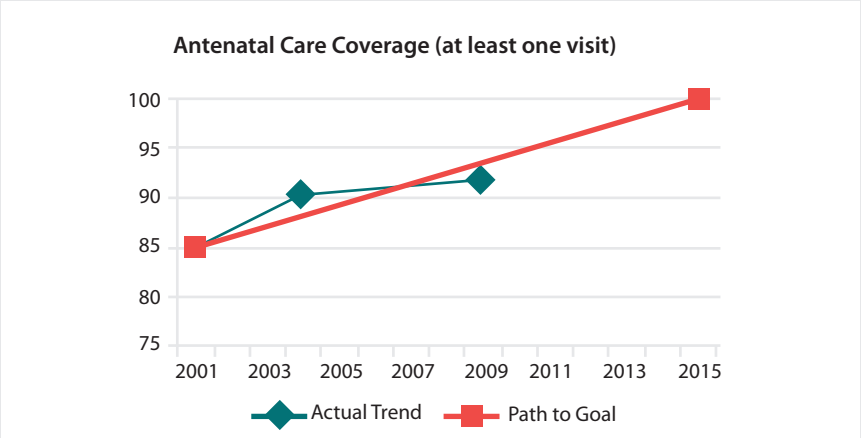
The causes of maternal deaths in Lesotho can be prevented with quality PNC[29]. One of the goals of the Roadmap therefore is to increase the proportion of women receiving essential postpartum, newborn care and FP services. The MoH recommends a postpartum visitation schedule as follows:

1st consultation	within 48 hours
2nd consultation	5-7 days
3rd consultation	4-6 weeks

However, in most cases, this schedule is not adhered to as women are discharged immediately after delivery and do not make it to the first and second consultations because of difficulties in accessing health facilities. Over half the women (53 percent) reported having made the first consultation only after six weeks.[30]

28. MoHSW, 2009.
29. MoHSW (2011) Focused Postnatal Care. Orientation Package for Health Service Providers in Lesotho

FIGURE 8: **ANTENATAL CARE COVERAGE (%)**



The identified priority key interventions for both ANC and PNC include:

- Implementation of the supermarket approach for the first MNCH services (ANC,PNC, FP and immunization services);[31]
- Integrated community outreach and mobile SRH, MNCH and FP services;
- Implementation of ANC and PNC guidelines;
- Improvement of procurement and logistics systems as well as scaling up of inventory systems in all health facilities;
- Community mobilization and empowerment on the importance of SRH and MNCH services;
- Scaling up of customer care training.

3.4 INCREASED ACCESS TO FAMILY PLANNING SERVICES

Although fertility rates in 2009 have dropped from the 2004 figure, unmet FP needs are still evident. This is especially seen among teenagers, who have high rates of unplanned pregnancies. The unmet need for FP services by married women aged 15 to 49 for the purposes of both spacing and limiting births has been declining from 30.9 percent in 2004 (2004 DHS) to 23 percent in 2009 (2009 DHS). The 2009 DHS reveals that the unmet need is higher among rural (26 percent) than urban women (15 percent). The need is also higher among women in mountainous areas (33 percent) compared to those who live in lowlands (18 percent).

30. DHS, 2009.

31. A supermarket approach refers to providing all maternal and neonatal health services on all days of the week as opposed to the current practice of scheduling services according to certain days of the week.

The non-use of FP services could be attributed to misinformation or lack of information, difficulty accessing quality FP services, and opposition from either the husband or in-laws, among other factors. More investment is needed to improve access to FP services. The interventions that seek to improve access to FP services include:

- Capacity-building of HRH in both natural and artificial methods of FP;
- Strengthening of the Community Based Distributors (CBD) programme;
- Improving the procurement, distribution and storage of FP commodities;
- Empowering communities with knowledge on the benefits of FP and debunking myths on the use of FP commodities;
- Strengthening village health posts and running mobile FP clinics.

TABLE 5: KEY INTERVENTIONS AND PRIORITIZED ACTIONS

Target 5a: Reduce the MMR by ¾ between 1990 and 2015 (global)
Reduce MMR from 762/100 000 to 300/100 000 live births (Lesotho target)
Indicator: MMR

Key interventions	Indicator
1. Improved skilled service delivery	1.1 Proportion of deliveries conducted by skilled personnel/ birth attendant (SD rate)
2. Strengthening provision of EmONC	2.1 Proportion of health centres and hospitals providing basic BEmONC and CEmONC services respectively
3. Improve quality of ANC and PNC	3.1. Proportion of women who received quality ANC 3.2 Proportion of women who received quality PNC
4. Increase access to FP services	4.1 Proportion of women and men who receive FP services

	#	Prioritized actions
	1	Provision of adequate and functional Maternity Waiting Homes at health centres and hospitals
	2	Provision of adequate quantity and quality of HRH
	3	Improvement of referral systems and development of protocols and guidelines for referral
	4	Improvement of health centre physical infrastructure and roads connecting health centres to hospitals and other means of communication including cellular coverage
	1	Provision of adequate numbers and scaling up of training of professional nurses and medical doctors in BEmONC and CEmONC skills respectively
	2	Improvement of referral and emergency transport systems
	3	Improvement of the procurement and inventory management of BEmONC and CEmONC equipment and supplies
	4	Establishment and equipping of regional blood bank stations with basic equipment, adequate and skilled human resources
	5	Improvement of the monitoring (use of labour obstetric records/partographs) during all stages of labour, and for newborn and postnatal care
	1	Implementation of supermarket approach for the first MNCH services (ANC, PNC, FP and immunization).
	2	Conduction of integrated community outreach and mobile SRH, MNCH and FP services
	3	Implementation of ANC and PNC guidelines
	4	Improvement of procurement and logistics systems as well as scaling up of inventory systems in all health facilities
	5	Community mobilization and empowerment via information on importance of SRH and MNCH services
	6	Scaling up of customer care training
	1	Capacity-building of HRH on both natural and artificial methods of FP
	2	Strengthening of the CBD programme
	3	Improving the procurement, distribution and storage of FP commodities
	4	Empowerment of communities through information on benefits of FP and debunking myths about use of FP commodities
	5	Strengthening of village health post and running mobile FP clinics

IV. BOTTLENECK ANALYSIS

Photo: WHO

INTRODUCTION

The MoH continues to encounter challenges in the implementation of interventions geared towards improving maternal health. The identified constraints are related to policy and planning, budgeting and financing and service delivery. This chapter has attempted to identify sector-specific and cross-sector bottlenecks that are impeding effective implementation of prioritized interventions.

The three delay system has been used to analyse factors that preventing women from using health services during pregnancy, labour and delivery, resulting often in death. Figure 9 below shows the three delays attributed to maternal mortality and the factors contributing to these delays:

The delivery of quality health services is dependent on the availability of skilled human resources, available infrastructure and adequate equipment and supplies. The utilization of health services is affected by access, affordability and availability of needed services. Furthermore, the Basotho are not very vocal in their demands for accessing services as they tend to accept the status quo. This in part may also stem from a lack of awareness about their rights to demand appropriate health care services from the state.

Based on the identified key interventions, stakeholders undertook a detailed analysis of the causes preventing the implementation of the strategies. The identified bottlenecks per the MAF methodology are discussed below.

FIGURE 9: THE THREE DELAY MODEL AND CONTRIBUTING FACTORS

Delay in making a decision to seek care	Delay in reaching care	Delay in reaching care
• Socio-cultural barriers and low status of women affecting their decision-making power and ability to command resources • Failure to recognize complications • Poor accessibility of maternity homes • Poor communication systems	• Weak referral systems • Lack of community transportation • Absence of fully functional ambulance system • Limited hours of operation of the nearest health facility	• Limited health care personnel and inadequate skills • Inadequate equipment and supplies • Unavailability of blood and blood products • Lack of electronic monitoring devices • Inadequate infrastructure, water, electricity at health center level

4.1 IMPROVED SKILLED SERVICE DELIVERY

Despite the policies put in place to enhance access to skilled birth attendants, and the high ANC coverage in the country, access to a skilled birth attendant remains a major challenge. The unpredictable nature of the complications of labour and delivery warrant that individuals should deliver in a health facility where emergency care can be offered if needed. This intervention is hampered mainly by supply side issues, further exacerbated by budgetary constraints. The main bottlenecks underlying low facility-based delivery include:

• **Inadequate availability of and underutilization of existing Maternity Waiting Homes:** The practice of utilizing Maternity Waiting Homes has been seen to have increased access for women to skilled service delivery, particularly for pregnant women coming from afar. Presently there are approximately 150 such homes unevenly distributed amongst all the 181 health facilities in the country.[32] However, even these are not being utilized as authorities do not provide food in these homes. In addition, some waiting homes are in a bad state and require major renovations and repairs.

• **Lack of required health personnel:** The minimum complement of skilled health personnel is vital for quality obstetric services. However, health facilities in the country are not appropriately staffed and most do not adhere to the stipulated minimum staffing requirements. Health centres have only 28 percent of the minimum staffing requirement.[33] Furthermore, the available staff are not appropriately skilled or trained in EmONC. This situation is aggravated by the failure to implement retention strategies for HRH that were developed to address turnover. Generally, working conditions at the health centres are poor, with inadequate equipment and supplies, and poor amenities and communication for emergencies, including transport.

• **Health centres not open 24 hours:** Of the 160 health centres administered by the GoL, CHAL and Red Cross in the country, none operates for 24 hours and all days of the week. Lack of security at these facilities has been cited as the main reason for staff not wanting to work at night. This affects both supply and demand for the services and is a serious bottleneck in the provision of reproductive health services.

4.2 STRENGTHENING PROVISION OF EMERGENCY OBSTETRIC AND NEONATAL CARE

Although most obstetric complications are preventable with good quality ANC, intranatal care and PNC, their occurrence is largely unpredictable. Therefore, access to EmONC offers women who develop obstetric complications a high chance of survival. This intervention is constrained mainly by supply side issues identified below.

- Limited scope of practice to provide BEmONC and CEmONC signal functions: The Lesotho Medical and Dental Council and the Lesotho Nursing Council prescribes the scope of practice for doctors and nurses respectively and this does not include provision of some

32. As reported and documented by DHMTs.
33. Minimum staffing requirement: one nurse clinician; two registered midwives, two nursing assistants.

BEmONC and CEmONC signal functions by the staff at the health facilities. For instance, only a qualified anaesthetist can administer anaesthesia to a patient undergoing caesarean section. At present there are 10 qualified anaesthetists across the 16 hospitals in the country (eight Government and eight CHAL), while the minimum standard is two anaesthetists per hospital. Furthermore, midwives are also not permitted to carry out manual vacuum aspiration, an emergency obstetric procedure for removing retained placenta. This is a common cause of mortality on account of haemorrhage.

- **Inadequate BEmONC and CEmONC equipment and supplies:** Most health facilities do not have the necessary complement of supplies for treatment of obstetric complications, such as vacuum extractors. There is also a perennial shortage of essential drugs.

- **Inadequate blood and blood products:** Availability of appropriate quantity of blood and its products is absolutely essential in health facilities considering that nearly 30 percent of maternal mortality is caused by haemorrhage.[34] At the moment there is only one central blood bank in the country supplying all health facilities. There are no provisions for processing and storing blood in the health facilities, which adversely affects timely treatment of the patients. The central blood bank is not able to effectively mobilize communities to donate blood which leads to scarcity.

- **Poor monitoring during pregnancy, labour, delivery and the postnatal period:** Pre-eclampsia/eclampsia, (12 percent), prolonged labour (14 percent) and postpartum infection (34 percent) are major factors in maternal mortality. These are preventable causes through appropriate monitoring during pregnancy, intranatal and post labour. However, lack of adequate supplies of urine and blood testing reagents, labour obstetric records and skilled staff hampers monitoring during these periods. Further, the lack of space available in health facilities prevents mothers and neonates from being able to stay in for monitoring after delivery.

4.3 IMPROVED QUALITY OF ANTENATAL CARE AND POSTNATAL CARE

ANC is an entry point into MNCH. Timely attendance and frequent visits to ANC are important for early diagnosis and management of obstetric problems. Available data has, however, shown that, although ANC coverage is high in Lesotho, with 92 percent of women going for ANC at least once (LDHS, 2009), most women commence ANC late and do not attend the recommended four visits. There is gross inequality in the utilization of ANC services by place of residence, parity and age. The government has adopted focused PNC and recommends that the first ANC visit should be prior to 16 weeks, while immediate postpartum care should be within 48 hours postpartum. Immediate postpartum care gives the nurse the opportunity to rule out any factors that may cause either bleeding or puerperal sepsis. The bottlenecks underlying poor utilization and provision of both quality ANC and PNC include:

- Failure to practice the supermarket approach: The health facilities in the country follow a routine of scheduled visits, whereby certain services are offered only on designated days.

34. Causes of maternal mortality due to bleeding: complications of abortion (20 percent); haemorrhage (7 percent); ectopic pregnancy (3 percent).

This effectively limits access for expecting mothers and constrains monitoring during and post pregnancy. Health facilities need to offer all essential services such as ANC and PNC on a daily basis.

- Inadequate equipment and supplies for ANC and PNC: There is a chronic shortage of supplies such as urine testing reagents, functioning blood pressure monitoring machines and other equipment in the health facilities which are essential for ANC and PNC. For instance, it is reported that 12 percent of women die from pregnancy-induced hypertension, which can be managed if diagnosed and regularly monitored.

4.4 INCREASE ACCESS TO FAMILY PLANNING SERVICES

FP assists individuals to plan for pregnancies thus avoiding unplanned pregnancies. Through FP, couples are able to decide when and how many children to have. This is a service delivery issue with both supply and demand aspects. The main bottlenecks that hinder access to FP are:

- **Lack of equipment and supplies (commodities):** On the supply side, there are insufficient quantities and varieties of FP commodities, which prevent effective use. Further knowledge dissemination about FP methods is somewhat constrained by the unavailability of different types of commodities.

- **Low levels of awareness among male partners and relatives:** Basotho society is largely male dominated with regard to decision-making. Women have little say in reproductive health choices, including when and where to seek health services. In fact, recourse to FP methods is also sanctioned by the man or the mother-in-law. Therefore, low levels of awareness among the men and the mothers-in-law about the benefits of FP seriously hamper the use of these methods. FP is essential in mitigating the threat from unwanted pregnancies. For instance, abortions cause 20 percent of maternal deaths.

4.5 CROSS-CUTTING ISSUES

The following bottlenecks are identified as cross cutting across all the above mentioned intervention areas. These are significant constraints that prevent optimal delivery and utilization of services. They can be variously categorized as policy and planning issues, budgetary constraints and service delivery, especially supply and demand issues.

- **Inadequate infrastructure:** This bottleneck refers to poor road and communications infrastructure which prevent access to health facilities for patients. In a number of cases the absence of good roads from health centres to hospitals also causes avoidable delays in accessing appropriate health care in time. This lack of infrastructure also affects the referral system.

- **Inadequate skilled HRH:** The non-availability of skilled staff in adequate numbers in health facilities is a major reason for rising MMR. Patients are unable to receive appropriate quality care even when they get to the facilities. The minimum staffing complement is neither present nor sufficient. The retention strategies are not being implemented and poor working conditions are also responsible for the high attrition rate in these facilities.

- **Inadequate equipment and supplies:** The health facilities commonly suffer from a lack of necessary equipment and drugs to treat and manage patients. This becomes a serious problem even as patients manage to access the health facilities and skilled care.

- **Inadequate customer care and outreach services:** Lack of skilled staff and inadequate resources prevent appropriate customer care as well as outreach services to educate and disseminate information on reproductive health. It also prevents the provision of integrated MNCH and FP services.

- **Inadequate M&E:** The health system in the country is guided by numerous policies and strategies designed to provide quality health services to the citizens. However, a lack of regular evaluation M&E of these policies and strategies prevents timely identification of challenges and the institution of remedial measures. The situation is further compounded by a lack of accountability of the health service providers given the lack of a functioning performance-based management system.

- **Cultural barriers and religious belief systems:** Cultural beliefs and practices have a bearing on the utilization of health services. Lesotho is a patriarchal society with women being treated as inferiors, which perpetuates gender inequality, which in turn has a bearing on sexual and reproductive beliefs and practices. For example, women have to seek permission of their husbands before seeking any SRH services as they cannot make decisions independently. Cultural barriers and having to seek permission have been cited as barriers to the utilization of SRH services.[35] Some religious beliefs also lead to low health-seeking behaviour. For instance, the Roman Catholic Church discourages recourse to artificial FP methods. There is also a prevalence of traditional techniques for birthing and FP. One of the common beliefs is that a placenta should be buried to prevent further pregnancies. The delay in initiation of ANC is most often caused by mothers-in-law who would like to conceal the pregnancies of their daughters-in-law for fear of bewitchment. Traditional medicines are also given to a pregnant woman at different stages of her pregnancy. This points to the urgent need for community empowerment and mobilization to complement the other strategies.

35. DHS, 2009.

V. IDENTIFYING SOLUTIONS

Photo: WHO

To address the prioritized bottlenecks identified in the previous section, cost-effective and targeted solutions for the proposed four intervention areas have been identified, taking into consideration their impact (magnitude, speed, sustainability and causes of maternal mortality in Lesotho) and feasibility (governance, capacity and availability of financial resources) to accelerate progress in maternal health in Lesotho.

5.1 IMPROVE SKILLED SERVICE DELIVERY

Proposed key prioritized solutions:

- **Expedite transfer of Maternity Waiting Homes:** Maternity Waiting Homes enhance access to skilled services especially for mothers arriving from distant and hard to reach areas. Therefore, expediting the handing over of these homes and health centres to local authorities, which have been refurbished or constructed by the Millennium Challenge Account will give Lesotho a speedy and cost effective solution in the immediate term. Construction of additional Maternity Waiting Homes and the refurbishment of these homes in hospitals would also enhance access to skilled services.

- **Provide food at Maternity Waiting Homes:** One of the reasons for the underutilization of existing Maternity Waiting Homes is the unavailability of food. There is an expectation that women will bring their own food which is not practical given both high levels of poverty and the long distances that some of them travel. Therefore providing food in 160 the health centres, revitalizing homestead gardens and establishing keyhole gardens would remove this demand side constraint.

- **Enhance communications:** Enhancing communication through improvement of cellular coverage and procurement of transmitters where network coverage cannot be improved would improve access to the referral system. Establishment of toll free hotlines at hospitals will further improve access to emergency referral services.

- **Improve road infrastructure:** Construction of basic roads that connect health centres to hospitals will improve access to health facilities, particularly given the country's mountainous and difficult terrain.

- **Increase ambulance and emergency services:** Provision of fully functional (equipment and ER personnel) and appropriate ambulances with trained personnel will greatly alleviate mortality rates due to timely intervention.

- **Enhance community resources:** Providing assistance to communities to mobilize resources for transport from community to health centres is an essential aspect of accessing health facilities and increases their timely utilization.

- **Maintain medical equipment:** Development of a maintenance plan for all health facilities including through the recruitment and training of maintenance staff will support the continuous availability of functional medical equipment, which is necessary for treatment and care.

- **Provide incentive packages:** Provision of attractive incentives packages for health care workers will provide the appropriate motivation to accept deployment especially in the hard to reach areas. Further implementation of the retention strategy is

also necessary to retain the services of skilled and trained personnel in the health centres.

- **Enhance performance monitoring:** Capacity-building of mentors/public health nurses in MNCH is essential to ensure appropriate service. Regular monitoring of health centres by DHMTs would also enhance quality of services.

5.2 STRENGTHEN PROVISION OF EMERGENCY OBSTETRIC AND NEONATAL CARE

Proposed key prioritized solutions include:

- **Orientation of doctors and nurses:** There is an urgent need for capacity-building of doctors on CEmONC skills to include administration of anaesthesia and on BEmONC skills for nurse midwives to provide the necessary care to pregnant women.

- **Improvement in procurement procedures:** Efficient and improved procurement and inventory management for BEmONC and CEmONC equipment and supplies is important to ensure availability and utilization. Further, the sufficient supply and utilization of Lesotho Obstetric Report for monitoring during pregnancy, labour, delivery and neonatal care is also absolutely essential.

- **Establishment of regional blood banks:** Establishment and equipping regional blood bank stations with basic equipment and adequate staff will help to ensure consistent supply in blood and its products in a timely manner.

- **Reinforcement of patient tracking systems:** The implementation of a patient tracking tool at the community level for MNCH services needs to be revitalized to monitor and track pregnant women to ensure their timely attendance of clinics.

5.3 IMPROVE QUALITY OF ANTENATAL AND POSTNATAL CARE

Proposed key prioritized solutions include:

- **Implementation of the supermarket approach:** This approach ensures the availability of all necessary services (e.g., ANC, PNC, immunizations) for MNCH at all times rather than on scheduled days. Implementation and monitoring of the use of ANC and PNC guidelines should also be ensured.

- **Integration of community outreach services:** Community outreach programme and mobile services for HIV, SRH, MNCH and FP services are not being provided in an integrated manner presently. This results in low awareness and high cost of individual programmes. Therefore, integration of ANC education into pre-delivery care services e.g., FP and SRH programmes, is essential. This will also include community empowerment through information on the importance of ANC attendance, and social mobilization to educate males and mothers in-laws to recognize danger signs during pregnancy, labour and delivery.

- **Review of staffing requirements:** A review and immediate implementation of a full staff complement at the health centre level is essential to provide appropriate skilled services. This will also ensure the availability of round the clock services.

- **Decentralization of procurement:** The procurement of supplies and equipment, and maintenance and repair of vehicles needs to be decentralized to ensure speedy turnaround times. Further, new staff should be provided appropriate training on procurement and logistics. Scale-up in the proper use of the inventory system in all health facilities is also essential.

5.4 INCREASE ACCESS TO FAMILY PLANNING SERVICES

Proposed key prioritized solutions include:

- **CBD programmes:** The effective and efficient use of trained CBDs to provide FP services needs to be stepped up, which will enhance access to FP services.

- **Capacity-building of HRH** on both artificial and natural methods of FP is needed to increase the uptake of FP services.

- **Community outreach and awareness** is required to empower males and in-laws on the benefits of FP to the family, community and society as a whole.

TABLE 6: PRIORITIZED SOLUTIONS FOR ACCELERATING PROGRESS TOWARDS MDG 5 IN LESOTHO

MDG Goal 5:	**Improve Maternal Health**
Target 5a:	**Reduce the MMR by ¾ between 1990 and 2015 (global)** **Reduce MMR from 762/100 000 to 300/100 000 live births (Lesotho target)**
MDG Indicator:	**5.1 MMR** **5.2. Proportion of births attended by skilled birth attendants**

Key intervention areas	Prioritized bottlenecks
1. Improve skilled service delivery	1.1 Inadequate number and underutilization of existing Maternity Waiting Homes
	1.2 Weak referral systems, protocols and service guidelines at all levels of care
	1.3 Lack of adequate (quality and quantity) of required health personnel due to non-implementation of retention strategy for HRH

	Prioritized accelerated solutions	Potential partners
	1.1a Expediting of the handing over of refurbished /constructed shelters in health centres	MoH
	1.1b Additional construction and refurbishment of Maternity Waiting Homes in hospitals and increase capacity of available houses	MoH
	1.1c Provision of food in Maternity Waiting Homes at health centre level	WFP FAO MoA
	1.1d Establishment of keyhole gardens at the health centres	MoA
	1.1e Provision of cell phones to VHW responsible for MCH services	UN MoH
	1.2a Procurement of 20 fully equipped and functional ambulances	MoCST
	1.2b Improvement of cellular network coverage in facilities where it is either poor or unavailable	MoCST
	1.2c Establishment of toll free hotlines in all 19 hospitals	MoH MoCST
	1.2d Provision of cell phones to all remaining health centres without them	MoH MoCST
	1.2e Procurement of transmitters for facilities situated in places where it may not be possible to improve network coverage	MoH MoCST
	1.2f Provision of cell phones to VHW responsible for MNCH services	MoH WHO
	1.3a Expedite the implementation of retention strategy	MoH
	1.3b Roll out performance-based financing to all districts	MoH WB
	1.3c Training/capacity-building of selected senior nurses on MNCH for mentoring others	MoH
	1.3d Provision of incentive packages for MNCH mentors at health centres	MoH
	1.3e Increase staffing complement at health centre level	MoH MoPS MoF

MDG Goal 5:	**Improve Maternal Health**
Target 5a:	**Reduce the MMR by ¾ between 1990 and 2015 (global)** **Reduce MMR from 762/100 000 to 300/100 000 live births (Lesotho target)**
MDG Indicator:	**5.1 MMR** **5.2. Proportion of births attended by skilled birth attendants**

Key intervention areas	Prioritized bottlenecks
1. Improve skilled service delivery	1.4 Health centres not opening for 24 hours, 7 days a week due to lack of security
	1.5 Inadequate accessibility to hospital as a result of poor road infrastructure from health centre to hospital
	1.6 Lack of functioning performance based management, monitoring and accountable health system
	1.7. Poor infrastructure, lack of equipment and supplies at health centre level
2. Strengthening provision of EmONC	2.1 Limited scope of practice, shortage and inability to retain skilled HRH to provide BEmONC and CEmONC signal functions
	2.2 Inadequate BEmONC and CEmONC equipment and supplies
	2.3 Inadequate blood and blood products
	2.4 Poor monitoring during pregnancy, labour, delivery and postnatal period

	Prioritized accelerated solutions	Potential partners
	1.4a Employment of professional security in all health centres	MoH
	1.4b Community mobilization to provide security services at health centres	MoLGCA
	1.5a Construction of basic roads that connect health centres to hospitals	MoPWT MoLGCA
	1.6a Implementation of appraisal systems	MoH MoPS UNDP
	1.6b Strengthening of leadership capacity of staff at all levels	
	1.7a Expedite completion of refurbishment and installation of basic services such as water and electricity, and furniture at some health facilities	MoH
	1.7b Expedite purchase of equipment and supplies	MoH
	1.7c Establishment of maintenance plan for all health facilities including recruitment and training of available maintenance people and outsourcing of maintenance services when necessary	MoH MoLGCA
	2.1a Orientation and training of doctors and midwives on CEmONC and BEmONC skills, respectively	MoH WHO UNICEF
	2.2a Improvement of the procurement and inventory management of BEmONC and CEmONC equipment and supplies	MoH WHO
	2.3a Establishment and equipping of regional blood bank stations with basic equipment and adequate human resources	MoH MoPS
	2.4a Ensure sufficient supply and utilization of the Lesotho Obstetric Record	MoH
	2.4b Strengthening maternal death audits and dissemination of findings	
	2.4c implementation of ANC and PNC guidelines	

MDG Goal 5:	**Improve Maternal Health**
Target 5a:	**Reduce the MMR by ¾ between 1990 and 2015 (global)** **Reduce MMR from 762/100 000 to 300/100 000 live births (Lesotho target)**
MDG Indicator:	**5.1 MMR** **5.2. Proportion of births attended by skilled birth attendants**

Key intervention areas	Prioritized bottlenecks
3. Improve quality of ANC and PNC	3.1 Failure to practice supermarket approach
	3.2 Lack of outreach and mobile clinic services for MNCH services
	3.3 Cultural barriers leading to low health-seeking behaviour
	3.4 Inadequate equipment and supplies for ANC and PNC
4. Increase access to FP services	4.1 Inadequate number of skilled HRH on artificial and natural methods of FP
	4.2 Lack of equipment and supplies
	4.3 Low level of involvement by male partners and in-laws
	4.4 Poor community outreach services associated with lack of transport
	4.5 Customary and religious beliefs systems and myths associated with FP use
	4.6 Poor customer care

	Prioritized accelerated solutions	Potential partners
	3.1a Implementation of supermarket approach for the first MNCH services (e.g. ANC ,PNC, immunizations)	MoH MoLGCA MoPS MoF
	3.1b Implementation of full staff complement per MoH quality assurance guidelines	
	3.1c Increase in current staff complement by a minimum of three midwives per H/C and two nursing assistants to accommodate night duty services and community outreach	
	3.1d Recruitment and employment of pharmacy technicians, counsellors, data clerks, account clerks at health centre level	
	3.2a Conducting of integrated SRH community outreach programs and mobile clinics (integrated SRH, MNCH and FP services)	MoH UNICEF
	3.3a Strengthen advocacy on cultural factors affecting maternal health	MoH MoLGCA (DHMT) UNICEF
	3.3b Community empowerment on importance of ANC and PNC attendance, danger signs during pregnancy, labour and delivery and postpartum through social mobilization targeting males and mothers in-laws	
	3.4a Orientation training of new staff and refresher training for old staff on procurement and logistics systems	MoH MoLGCA (DHMT)
	3.4b Decentralization of procurement of equipment, supplies and vehicle maintenance and repairs	
	3.4c Scale-up of proper use of inventory system in all health facilities	
	4.1a Capacity-building of HRH on both artificial and natural methods of FP	MoH , UNFPA , WHO
	4.2a Intensify training in management of procurement, logistics and supplies	MoH
	4.3a Education of male partners and in-laws on the benefits of FP to the family, community and society	MoH UNFPA
	4.4a integration of FP services into other SRH outreach programmes	MoH , UNFPA
	4.5a Education of communities on benefits of FP and dispelling of myths	MoH UNFPA
	4.5b Intensify, effective and efficient use of trained CBDs, and ensure monitoring and support	
	4.5c Informing of health care providers on natural methods of FP	
	4.5d Procurement of tools for monitoring natural method of FP commodities and IEC materials	
	4.6a Scale-up of training of trainers on customer care	MoH

VI. LESOTHO MAF ACTION PLAN AND RESOURCE PROFILE

Photo: WHO

Lesotho's MoH cannot succeed alone in attaining the key interventions and proposed solutions that have been identified, without good financial support, commitment and overall support of the Government and its line ministries and stakeholders including development partners, civil society organizations and NGOs. Table 9 shows the Lesotho MAF Action Plan, which depicts the key interventions, prioritized bottlenecks and accelerated solutions, potential partners, available resources and resource gaps. It is important to note that the Action Plan envisages that all the targets may not be achieved by 2015 but at least an accelerated implementation would ensure achievement by 2017. This is also aligned with the NSDP for 2012 to 2017.

6.1 BUDGET

The budget for the MAF totalling $105,781,562 (M952,034,065)[36] takes into account all the inputs required for its implementation, irrespective of whether they have been allocated or not. The budget makes provision for:

1. Improved skilled delivery (M750,322,109);
2. Strengthening EmONC (M16,276,653);
3. Improving the quality of ANC and neonatal care (M165,160,223);
4. Increasing access to FP services (M20,275,080).

Significant elements of the budget have already been allocated, in particular for upgrading roads, which is part of the capital budget allocations of the Ministry of Local Government and Chieftainship Affairs and the Roads Directorate. Some recurrent costs, for example, salary provisions for vacant health worker posts, are also reflected in the recurrent budget of the MoH.

Nevertheless, various dimensions of the budget have not been covered and it remains the responsibility of the GoL, first to identify and isolate these gaps and then to secure resources for them, either through the disbursement of its own funds, or through funding by development partners. The GoL will need to assess the sustainability of some the recurrent expenditure requirements of the MAF to ensure that where possible they can be integrated into future budget allocations.

The budget total of M952,034,065 assumes an increasing rate of implementation over the period 2013 to 2015 and is allocated by year as follows:

2013: M339,459,317
2014: M317,288,330
2015: M295,277,468

36. Lesotho's currency, the loti, has an exchange rate of $1 to M10 at the time of this report.

TABLE 7: MAF BUDGET BY COST CATEGORY AND ACTIVITY AREA					
	2013	2014	2015	Total	Total in US$ (at exchange rate of M10 = US$ 1)
Grand total MAF action plan cost (in maloti)	**339,492,300**	**317,281,313**	**295,260,452**	**952,034,065**	**105,781,562**
Infrastructure and operating costs					
Construction costs (additional staff housing for three/health centre)	33,779,196	33,779,196	33,779,196	101,337,588	11,259,732
Construction costs (Maternity Waiting Homes)	17,145,918	16,631,540	0	33,777,458	3,753,050
Equipment purchases (Maternity Waiting Homes)	542,000	525,740	0	1,067,740	118,637
Rehabilitation costs (Maternity Waiting Homes)	375,000	130,000	55,000	560,000	62,222
MWH operating costs (food supply)	1,848,000	3,048,000	4,212,000	9,108,000	1,012,000
Equipment purchases (health centres)	1,640,616	0	0	1,640,616	182,290
Communication equipment (purchase and operating cost)	2,589,540	1,637,540	1,637,540	5,864,620	65,1624
Vehicle purchases	16,016,000	0	0	16,016,000	1,779,555
Vehicle maintenance and repair costs	800,800	800,800	800,800	2,402,400	266,933
Vehicle fuel costs	91,940	91,940	91,940	275,820	30,646
Vehicle driver salaries	1,600,000	1,600,000	1,600,000	4,800,000	533,333
Subtotal	**76,429,010**	**58,244,756**	**42,176,476**	**176,850,242**	**19,650,026**

Human resources summary – Lesotho MAF					
Salaries (additional staff)	157,475,689	159,648,644	161,924,775	479,049,108	5,3227,678
Benefits	0	0	0	0	0
Incentives (hard to reach health centres)	3,919,200	3,919,200	3,919,200	11,757,600	1,306,400
Subtotal	**161,394,889**	**163,567,844**	**165,843,975**	**490,806,708**	**54,534,078**
Programme Costs					
In-service / refresher training	18,672,582	13,183,234	4,969,522	36,825,338	4,091,704
Supportive supervision and mentorship	746,700	746,700	746,700	2,240,100	248,900
Development and printing of materials	1,111,839	401,499	386,499	1,899,837	211,093
Social mobilization outreach activities	100,000	100,000	100,000	300,000	33,333
Subtotal	**20,631,121**	**14,431,433**	**6,202,721**	**41,265,275**	**4,585,030**
Other supportive costs					
Road construction	80,750,000	80,750,000	80,750,000	242,250,000	26,916,666
Keyhole gardens for health centres	287,280	287,280	287,280	861,840	95,760
Subtotal	**81,037,280**	**81,037,280**	**81,037,280**	**243,111,840**	**27,012,426**

TABLE 8: MAF BUDGET BY ACTIVITY
Activity area
1. Improved skilled service delivery
1.1 Inadequate numbers and underutilization of MWH
1.1a Expediting the handing over of refurbished/constructed shelters in health centres
1.1b Construction/refurbishment of Maternity Waiting Homes
1.1c Renovation of Maternity Waiting Homes
1.1d Provision of food in in Maternity Waiting Homes
1.1e Establishing of keyhole gardens in health centres
1.2 Weak referral systems, protocols and service guidelines at all levels
1.2a Procurement of 20 fully equipped ambulances, two for each DHMT(includes operating costs)
1.2b Improvement of cellular network coverage in facilities where it is either poor or not available
1.2c Establishment of toll free hotlines at hospital level (19 hospitals)
1.2d Provision of cell phones to remaining health centres without them
1.2e Procurement of transmitters for facilities situated in places where it may not be possible to improve coverage
1.2f Provision of cell phones to VHW responsible for MCH services
1.2g Developing, printing and dissemination of national protocols and service guidelines on referrals
1.3Lack of adequate quantity and quality of required HRH due to non-implementation of retention strategy
1.3a Expediting the implementation of retention strategy
1.3b Rolling out performance based financing to all districts
1.3c Construction of additional staff houses in health centres (three per health centre)
1.3d Training of selected senior nurses in facilities on MCH for mentoring others
1.3e Provision of incentive packages for MNCH mentors for health centres (per diem costs for conducting mentoring in health facilities)
1.3f Increase in staffing complement at health centre level
1.4 Health centres not opening 24/7 due to lack of security
1.4a Provision of professional security in all health centres
1.4b Community mobilization to provide security services at health centre level

	Cost estimate			
	2013	2014	2015	TOTAL
	265,198,552	**250,595,918**	**234,527,638**	**750,322,109**
	20,198,198	**20,622,560**	**4,554,280**	**45,375,038**
	17,687,918	17,157,280	0	34,845,198
	375,000	130,000	55,000	560,000
	1,848,000	3,048,000	4,212,000	9,108,000
	287,280	287,280	287,280	861,840
	16,098,984	**3,277,024**	**3,277,024**	**22,653,032**
	13,339,484	1,639,484	1,639,484	16,618,452
	180,000	180,000	180,000	540,000
	910,140	910,140	910,140	2,730,420
	1,499,400	547,400	547,400	2,594,200
	169,960	0	0	169,960
	34,560,256	**34,468,696**	**34,468,696**	**103,497,648**
	33,779,196	33,779,196	33,779,196	101,337,588
	91,560	0	0	91,560
	689,500	689,500	689,500	2,068,500
	111,280,288	**111,280,288**	**111,280,288**	**333,840,865**
	111,280,288	111,280,288	111,280,288	333,840,865

Activity area
1. Improved skilled service delivery
1.5 Inadequate accessibility of hospitals as a result of poor roads from health centres to hospitals
1.5a Construction of basic roads that connect communities/facilities to health centres
1.6 Lack of functioning performance-based management, monitoring and accountable health systems
1.6a Implementation of appraisal systems
1.6b Strengthening of leadership capacity of staff at all levels (cost for training on district health management)
1.7 Poor infrastructure, lack of equipment and supplies at health centre level
1.7a Refurbishment and installation of basic services such as water and electricity, and furniture at some health facilities
1.7b Expediting purchase for equipment and supplies (provision of delivery packs, Ves, MVA kits and newborn resuscitation kits)
1.7c Establishment of maintenance plan for all health facilities including recruitment and training of available maintenance people and outsourcing of maintenance services when necessary (cost for training on equipment maintenance)
Maintaining budget
2. Strengthening provision of EmONC
2.1 Limited scope of practice, shortage and inability to retain skilled HRH to provide BEmONC and CEmONC and inadequate equipment and supplies
2.1a Training of doctors and midwives in EmONC skills
Training of doctors in anaesthesia
Attachment of nurses/midwives to hospitals
Training of ambulance drivers in first aid
2.2 Inadequate BEmONC and CEmONC equipment and supplies
2.2a Improving the procurement and inventory management of BEmONC and CemONC equipment and supplies (training)
2.3 Inadequate blood and blood products
2.3a Establishment and equipping of regional blood banks
Review of blood transfusion policy
Training of laboratory technicians at hospital level in processing blood
Provision of vehicles for social mobilization for voluntary blood donation (includes operating costs)
IEC materials

	Cost estimate			
	2013	2014	2015	TOTAL
	265,198,552	**250,595,918**	**234,527,638**	**750,322,109**
	80,750,000	**80,750,000**	**80,750,000**	**242,250,000**
	80,750,000	80,750,000	80,750,000	242,250,000
	592,050	**197,350**	**197,350**	**986,750**
	592,050	197,350	197,350	986,750
	1,718,776	**0**	**0**	**1,718,776**
	1,640,616	0	0	1,640,616
	78,160	0	0	78,160
	0	0	0	0
	8,143,194	**4,595,656**	**3,528,853**	**16,276,653**
	6,486,894	**4,355,124**	**3,278,322**	**14,120,340**
	4,244,370	2,176,600	1,458,322	7,879,292
	358,524	358,524	0	717,048
	1,876,000	1,820,000	1,820,000	5,516,000
	8,000	0	0	8,000
	87,460	**0**	**0**	**87,460**
	87,460	0	0	87,460
	1,294,404	**151,016**	**151,016**	**1,596,436**
	169,960	0	0	169,960
	157,428	0	0	157,428
	967,016	151,016	151,016	1,269,048

Activity area
3. Improve quality of ANC and PNC
3. 1 Failure to practice supermarket approach
3.1a Implementation of supermarket approach for the first MNCH services (e.g, ANC, PNC, immunization)
3.1b Implementation of full staff complement per MOH quality assurance guidelines (incentives for 46 hard to reach health centres)
3.1c Increase in current staff complement by a minimum of three midwives and two nursing assistants to accommodate night duty services and community outreach
3.1d Recruitment and deployment of pharmacy technicians, counsellors, data clerks at health centre level
3.2 Lack of outreach and mobile clinic services for MNCH services
3.2a Integrated community outreach programme and mobile clinics for Integrated SRH, MNCH and FP services (outreach vehicle purchase and operating costs, including drivers' salaries)
3.3 Cultural barriers leading to low health-seeking behaviours
3.3a Strengthening of advocacy and social mobilization on cultural factors affecting maternal health (cost of IEC materials)
3.3b Community empowerment through awareness of the importance of ANC and PNC attendance, and learning to identify the danger signs during pregnancy, labour and delivery and postpartum, through social mobilization targeting males and mother-in laws
3.4 Inadequate equipment and supplies for ANC
3.4a Training of new staff and refresher training of old staff on procurement and logistics system for drugs and supplies
3.4b Decentralization of procurement of equipment and supplies and vehicle maintenance and repair of vehicles; develop a policy on decentralization, set up a consultancy and workshops
3.4c Scale up of proper use of inventory system in all health facilities
Printing and distribution of inventory tools

	Cost estimate			
	2013	2014	2015	TOTAL
	55,487,651	**54,002,646**	**55,669,927**	**165,160,223**
	50,114,601	**52,287,556**	**54,563,687**	**156,965,843**
	3,919,200	3,919,200	3,919,200	11,757,600
	46,195,401	48,368,356	50,644,487	145,208,243
	4,202,240	**702,240**	**702,240**	**5,606,720**
	4,202,240	702,240	702,240	5,606,720
	403,000	**400,000**	**400,000**	**1,203,000**
	303,000	300,000	300,000	903,000
	100,000	100,000	100,000	300,000
	767,810	**612,850**	**4,000**	**1,384,660**
	608,850	608,850	0	1,217,700
	154,960	0	0	154,960
	4,000	4,000	4,000	12,000

Activity area
4: increase access to FP services
4.1,Inadequate number of skilled HRH on artificial and natural methods of FP
Developing, printing and distribution of FP training material and scaling up strategy
4.1a Capacity-building of health workers on both artificial and natural methods of FP
4.2 Lack of equipment and supplies
4.2a Intensification of training on procurement and management of logistics and supplies
4.3 Low levels of male partner involvement
4.3a Empowerment of male partners and in-laws on the benefits of FP to the family, community and society
4.4 Poor community outreach services associated with lack of transport
4.4a Integration of FP services with other SRH programs
4.5 Customary and religious belief systems and myths associated with FP use
4.5a Empowerment of communities through knowledge about benefits of FP and dispelling of myths
4.5b Intensification of effective and efficient use of trained community based distributors and ensure monitoring of support (training)
4.5c Quarterly supportive supervision
4.5d Empowerment of health care providers on natural FP methods
4.5e Procurement of tools for monitoring natural methods of FP commodities and IEC materials
4.6 Improvement in customer care
4.6a Scaling up of training of trainers on customer care training
GRAND TOTAL

	Cost estimate			
	2013	2014	2015	TOTAL
	10,629,920	**8,094,110**	**1,551,050**	**20,275,080**
	2,169,260	**1,508,850**	**1,493,850**	**5,171,960**
	177,460	15,000	0	192,460
	1,991,800	1,493,850	1,493,850	4,979,500
	8,373,200	**6,585,260**	**57,200**	**15,015,660**
	8,316,000	6,528,060	0	14,844,060
	57,200	57,200	57,200	171,600
	87,460	**0**	**0**	**87,460**
	87,460	0	0	87,460
	339,459,317	**317,288,330**	**295,277,468**	**952,034,065**

GOVERNMENT OF LESOTHO ALLOCATIONS TO THE MAF BUDGET

The MoH currently budgets by department programmes to reflect both capital and recurrent expenditure. The aggregated nature of the MoH budget does not allow the identification of allocations to specific activities or departmental objectives such as maternal health. Budget items such as salary costs, the cost of drugs and vaccines and the costs of outreach activities are allocated to programmes, including to the Family Health Division which is responsible for SRH and MNCH, as well as other health objectives. This has constrained the ability to determine in detail the MoH's and indeed the GoL's current allocations towards SRH including MNCH activities. With the commencement of the MAF, the MoH proposes to allocate at least 50 percent of the MAF costs, with the exception of road upgrading costs which are fully funded. (The nature of the MoH's budget provides opportunity for technical assistance to assist the ministry to move towards activity and programme based budgeting, critical for improved planning, budgeting and monitoring and evaluation).

TABLE 9: MAF ACTION PLAN: KEY INTERVENTIONS, BOTTLENECKS, SOLUTIONS, BUDGET REQUIREMENTS, POTENTIAL PARTNERS AND RESOURCE GAPS

MDG Goal 5:	To Improve Maternal Health
Target 5a:	To reduce the MMR by ¾ between 1990 and 2015
MDG Indicators:	5.1 Maternal Mortality Ratio

Key intervention Area(s)	Prioritized bottlenecks	Prioritized accelerated solutions
1. Improve skilled service delivery	1.1 Inadequate and underutilized Waiting Mothers Homes	Expediting the handing over of 130 refurbished / constructed shelters in health centres
		Additional construction and refurbishment of 197 maternity waiting homes in hospitals and increasing capacity of available houses
		Provision of food for Maternity Waiting Homes in 160 health centres
		Revitalization of homesteads and/or establishment of keyhole gardens in 160 health centres
	Weak referral systems, protocols and service guidelines at all levels of care	Procurement of 20 fully equipped and functional ambulances for DHMTS
		Improvement of cellular network coverage in 10 facilities where it is either poor or unavailable
		Establishment of toll free hotlines in all 16 hospitals (8 GoL, 8 CHAL)
		Provision of cell phones to all remaining health centres that were not provided them

	Potential partners	Total cost US$	Available funds		Resource gap
			Government	Partners	
	MOH, UNFPA				
	UNFPA	$3,933,910	$1966955	UNFPA $100,000 WFP $37,000	$1,829,955
	WFP, FAO	$1,012,000	$506,000		$506,000
	MoAFS	$95,760	$47,880		$47,880
	UN, MoH	$1,846, 494	$923,247		$923,247
	MoCST, MoH,				
	MoCST, MoH, UN	$60,000	$30,000	$30,000, UNDP	
	MoH, MoCST, UN	$303,380	$151,690		$151,690

MDG Goal 5:	To Improve Maternal Health
Target 5a:	To reduce the MMR by ¾ between 1990 and 2015
MDG Indicators:	5.1 Maternal Mortality Ratio

Key intervention Area(s)	Prioritized bottlenecks	Prioritized accelerated solutions
1. Improve skilled service delivery	Weak referral systems, protocols and service guidelines at all levels of care	Procurement of transmitters for facilities situated in places where it may not be possible to improve network coverage.
		Provision of cell phones to 7,140 VHWs
		Additional construction of three staff houses in 46 hard to reach health centres
		Development of referral guidelines and protocols
		Contingency plan for referral of patients during times of disaster (flooded roads and damaged bridges) e.g., use of helicopters
	Lack of adequate (quality & quantity) of required health personnel associated with non-implementation of retention strategy for HRH	Expediting the implementation of an HRH retention strategy
		Implementation of performance-based financing to all districts
		Training/capacity-building of selected 20 senior nurses in MNCH for mentoring others
		Provision of incentive packages to 20 selected MNCH mentors for health centres
		Double the current staffing complement of three professional nurses and two nursing assistants at health centre level
		Construction of five additional staff houses in 46 hard to reach facilities
	Health centres not open for 24hours and 7 days a week due to lack of security	Employment of professional security in all health centres
		Community mobilization to provide security services at health centre level
	Inadequate accessibility to hospital as a result of poor roads from health centres to hospitals	Construction of basic roads that connect 16 health centres to hospitals
	Lack of functioning performance-based management, monitoring and accountable health system	Implementation of appraisal systems in all (182) health facilities
		Strengthen leadership capacity of staff at all levels

	Potential partners	Total cost US$	Available funds		Resource gap
			Government	Partners	
	MoH, MoCST, UN				
	MoH, MoCST, UN	$288,244	$144,122		$144,122
	MoH, WHO	$18,884	$9,442	WHO $30,000	+20,558
	MoH, MoPS, MoF				
	MoH, WB	$11,200,000	$5,600,000	World Bank $11,200,000	+5,600,000
	MoH, WHO, UNFPA	$10,173	$5,086.5	WHO $25,000 UNFPA $150,000	+169,913.5
	MoH, UNFPA, WB	$229,833	$114,916.5	UNFPA $50,000	$64,916.5
	MoH, MoPS, MoF				
		$11,259,732	$5,629,866		$5,629,866
	MoH	$333,840,865	$166,920,433		$166920433
	MoLGCA				
	MoPWT, MoLGCA	$26,916,666	$26,916,666		
	MoH, MoPS				
		$109,638	$54,819		$54,819

MDG Goal 5:	To Improve Maternal Health
Target 5a:	To reduce the MMR by ¾ between 1990 and 2015
MDG Indicators:	5.1 Maternal Mortality Ratio

Key intervention Area(s)	Prioritized bottlenecks	Prioritized accelerated solutions
1. Improve skilled service delivery	Poor infrastructure, lack of equipment and supplies at health centre level	Expedite completion of refurbishment and installation of basic services such as water and electricity, and furniture in 67 health centres
		Purchase of birthing equipment and supplies
		Establishment of maintenance plan for all 182 health facilities including recruitment and training of available maintenance people and outsourcing of maintenance services when necessary
2. Strengthening provision of Emergency and Obstetric and neonatal Care	Limited scope of practice and inability to retain as well as shortage of skilled HRH to provide BEmONC and CEmONC signal functions	Orientation and in-service training of 38 doctors and 619 midwives on CEmONC and BEmONC skills, respectively.
		Training of five mentors for doctors on CEmONC
	Inadequate BEmONC and CEmONC equipment and Supplies	Improving the procurement and inventory management of BEmONC (160 health centres) and CEmONC (16 hospitals) equipment and supplies
	Inadequate trained advanced midwives	Training of 15-20 advanced midwives
	Lack of training of nurse anaesthetist	Training of 12 nurse anaesthetists
	Inadequately trained pharmacists on logistics and quantification	Training of pharmacists on logistics and quantification
	Inadequate blood and blood products	Revitalization and equipping of two regional blood bank stations with basic equipment and adequate human resources and purchasing of two 4x4 vehicles
		Revitalization of blood processing and storage at all 16 hospitals
		Ensure sufficient supply and utilization of Lesotho Obstetric Record
	Poor monitoring during pregnancy, labour, delivery and postnatal period	Strengthening maternal death audit and dissemination of findings to 182 health facilities

	Potential partners	Total cost US$	Available funds		Resource gap
			Government	Partners	
	MoH				
	MoH	$182 290	$91,145		$91,145
	MoH, MoLGCA	$8 684	$4,342		$4,342
	MoH, WHO, UNFPA	$955,148	$477574	WHO $20,000 UNFPA $200,000 UNICEF $15,000	$242,574
	UNFPA				
	MoH, WHO	$9 717	$4,858		$4,858
	WB	$150,000	$75,000	WB $150,000	+$75,000
	WB	$156,000	$78000	WB $156,000	+$78,000
	World Bank	$150,000	$75,000	WB $150,000	+$75,000
	MoH, MoF, MoPS	$158,497	$79,248		$79,248
	MoH, UNICEF, WHO, UNDP				
	MoH, WHO, UNFPA	$20 000	$10,000	WHO $15,000 UNFPA $300,000	+$305000
	WHO, UNFPA	$32 490	$16,245		$16,245

MDG Goal 5:	To Improve Maternal Health
Target 5a:	To reduce the MMR by ¾ between 1990 and 2015
MDG Indicators:	5.1 Maternal Mortality Ratio

Key intervention Area(s)	Prioritized bottlenecks	Prioritized accelerated solutions
3. Improve quality of antenatal care (ANC) and postnatal care (PNC)	3.1 Failure to practice supermarket approach	3.1a Implementation of supermarket approach for the first MNCH services (e.g., ANC ,PNC, immunizations)
		3.1b Implement full staff complement as per MoH quality assurance guidelines
		3.1c Increase current staff complement by a minimum of two midwives per health centre and one nursing assistant to accommodate night duty services and community outreach
		3.1d Recruitment and employment of pharmacy technician, counsellors, data clerks, account clerks at health centre level
		3.1e Implementation of ANC and PNC guidelines
	3.2 Lack of integrated outreach and mobile clinic services for MNCH services	3.2a Provide transport for conduction of outreach services
		3.2b Conducting community outreach programmes and mobile clinics for integrated SRH, MNCH and FP services
		3.3a Strengthen advocacy around cultural factors affecting maternal health
	3.3 Cultural barriers leading to low health-seeking behaviours	3.3b Community empowerment through knowledge of importance of ANC and PNC attendance, recognizing danger signs during pregnancy, labour and delivery and postpartum, carried out through social mobilization targeting males and mothers in-laws
		3.4a Orientation and training of new staff and refresher training of old staff on procurement and logistics systems
	3.4 Inadequate equipment and supplies for ANC and PNC	3.4b Decentralization of procurement of equipment, supplies and vehicle maintenance and repairs
		3.4c Scale up proper use of inventory system in all health facilities

	Potential partners	Total cost US$	Available funds		Resource gap
			Government	Partners	
	MoH, MoPS, MoLG, MoF				
	MOH, WHO, UNFPA			WHO $30,000 UNFPA $50,000	+$80,000
	MoH, UNFPA			UNFPA $200,000	+$200,000
	MoH				
	MoH, MoLG, UNFPA			WHO $150,000 UNFPA $100,000	+$250,000
	MoH, MoLG				
				PIH $29370	+$29370

MDG Goal 5:	To Improve Maternal Health
Target 5a:	To reduce the MMR by ¾ between 1990 and 2015
MDG Indicators:	5.1 Maternal Mortality Ratio

Key intervention Area(s)	Prioritized bottlenecks	Prioritized accelerated solutions
4. Increase Access to FP services	4.1 Inadequate skilled HRH on artificial and natural methods of FP	4.1a Capacity-building of HRH on both artificial and natural methods of FP
	4.2 Lack of FP equipment and supplies	4.2a Intensify training on management of procurement, logistics and supplies
	4.3 Low levels of male partners and in-laws involvement	4.3a Empowerment of male partners and in-laws on the benefits of FP to the family, community and society
	4.4 Poor community out-reach services due to lack of transport	4.4a integration of FP services into other SRH outreach programmes
	4.5 Customary and religious beliefs systems and myths associated with FP use	4.5a Empowerment of communities on benefits of FP and expulsion of myths around FP
		4.5b Intensify, effective and efficient use of trained CBD and ensure monitoring and support
		4.5c Training of health care providers on natural FP methods
		4.5d Procurement of tools for monitoring natural method of FP commodities and IEC materials
	4.6 Poor customer care	4.6a Scale-up of customer care training

	Potential partners	Total cost US$	Available funds		Resource gap
			Government	Partners	
	MoH, UNFPA, WHO			WHO $25,000 UNFPA $1,000,000	+$1,025,000
	MoH, UNFPA			UNFPA $600,000 PIH $29370	+$629,370
	MoH, UNFPA			UNFPA $200,000	+$200,000
	MoH, UNFPA	$200,000	$100,000	UNFPA $200,000	+$100,000
	MoH, UNFPA	$600,000	$300,000	UNFPA $600,000	+$300,000
	MoH, UNFPA			WHO $10,000 UNFPA $200,000	+$210,000

6.2 IMPLEMENTATION AND MONITORING FRAMEWORK

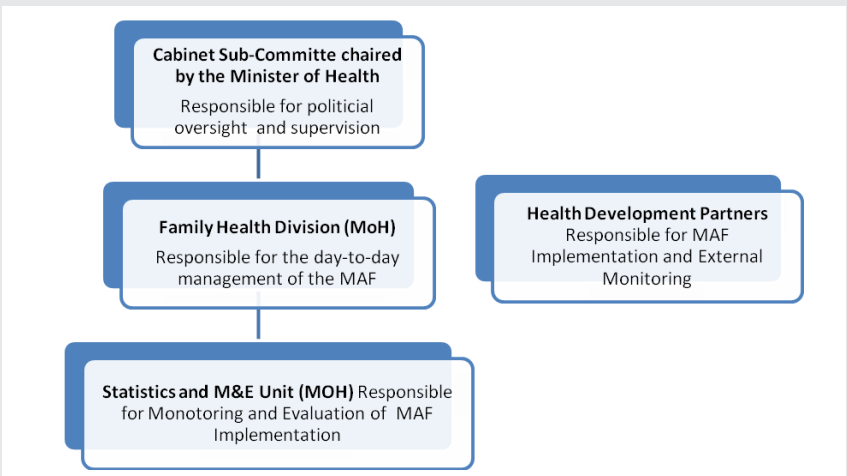
6.2.1 MAF IMPLEMENTATION ARRANGEMENTS

The GoL has proposed allocating overall responsibility for oversight and supervision of the MAF to a Cabinet Sub-Committee to be chaired by the Honourable Minister of Health, with the membership of ministers who ministries have some responsibility in ensuring the achievement of MAF objectives, namely the Ministries of Finance; Development Planning; Public Service; Social Welfare; Public Works and Transport; Local Government and Chieftainship Affairs; Communications, Science and Technology; and Agriculture and Food Security; with ministers from additional ministries being requested to participate as and when required. The Cabinet Sub-committee will meet on a quarterly basis to review the implementation of the MAF.

It is proposed that the Health Development Partners that include international organizations and health sector implementing partners should, in collaboration with the MoH, constitute a second oversight body, although this body will also have an implementation responsibility.

The day-to-day management and implementation of MAF processes will be carried out by the Family Health Division in the MoH in collaboration with the District Authorities and District Health Management Teams. Clear targets and reporting timelines will be stipulated for review by the Family Health Division and the Health Development Partners forum on a monthly basis. M&E will be the responsibility of the Statistics and Monitoring and Evaluation Unit in the MoH on a biannual basis. The proposed structure is graphically represented in figure 9.

FIGURE 10: PROPOSED MAF IMPLEMENTATION STRUCTURE



6.2.2 MONITORING AND EVALUATION

Good health strategies and plans are often weakened by poor M&E frameworks. Among the many efforts in the health sector that aim to improve overall health outcomes; the MAF interventions were identified and adopted on the basis of their effectiveness in influencing the improvement in maternal health. Even evidence-based interventions such as the MAF's that have been proven to work elsewhere need strong M&E frameworks to enhance efficient and effective implementations. It is on this basis that this M&E framework is developed. The main objective of this M&E framework is to track the implementation of the key interventions and prioritized solutions. The framework will provide detailed guidance on how to monitor and evaluate the implementation of MAF interventions to curb the high MMR in Lesotho. In addition, the M&E framework will encourage accountability and transparency. It is anticipated that this framework will facilitate the documentation of lessons learnt and the sharing of experiences while also documenting best or promising practices.

This framework does not exist in isolation but it is nested in the National M&E plan which monitors implementation of the National Health Sector Strategic Plan. The Ministry of Health (MoH) operationalizes the long-term strategic plan into annual operational plans at both central and district levels. These operational plans are monitored through the Quarterly Reviews conducted for all districts and the central level programmes. These reviews monitor output level indicators.

The AJR is conducted annually to assess the sector's yearly progress and the performance of all the districts on selected outcome level indicators. In the same context, the Family Health Division, which is responsible for coordination of SRH and MNCH initiatives, will ensure that its objectives in the operational plan are aligned with MAF interventions. The M&E framework of the MAF will therefore be aligned to the MoH's review processes.

Table 10 reflects the implementation of the M&E framework, which includes process indicators. The process indicators will basically show how well the planned activities are being run and how effective they are. Since this will be monitored quarterly, the challenges will be identified and corrective measures implemented regularly. On the other hand, table 11 shows results of the monitoring framework and impact indicators for the MAF. The M&E framework will be aligned to the MoH's review processes, whereby quarterly reviews to monitor progress of selected indicators at the district and central level will be undertaken. The central level will turn produce performance reports at the end of each quarter. The AJR report, which assesses and documents national and district performance throughout the year, will be produced and disseminated annually.

TABLE 10: M&E FRAMEWORK

Objective: Increase the proportion of deliveries conducted by skilled attendant from 40% (AJR) In 2012 to 85% by 2017 (45% in 2013: 60% in 2014; 69% in 2015; 85% in 2017)	
Acceleration solution/activities	**Monitoring indicators**
Expediting the handing over of 52 refurbished / constructed health centres that are AIA certified	Number of refurbished/constructed health centres that are AIA certified handed over
Expediting completion of refurbishment and certification of 94 health facilities and installation of all basic amenities by MCC/MCA	Proportion of health centres completed, refurbished and certified
	Proportion of health centres with all basic amenities installed
Provision of food for Maternity Waiting Homes in 160 health centre level	Proportion of health centres of which Maternity Waiting Homes provide food
Provision of cell phones to 7,140 VHWs	Proportion of VHWs provided with cell phones
Conducting of Pitsos on community empowerment through information on importance of ANC attendance and danger signs during pregnancy	Proportion of health facilities conducted Pitsos on importance of ANC attendance and danger signs during pregnancy
Community outreach programmes and mobile clinics for iIntegrated SRH, MNCH and FP services, by 160 health centres	Proportion of health centres that conducted integrated SRH community outreach and mobile services
	Proportion of villages reached through integrated SRH community outreach programmes
Training of health care workers in customer care	Proportion of health facilities with staff trained in customer care
	Proportion of staff in health facilities trained in customer care
Review, printing and dissemination of referral guidelines	Referral guidelines reviewed and printed
	Proportion of health facilities with referral guidelines
Increase in the proportion of health facilities with full-time staff complement from 1% in 2011 to 30% in 2017	Proportion of health centres with full staff complement
	Proportion of hospitals with full staff complement
MNCH mentoring sessions in all health facilities by 2017	Proportion of health facilities whose members received mentoring in MNCH
	Proportion of health facility personnel that received mentoring in MNCH

	Baseline (%)	Implementation timeline (by %) April 2013-2017				Monitoring mechanisms	Responsible entity
		2014	2015	2016	2017		Organization responsible for data collection and analysis
	43 (31%) of facilities handed over by May 2013	35	52			MCA/MoH Report	MoH
	38	60	100			MCA/MoH Report	MoH
	21	60	100			MCA/MoH Report	MoH
	0	25	50	75	100	MoH Report	MoH
	0	25	50	75	100	MoH Report	MoH
	10	50	70	100		MoH Report	MoH
	PNC 23 FP 43	55	70	100		MoH Report	MoH
	10	40	60	80			MoH
	20	40	60	100		MoH Report	MoH
	10	40	70	100		MoH Report	MoH
	0	100				MoH Report	MoH
	0	100				MoH Report	MoH
	1	10	15	20	30	MoH Report	MoH
	0	5	10	15	20	MoH Report	MoH
	0	20	50	60	100	MoH Report	MoH
	0	20	50	60	100		

Objective: Increase the proportion of deliveries conducted by skilled attendant from 40% (AJR) In 2012 to 85% by 2017 (45% in 2013: 60% in 2014; 69% in 2015; 85% in 2017)	
Acceleration solution/activities	**Monitoring indicators**
Provision of all health centres with professional security	Proportion of health centres with professional security services
Construction of basic roads that connect 16 health centres to hospitals	Proportion of health centres with improved road infrastructures
Establishment of functional maintenance plan in all health facilities	Proportion of health centres with functional maintenance plan
Objective : To reduce institutional maternal deaths from 49 in 2012 to 5 In 2017	
Procurement of 20 fully equipped and functional ambulances for DHMTS	Number of fully equipped and functional ambulances procured for DHMT
Provision of means of communication in all health centres	Proportion of health centres with means of communication
Establishment of toll free hotlines in 16 hospitals (8 GoL and 8 CHAL)	Proportion of GoL and CHAL hospitals with free hotlines
Training of all doctors and midwives in health facilities in EmONC skills	Proportion of hospitals with doctors trained on EmONC
	Proportion of health facilities with nurse midwives trained in EmONC
Procurement and inventory management of EmONC equipment in all health facilities	Proportion of health centres with complete EmONC equipment
	Proportion of hospitals with complete CEmONC equipment
Availability of EmONC supplies at all times in all health facilities	Proportion of health facilities with no EmONC stock out for more than 28 days
CEmONC mentoring sessions for doctors in hospitals by 2017	Proportion of hospitals with doctors mentored on CEmONC
	Proportion of doctors received CEmONC mentoring sessions
Establishment of two regional blood bank stations	Number of fully functional regional blood banks
Community empowerment by disseminating knowledge of importance of PNC attendance	Proportion of health facilities conducting Pitsos on importance of PNC attendance
Support for maternal death audit review	Proportion of District committees that produce annual report
Implementation of supermarket approach for the first MNCH services (e.g., ANC ,PNC, immunizations) in all health facilities	Proportion of facilities implementing supermarket approach for first MNCH visits

	Baseline (%)	Implementation timeline (by %) April 2013-2017				Monitoring mechanisms	Responsible entity
		2014	2015	2016	2017		Organization responsible for data collection and analysis
	20	46.7	73.3	100		MoH Report	MoH
	90	92	94	96	100	MoH Report	MoH
	20	60	100			MoH Report	
Objective : To reduce institutional maternal deaths from 49 in 2012 to 5 In 2017							
	0	5	15	20		MoH Report	MoH
		40	60	100		MoH Report	MoH
	0	25	50	75	100	MoH Report	MoH
	5	28.8	52.5	76.3	100	MoH Report	MoH
	10	32.5	55	77.5	100	MoH Report	MoH
	0	50	80	100		MoH Report	MoH
	0	50	80	100		MoH Report	MoH
	100	50	25	0		MoH Report	MoH
	0	50	80	100		MoH Report	MoH
	0	50	80	100		MoH Report	MoH
	0		1	2		MoH Report	MoH
	0	50	100	100		MoH Report	MoH
	0	25	50	75	100	MoH Report	MoH
	0	33.3	66.7	100		MoH Report	MoH

Objective: Increase the proportion of deliveries conducted by skilled attendant from 40% (AJR) In 2012 to 85% by 2017 (45% in 2013: 60% in 2014; 69% in 2015; 85% in 2017)	
Acceleration solution/activities	**Monitoring indicators**
Implement of ANC and PNC guidelines by all health facilities	Proportion of facilities that use ANC guidelines
	Proportion of facilities that use PNC guidelines
Strengthening of supply chain management in all health facilities through trainings	Proportion of health facilities with staff trained on supply chain management
Training of all VHWs on provision of specified FP commodities	Proportion of VHWs trained on provision of specified FP commodities
Establishment of the reporting system of maternal deaths in communities	Community-level reporting tools on maternal mortality developed
	Proportion of community maternal deaths notified within 48 hours

	Baseline (%)	Implementation timeline (by %) April 2013-2017				Monitoring mechanisms	Responsible entity
		2014	2015	2016	2017		Organization responsible for data collection and analysis
	0	50	100			MoH Report	MoH
	0	50	100			MoH Report	MoH
	0	33.3	66.7	100		MoH Report	MoH
	0	25	50	75	100	MoH Report	MoH
	0	System established	System fully functional			MoH Report	MoH
	0	25	50	75	100	MoH Report	MoH

TABLE 11: RESULTS FRAMEWORK

MAF Outcome: Maternal mortality reduced by ¾ in 2015 (reduced to 300/100 000 by 2015)

Results indicator	Baseline (%)	Unit of measurement %	Overall target (%)
Output 1: Proportion of pregnant women attending their first ANC visit during the first trimester	92 (2009)		98
Output 2: Proportion of pregnant women who made four ANC visits during pregnancy	70.4 (2009)		90
Output 3: Proportion of pregnant women delivering in health facilities	61 (2009)		80
Output 4: Proportion of obstetric referrals made from health centres to hospitals with positive pregnancy outcome for mother and baby delivered			100
Output 5: Proportion of pregnant women adequately managed for labour using partograph			100
Output 6: Proportion of mothers who attended PNC within two days after delivery in the last 12 months	23 (2004)		50
Output 7: Proportion of maternal deaths notified in the districts within 24 hours			100
Output 8: Proportion of health facilities conducting maternal deaths review	9.1 (2013)		100
Output 9: Number of times each type of FP commodity was in stock			100
Impact indicators (%)			
MMR	1155/100 000 (DHS 2009)		
Proportion of deliveries supervised by skilled attendant	62 (DHS 2009)		
Contraceptives prevalence rate	47 (DHS 2009)		
Proportion of unmet FP needs	23 (DHS 2009)		

	Cumulative targets values (by %)					Frequency	Data source	Monitoring mechanisms	Organization responsible for data collection and analysis
	2013	2014	2015	2016	2017				
		93.5	95	96.5	98	Quarterly/Annually	AJR	HMIS reports	MoH
	70	80	90			Quarterly/Annually	AJR	HMIS reports	MoH
		75.3	80.2	85.2	90	Quarterly/Annually	AJR	HMIS reports	MoH
	25	50	75	100		Quarterly/Annually	AJR	HMIS reports	MoH
		33.3	66.7	100		Quarterly/Annually	AJR	HMIS reports	MoH
		32	41	50		Quarterly/Annually	AJR	HMIS reports	MoH
		25	50	75	100	Quarterly/Annually	AJR	HMIS reports	MoH
	9.1	31.8	54.8	77.3	100	Quarterly/Annually	AJR	HMIS reports	MoH
	100	33.3	66.7	100		Quarterly/Annually	AJR	HMIS reports	MoH
Impact indicators (%)									
	2013	2014	2015	2016	2017		Source		comment
	300/ 100 000		300/ 100 000			Five Years		DHS	2015 figures obtained for Lesotho action plan road map
	80		80			Five Years		DHS	
	60		60			Five Years		DHS	
	8		8			Five Years		DHS	

VI. ANNEXES

Photo: WHO

ANNEX 1

COUNTRY BACKGROUND

Lesotho is a landlocked mountainous country, surrounded by South Africa. The country occupies a land area of approximately 30,355 square kilometres. Mountains cover the majority of the country's terrain (59 percent) and less than 10 percent of the land is arable.[37] It is divided into 10 administrative districts, which differ in terms of topography, size, climate and level of development. The country is divided into four ecological zones, namely, the mountains, foothills, Senqu River Valley and the lowlands.[38] Lesotho has an estimated population of 1,880,661 million.[39] When disaggregated by gender, 51.3 percent of the population is female, while males constitute 48.7 percent. The urban and rural population of Lesotho constitute 23.8 percent and 76.2 percent, respectively. The population growth rate is 1 percent and is reported to be the lowest in the Southern African Region, with life expectancy at 41 years.[40]

Lesotho's economy is characterized by subsistence farming and 75 percent of the population depends on it,[41] though it contributes only 7.1 percent to the country's GDP.[42] With an HDI value of 0.461 it falls in the category of low human development countries and ranks 158 out of 186 countries surveyed.[43] The report further notes that 43.4 percent of the population lives on less than $1.25per day. Recent estimates from the Household Budget Survey indicate that 57.3 percent of the population is below the national poverty line. This marks a slight increase from the previous survey in 2002/2003.

37. LDHS, 2009.
38. Ibid.
39. Bureau of Statistics (2006) Lesotho Population Census.
40. LDHS, 2009.
41. LDHS, 2009.
42. Statistical Year book 2010 – Bureau of Statistics, Lesotho.
43. Human Development Report 2013, United Nations Development Programme.

ANNEX 2

MAF STAKEHOLDERS

MAF METHODOLOGICAL WORKSHOP: PARTICIPANTS AND OFFICIALS CONSULTED		
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K. Ntoampe	MoH	CHE
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NAME	INSTITUTION	POSITION
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Matlotlo	MoH	AEP
Lenesa Leaoo	MoH	EP
R. Thejane	MoH	AEP
Mokubisane Khachane	MoH	Nursing officer
L. Matete	MoH	HR
M Makopela	MoH	HR
M. Tsoele	MoH	Decentralization TA
M. Mokete	MoH	Facilities Manager
K. Kikine	Roads Directorate	Manager
M. Lepolesa	MoLGCA	Manager
S. Letlola	MoLGCA	Senior Engineer
M. Ramoelela	MoH	Financial Controller
M. Ramoseme	MoH	Statistics and M&E
M. Matsoso	MoH	Statistics and M&E

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REFERENCES

1. CARE. *Promoting Quality Maternal and New-born; A Reference Manual for Programme Managers*, 1998.
2. Christian Health Association of Lesotho. Assessment of Partnerships Between Government of Lesotho and Christian Health Association of Lesotho, 2011.
3. Government of Ghana. MDG Acceleration Framework and Country Action Plan. Maternal Health – 2010.
4. Government of Lesotho and Ministry of Health. National Family Planning Guidelines – 2011.
5. Government of Lesotho and UNICEF. Emergency Obstetric Care Assessment Lesotho – 2005.
6. Government of Lesotho, Ministry of Health and National AIDS Commission. Behaviour Change Communication in Lesotho; National Behaviour Change Communication Strategy 2008-2013 – 2008.
7. Government of Lesotho, Ministry of Health and Social Welfare. Human Resources Development and Strategic Plan 2005-2025 – 2005.
8. Government of Lesotho, Ministry of Health and Social Welfare. Lesotho Health Sector Reforms. Phase 1: Capacity Building; District Health Package – 2003.
9. Government of Lesotho, Ministry of Health and Social Welfare. Monitoring and Evaluation – Strategic Plan 2004 to 2009 – 2004.
10. Government of Lesotho, Ministry of Health and Social Welfare. Retention Strategy for the Workforce – 2010.
11. Government of Lesotho/United Nations. Report on the joint visit of the Ministry of Health and Social Welfare and UN Agencies: Delivering as One on maternal and neonatal health in Lesotho in 2010.
12. Government of Lesotho. Demographic and Health Survey – 2009.
13. Government of Lesotho. Government of Lesotho/Government of the United State Partnership Framework to Support Implementation of the Lesotho National HIV and AIDS Response- 2009.
14. Government of Lesotho. Lesotho Vision 2020.
15. Government of Lesotho, Ministry of Health and Social Welfare. Lesotho Information System; Review and Assessment – 2007.
16. Government of Lesotho, Ministry of Health. Strategic Plan for the Elimination of Mother to Child Transmission of HIV and for Paediatric HIV Care and Treatment – 2011.
17. Government of Lesotho. National Adolescent Policy – 2006.
18. Government of Lesotho. National Health Policy – 2011.
19. Government of Lesotho. National HIV and AIDS Testing and Counselling Policy – 2011.
20. Government of Lesotho. National Reproductive Health Policy – 2008.

21. Government of Lesotho. National Strategic Development Plan – 2012.
22. Government of Lesotho. Poverty Reduction Strategy 2004/2005 – 2006/2007 – 2004.
23. Government of Lesotho. Report on the Quality and Responsiveness of Health Services to Meet the Needs of Women in Crisis Settings – 2005.
24. Government of Lesotho. Road Map for Accelerating Reduction of Maternal and New-born Morbidity and Mortality in Lesotho 2007-2015 – 2007.
25. Ministry of Finance and Development Planning. Annual Report for Global Fund Support in Lesotho; January 2009- December 2009.
26. Ministry of Health and Social Welfare. Annual Joint Review - 2009/2010/2011.
27. Ministry of Health and Social Welfare. Focused Postnatal Care; Orientation Package for Health Service Providers in Lesotho – 2008.
28. Ministry of Health and Social Welfare. HIV Prevention, Response and Model of Transmission Analyses – 2009.
29. Ministry of Health and Social Welfare. Human Resource Development and Strategic Plan -2005/2025 – 2004.
30. Ministry of Health and Social Welfare. Lesotho Roadmap – 2006.
31. Ministry of Health and Social Welfare. National Blood Transfusion Policy – 2006.
32. Ministry of Health and Social Welfare. National Health and Social Welfare Research Policy – 2007.
33. Ministry of Health and Social Welfare. National Policy on Orphans and Vulnerable Children – 2005.
34. Ministry of Health and Social Welfare. Qualitative Study on Knowledge, Practices and Health Seeking Behaviours among Basotho Mothers with Children aged 12-23 Months – 2009.
35. Ministry of Health and Social Welfare; Reproductive Health Policy – 2009.
36. Ministry of Health, Irish Aid, USAID. Lesotho Health Systems Assessment – 2010.
37. Ministry of Health. Health Facility List – 2013.
38. Organisation of African Unity. Abuja Declaration on HIV and AIDS, Tuberculosis and other Related Diseases – 2001.
39. United Nations (2010), MDG Acceleration Framework

October 2013