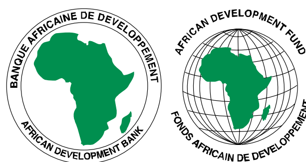
AFRICAN DEVELOPMENT BANK GROUP



LESOTHO

HEALTH SERVICES DEVELOPMENT PROGRAMME

Project Performance Evaluation Report (PPER)

OPERATIONS EVALUATION DEPARTMENT
(OPEV)

JANUARY 1995

INTERIM PROJECT PERFORMANCE AUDIT REPORT
HEALTH SERVICES DEVELOPMENT PROGRAMME

ABBREVIATIONS

ADB	:	African Development Bank
ADF	:	African Development Fund
AIDS	:	Auto-Immune Deficiency Syndrome
CB	:	Citizens Band Radio-Telephone
CSSD	:	Central Sterilization Services Department
DANIDA	:	Danish International Development Agency
ESAP	:	Extended Structural Adjustment Programme
EU	:	European Union
FP	:	Family Planning
FUA	:	Fund Units of Account
FYDP	:	Five Year Development Plan
GOL	:	Government of the Kingdom of Lesotho
HIV	:	Human Immuno-Virus
HMIS	:	Health Management Information System
HSA	:	Health Service Area
HSDP	:	Health Service Development Programme
HSDPI	:	Health Services Development Project (Immunisation)
IHC	:	Intersectoral Health Committee
MCH	:	Maternal and Child Health
MOH	:	Ministry of Health
MORD	:	Ministry of Rural Development
MPDE	:	Methodology for Project Design and Evaluation
NGO	:	Non-Governmental Organization
NHTC	:	National Health Training College
ODA	:	Overseas Development Administration (UK)
PCR	:	Project Completion Report
PHAL	:	Private Health Association of Lesotho
PHC	:	Primary Health Care
PIU	:	Project Implementation Unit
PPAR	:	Project/Programme Performance Audit Report
RHSP	:	Rural Health Services Project
SAP	:	Structural Adjustment Programme
SCF	:	Save-the-Children Fund
STD	:	Sexually Transmitted Diseases
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children Fund

WHO	:	World Health Organization

CURRENCY EQUIVALENTS

Currency Unit : Maloti (M)

Date	Maloti per UA
1982	1.193
1983	1.175
1984	1.415
1985	2.126
1986	2.704
1987	2.634
1988	2.990
1989	3.354
1990	3.476
1991	3.740
1992	3.994
1993	4.541
1994	5.025

Source: ADB Group Treasury Department (FTRY)

FUA 1.00 = BUA 0.921052
BUA 1.00 = FUA 1.085715

WEIGHTS AND MEASURES

1	Kilogramme (Kg)	=	2,204 lbs
1,000	Kgs	=	1 metric tonne (mt)
1	Kilometre	=	0.62 mile
1	metre (m)	=	1.09 yards
1	squatre metre (m^2)	=	10.76 square feet
1	acre (ac)	=	0.405 hectare (ha)
1	hectare (ha)	=	2.47 acres

GOVERNMENT FISCAL YEAR

1 April to 31 March

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This Interim Programme Performance Audit Report is based on the findings of a Bank Group post evaluation mission mounted in November 1994 comprising Mr H.D. AKROYD, Principal Post Evaluation Officer and Dr E.O. PRATT, MD MPH FWACP, Public Health Physician Specialist. Enquiries concerning the content of the Report should be addressed to Mr I.B.C. JOHN, Director, Operations Evaluation Office on Extension 4089.

INTERIM PROGRAMME PERFORMANCE AUDIT REPORT

HEALTH SERVICES DEVELOPMENT PROGRAMME

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INTERIM PROGRAMME PERFORMANCE AUDIT REPORT

LESOTHO: HEALTH SERVICES DEVELOPMENT PROGRAMME

PREFACE

1. This Interim Programme Performance Audit Report (PPAR) reviews the on-going Health Services Development Programme of the Government of the Kingdom of Lesotho (GOL) for which six ADF Loans embracing five projects and one study and totalling an equivalent of FUA 42.43 million (UA 39.08 million) were approved between 1976 and 1992 (Table 2.2). Other funds were provided by the GOL and, in the case of the Rural Health Services Project (RHSP) III, by the Organization of Petroleum Exporting Countries (OPEC). The ADF loans and total project costs were as follows:

	Loan	Approval Year	ADF Loan (UA million)	Total Cost (UA million)
1.	Health Services Development	1976	2.30	2.60
2.	RHSP I	1984	5.85	8.40
3.	RHSP Study	1984	1.14	1.14
4.	RHSP II	1987	11.67	13.13
5.	RHSP III	1991	7.07	10.39
6.	RHSP IV	1992	11.05	13.22
	Total		39.08	48.88

The scope of this interim PPAR covers the study and the first four of the five projects. A PPAR has already been produced for the Health Services Development Project (ref: ADF/BD/WP/87/95).

2. The envisaged sector goal of all the projects was to improve the health status of the target populations. The planned objective throughout was to provide (or produce) more and improved health care services on a sustainable basis. The Health Services Development Project

concentrated on the provision of immunization services, RHSP I on primary health care services and RHSP II and III on secondary health care services. Planned outputs were the provision of health care facilities and staff. Envisaged activities included construction works, the procurement of equipment, furniture and the services of civil works consultants and contractors and the training of medical staff. (Annex 2).

3. For all the projects the Borrower was the GOL and the Executing Agency the Ministry of Health (MOH). The rural clinics (health centers), funded under the aegis of RHSP I, were built by the clinics construction team of the Ministry of Rural Development.

4. This interim PPAR is based on data contained in the appraisal reports, the PPAR for the Health Services Development Project (ref: ADF/BD/WP/87/95), the draft PCR for the RHSP I and the PCR for RHSP II. Other documents were studied, produced by the Government and other donor organisations, concerning the status of the health sector in Lesotho. The main purpose of this Interim Programme Performance Audit Memorandum (PPAM) prepared by the ADB Group's Operations Evaluation Office (OPEV) is to complement the findings of the Bank Group to date, examining in greater detail various aspects of the projects and describing the findings of the Post Evaluation Mission which conducted studies in Lesotho in November 1994. The PPAR presents interim conclusions regarding the results of the programme together with lessons and recommendations drawn from the experience of the programme.

5. Copies of this report have been circulated to the Operations Departments of the Bank and to the Borrower and Executing Agency. Comments received have been reflected in the text.

BASIC LOAN/PROJECT DATA

DEVELOPMENT OF HEALTH SERVICES PROJECT

See PPAR reference: ADF/BD/WP/87/95

RURAL HEALTH SERVICES PROJECT I AND SECONDARY HEALTH CARE STUDY

1. Country : Kingdom of Lesotho
2. Project : RHSP I and Study
3. Loan Number
   RHSP I : CS/LES/H/84/10
   Study : CS/LES/H/84/12
4. Borrower : Government
5. Executing Agency : Ministry of Health
6. Planned Implementation
   Period : May 1984 to December 1987
   (44 months)

A. **THE LOANS**
ADF Loan (RHSP I)

	Appraisal	Actual
FUA million equivalent	6.35	6.35
UA million equivalent	5.85	5.85
Duration	50 years	50 years
Grace Period	10 years	10 years
Service Charge	0.75%	0.75%

ADF/TAA Loan (the Study)

	Appraisal	Actual
FUA million equivalent	1.24	1.24
UA million equivalent	1.14	1.14
Duration	50 years	50 years
Grace Period	10 years	10 years

Loan Negotiations	-	23 Nov. 1983
Loan Approval	-	20 Jan. 1984
Loan Signature	-	13 Mar. 1984
Entry into Force	-	12 Mar. 1985

B. **PROJECT DATA** (RHSP I and Study)

1. Cost

(a) **Appraisal Estimate)**

	FUA million	UA million	Maloti million
ADF (RHSP I)	6.35	5.85	6.82
ADF/TAA (Study)	1.24	1.14	1.33
Government	2.77	2.55	2.98
Total:	10.36	9.54	11.13

(b) **Actual Cost**

Total:	6.07	5.59	15.32
Actual % Planned:	58.6	58.6	137.7

2. Financing Plan (UA million)

	Foreign Exchange	Local Cost	Total Cost
ADF	4.52	1.33	5.85
ADF/TAA	0.75	0.39	1.14
Government	0.75	1.80	2.55
Total	6.02	3.52	9.54

3. Deadline: First Disbursement : 31 Dec. 1984
4. Actual First Disbursement
   RHSP I : 10 July 1985
   Study : 17 June 1986
5. Actual Last Disbursement
   RHSP I : 09 September 1994
   Study : 14 October 1993

6. Deadline: Last Disbursement : 31 Dec. 1990
7. Number of Extensions of Deadline for last Disbursement : Not known
8. Commencement of Works : 2 Feb. 1986
9. Completion (PCR page ii) : 31 Nov. 1990

C. PERFORMANCE INDICATORS

1. Approval to Entry into Force : 15 months
2. Planned to Actual Completion : 35 months
3. Implementation Status : Completed
4. Institutional Performance : Satisfactory
5. Consultant Performance : Satisfactory
6. Contractors Performance : Satisfactory
7. Suppliers Performance : Satisfactory
8. Overall Performance : Satisfactory

D. Missions

Preparation	:	10.10.82-28.10.82
Appraisal	:	23.09.83-09.10.83
Supervision	:	18.01.85-25.01.85
	:	13.02.87-01.03.87
Follow-up	:	17.11.85-25.11.85
	:	30.06.86-07-07-86
PCR	:	09.02.90-28-02-90

Source: PCR

E. DISBURSEMENTS

(a) RHSP I UA 5.85 million

Year	Planned	Actual	
		Year	Cumulative
1984	1.37	-	-
1985	1.49	0.81	0.81
1986	2.06	0.50	1.31
1987	0.93	0.94	2.25
1988		0.88	3.13
1989		0.71	3.84
1990		0.13	3.97

1991		0.03	4.00
1992		0.00	4.00
1993		0.65	4.65
1994	__	0.63	5.28
Totals	5.85	5.28	5.28
Undisbursed		0.57	0.57

Source: Summary ledger (03 January 1995).

(b) Study UA 1.14 million

Year	Planned	Actual	
		Year	Cumulative
1984	0.38	-	-
1985	0.46	-	-
1986	0.30	0.18	0.18
1987		0.23	0.41
1988		0.10	0.51
1989		0.12	0.63
1990			
1991			
1992			
1993		0.38	1.01
Totals		1.01	1.01
Undisbursed		0.13	0.13

Source: Summary Ledger (03 Jan. 1995)

In both cases disbursements extended over a period of ten years. Both loans still have undisbursed balances.

RURAL HEALTH SERVICES PROJECT II

1.	Country	:	Kingdom of Lesotho
2.	Project	:	Rural Health Services Project II
3.	Loan Number	:	F/LES/H/87/19
4.	Borrower	:	Government
5.	Executing Agency	:	Ministry of Health
6.	Planned Implementation Period	:	September 1987 to August 1991 (48 months)

A. **ADF LOAN**

	Appraisal Estimate	Actual
FUA million equivalent	12.70	12.70

(UA million equivalent)	11.70	11.70
Duration	50 years	50 years
Grace period	10 years	10 years
Service Charge:		
Years 11 to 20	0.75% pa	0.75% pa
Years 20 and on	3.00% pa	3.00% pa
Loan Negotiations	June 1987	14-16 July 1987
Loan Approval	July 1987	17 August 1987
Loan Signature	August 1987	26 November 1987
Entry into Force	September 1987	7 April 1988

B. PROJECT DATA

1. Project Cost

(a) Appraisal Estimate

	FUA million	UA million	Maloti million
ADF	12.67	11.67	31.17
GOL	1.59	1.46	3.91
Totals	14.26	13.13	35.08

(b) Actual Cost (PCR pp 20/21)

	FUA million	UA million	Maloti million
ADF	12.48	11.49	41.22
GOL	1.75	1.61	5.53
Totals	14.23	13.10	46.75

Note: At the time of the PCR there was an undisbursed ADF balance equivalent to UA 0.18 million.

2. Financing Plan

UA million			Maloti million		
Foreign	Local	Total	Foreign	Local	Total

	Exchange	Cost	Cost	Exchange	Cost	Cost
ADF	10.22	1.45	11.67	27.30	3.87	31.17
GOL	-	1.46	1.46	-	3.91	3.91
Total	10.22	2.91	13.13	27.30	7.78	35.08

Source: Appraisal Report.

3. Deadline for First Disbursement : 31 December 1988
4. Effective Date of First Disbursement : 9 May 1988
5. Effective Date of Last Disbursement : 13 December 1991
6. Deadline for Last Disbursement : 30 June 1993

		Planned	Actual
7.	Commencement of Works	May 1988	January 1989
8.	Completion of Works	December 1989	May 1991
9.	Project Completion	August 1991	August 1991

Sewerage works at Mokhotlong hospital were completed in July 1989.

C. PERFORMANCE INDICATORS

			Amount
1.	Cost Under-Run: UA	0.03	
	Over-Run: M		11.67

2. Time Over-Run

		Months
Entry into Force	:	7
First Disbursement	:	8
Last Disbursement	:	3
Commencement of Works	:	7
Completion of Works	:	17
Project Completion	:	0

3. Implementation Status : Completed
4. Institutional Performance : Satisfactory
5. Consultant Performance : Satisfactory
6. Contractors Performance : Satisfactory

7. Suppliers Performance : Satisfactory
8. Overall Performance : Satisfactory

D. **MISSIONS**

Type of Mission	Dates	Persons	Person-Days
Preparation/Appraisal	9-17 Jan. 1987	2	18
Technical Supervision	03.08.87-09.08.87		
	13.04.91-18.04.91		

Type of Mission	Dates
Follow-up	13.02.87-01.03.87
	05.02.88-15.02.88
	04.12.88-16.12.88
	09.09.89-16.09.89
	05.03.90-09.03.90
	11.01.91-28.01.91
Financing Supervision	23.06.89-02.07.89
PCR	12.09.92-25.09.92
	(Up-dated Feb. 1994)

Source: PCR

E. DISBURSEMENTS

UA million equivalent (Loan : UA 11.70 million)

Year	By Year			
	Planned at Appraisal	%	Actual	%
1987	0.06	0	-	-
1988	2.89	25	0.51	4
1989	5.51	47	3.97	34
1990	2.52	22	3.68	32
1991	0.69	6	2.25	19
1992			0.36	3
1993			0.72	6

1994			0.21	2
Totals	11.67	100	11.70	100

Year	Cumulative			
	Planned at Appraisal	%	Actual	%
1987	0.06	0	-	-
1988	2.95	25	0.51	4
1989	8.46	72	4.48	38
1990	10.98	94	8.16	70
1991	11.67	100	10.41	89
1992			10.77	92
1993			11.49	98
1994			11.70	100
Totals	11.67	100	11.70	100

Source: Summary Ledger (03 Jan. 1995)

EVALUATION SUMMARY

PROGRAMME GENESIS

1. The provision of health care services in Lesotho is organised at three levels: primary health care at the village health post and health centre level, secondary health care at the district level and tertiary care at the central level. The provision of facilities and services is shared by the Ministry of Health (MOH) and various non-governmental organisations (NGOs) which work in partnership with the MOH and follow and implement government health policies. The MOH and NGOs provide facilities and services approximately in the ratio 60:40. In 1992 there were 19 Health Service Areas (HSA) in Lesotho. Each HSA was based on one of 18 district hospitals (plus the Queen Elizabeth II Hospital in Maseru). Of the 18 district hospitals, the MOH and NGOs operated nine each (Annex 3).

2. Lesotho gained Independence in 1966. International support was given and Lesotho benefited from significant aid flows. The First Five Year Plan (1970-1974) was drawn up, in the context of which the Government, with the collaboration of ADF and the World Health Organisation, reviewed health needs. A project proposal was formulated which proved to be the first of five projects and one study for which ADF loans were approved between 1976 and 1992. All five projects were based on the evolving priorities set out in successive Five Year Plans. In this sense they made a significant contribution to the Government's health sector development programme. The first four projects have been completed and the fifth is in the course of implementation. It is in this framework that this interim programme performance audit was carried out in November 1994.

PROGRAMME DESCRIPTION AND COST

3. The envisaged sector goal of all the projects was to improve the health status of the target populations. The planned objective in all cases was to provide (or produce) more and improved health care services on a sustainable basis. The Health Services Development Project (1976)

concentrated on the provision of immunisation services, the Rural Health Services Project (RHSP) I of 1984 on primary health care services and the RHSP II, III and IV on secondary health care services. Planned outputs (or achieved components) comprised the establishment of planned facilities, equipment and staff (immunisation facilities, the construction of 10 and the rehabilitation of 23 clinics and the rehabilitation, on a phased basis, of 8 district hospitals) - see OPEV's retrospective logical framework matrix: Annex 2. Activities embraced procurement, construction and staff training. The three hospitals projects concerned facilities and services provided by the MOH - not those provided by NGOs.

4. The total cost of the five projects and study was equivalent to FUA 53.07 million (UA 48.88 million) and the ADF loans totalled the equivalent of FUA 42.43 million (UA 39.08 million). Other funds were provided by the Government and, in the case of RHSP III, by OPEC. In all cases the Borrower was the Government and the Executing Agency the MOH.

CONCEPTION, DESIGN, PREPARATION AND APPRAISAL

5. The conception, design, preparation and appraisal of the five projects were based on health policies and priorities expressed in successive Five Year Plans. A study of secondary health care needs was carried out prior to the formulation of the three projects concerning the rehabilitation of eight district hospitals - RHSP II (3 hospitals), RHSP III (2) and RHSP IV (3). For these three projects the study report (which mainly concerned construction and civil works) was used as a project preparation document. The three appraisal reports presupposed that MOH management and planning capacities and staffing and supply needs would automatically be satisfied.

6. No projected indicators were given in any of the five appraisal reports concerning the measurement of the achievement of the planned objective and sector goal. In all the appraisal reports due heed was paid to civil works location and siting criteria.

7. With the benefit of hindsight, three problems may be discerned: (a) the three hospitals projects concentrated on the facilities and services operated by the MOH and did not consider those operated by NGOs. The MOH improved hospital facilities can now provide better services them those of the NGOs. Thus the principle of the equitable provision of services could be lost. There is a danger too that clients will drift from the NGO to the MOH facilities. (b) The project planning processes concentrated on the provision of facilities and, to some extent, of staff. No provision was made for strengthening MOH institutional capacities and capabilities (manpower, financial and information management and planning systems). (c) By implication, assumptions were made concerning the continuity and sustainability of staffing and the provision of recurrent funds for the purchase of drugs and other consumable items. However RHSP II to IV did

incorporate a hospital facilities repair and maintenance capacity.

IMPLEMENTATION

8. As the programme unfolded there were progressive improvements regarding timely actions concerning the entry into force of loans after loan approval, total disbursements achieved and the timely achievement of project completion.

9. Some design revisions occurred: the Health Services Development Project (1976) became an immunisation services project following the suspension of planned components concerning buildings extensions at the Queen Elizabeth II Hospital - the undisbursed loan balance being cancelled. Loan "savings" on RHSP I were used to fund additional works requested for RHSP I and II. The number of health centres rehabilitated under RHSP I was increased from 23 to 31.

10. Implementation delays occurred but, for the first five loans, these did not give rise to cost over-run. Some of the delays are attributable to the fact that, initially and until the establishment of the Project Implementation Unit, MOH staff were unfamiliar with ADF practices and procedures.

11. The MOH submitted progress reports to ADF on a regular basis. Eight ADF supervision missions visited the Health Services Development Project, but of these only two were technical supervision missions. Much the same may be stated about RHSP I and II. The frequency of ADF technical supervision could have been better.

12. The first five of the six loans amounted to the equivalent of UA 28.03 million. Of this total the equivalent of UA 24.34 million (87%) was disbursed and utilised. The loan for RHSP IV was approved in 1992 but in late 1994 no disbursements had taken place despite the fact that civil works are well advanced. The optimum use of ADF funds was not achieved and is not being achieved.

ACHIEVEMENTS

13. Project outputs were established as planned and the MOH now has a good country coverage of 187 health centres and (to date) 5 upgraded and rehabilitated district hospitals. ADF contributed 22% of the health centres and, by the end of the programme, will have provided for upgrading and rehabilitation at 72% of the MOH district hospitals (or 40% of the district hospitals in Lesotho). The ADF supported facilities are, with a few exceptions at the health centre level, well provided with energy sources and water and communications services. More hospital beds are available than hitherto.

14. Operational problems include staff and transport constraints. The MOH is introducing cost recovery and social insurance schemes and is working on the decentralisation of health management services. There is a need to improve and streamline the referral system. Reports

are produced which are collated at district hospitals and the results sent on to the MOH; but there is no management feedback.

15. The quality and quantity of health care services provided have improved as a result of these ADF supported projects. The stress is however on the provision of curative services. More could be done in terms of the provision of preventive and promotive care services; given an improved provision of staff and vehicles. More Health Assistants are needed at health centres as is more frequent supervision of health centres from district hospitals.

16. Available statistics show an improvement since 1976 in the health status of the population of Lesotho, as a result of factors which include improved health services and better access to clean water supplies.

IMPACTS

17. General economic decline, structural adjustment measures, the introduction of cost recovery systems and declining employment opportunities in South Africa could lead to a situation where poorer people in Lesotho cannot afford to pay for health care services.

PERFORMANCE OF PARTIES

18. The performances of the Borrower and of the MOH's Project Implementation Unit (PIU) were satisfactory. ADF technical supervision was infrequent but good communications were maintained with the PIU. The performance of ADF was satisfactory. The performances of consultants, contractors and suppliers were, in general, satisfactory.

SUSTAINABILITY AND DEVELOPMENT

19. The health centres and ADF supported hospitals are well maintained and supplied with drugs. But reduced donor inputs plus budgetary constraints could lead to a slippage of standards. There is a need for improved management and planning capacities (financial, manpower development and information systems). Currently it is difficult to retain the services of skilled staff employed in the MOH and NGO sub-sectors. The increase in tuberculosis and AIDS related medical problems is a cause for concern and will place increased demands on the health system.

CONCLUSIONS, LESSONS AND RECOMMENDATIONS

20. The projects were not conceived and designed within the context of an overall health sector plan. Nevertheless they were proposed, approved and implemented in a sequenced order of priority. The health services delivery system was progressively and successfully strengthened.

21. Outputs were established as planned and within the bounds of financing provisions. The facilities provided are of good quality and are well maintained. There is now an increased and improved provision of health care services and the projects have contributed towards the achievement of improvements in the health status of the people of Lesotho. The overall performance of the programme is deemed to be satisfactory.

22. Key lessons are as follows:

1. Improving health facilities does not necessarily convey a sense of ownership unless the community fully comprehends the nature and extent of benefits.

2. Unless budgetary and management control is decentralised, the process of decentralisation is incomplete.

3. NGOs, which are involved in the implementation of government health policies, should be brought into the Government/donor project planning process.

4. Project success depends on sound project design work - which must include country, sector and institutional studies. Appropriate project preparation and appraisal parameters may then be set - including options concerning investment and operating costs in relation to possible benefits which may be realised and sustained.

5. When projects of this type are designed and prepared, the views of potential service providers and users should be sought.

6. An efficient and well organised Project Implementation Unit (PIU) is indispensable to satisfactory project implementation.

7. The sustainability of priority projects (eg: child immunisation) relies greatly on donor support in situations where the economy of a country is weak and budgetary constraints are profound.

8. Plans concerning the provision of hospital bed capacity must make allowance for envisaged population increments.

9. A sound Health Management Information System is necessary as a basis for successful health planning and management.

10. Baseline and projected data should be provided at appraisal such that the achievement of the project objective and sector goal may be monitored and evaluated.

11. Due attention should be paid to the provision of means and measures to ensure the continuity and sustainability of staffing of health projects.

23. Key recommendations for the consideration of the Government are as follows:

1. Budgetary provisions are required for the recurrent costs of high priority projects (eg: child immunization) to ensure their sustainability.

2. The GOL/MOH should strengthen its Coordination Secretariat to ensure the effective mobilisation of available donor resources.

3. On-going work regarding cost recovery measures should be continued. The fees structure should be arranged so as to be in line with plans for the streamlining of the patient referral system.

4. Donor assistance should be sought such that an effective Health Management Information System can be put in place - as a planning and management aid.

24. Key recommendations for the consideration of the Bank Group are as follows:

5. Project design should include the analysis of institutions and, if necessary, the provision of institutional strengthening activities - to complement investments in infrastructural outputs or components.

6. The possible use of solar resources for water heating and power should always be examined for such projects.

7. Project launching missions are desirable to minimize the incidence of start-up and implementation delays.

8. Project design work should commence with the production of a first draft logical framework matrix - showing the cause and effect project hierarchy and the linking assumptions.

9. The staffing of a Project Implementation Unit (PIU) should adequately reflect the envisaged activities to be implemented under the project or projects concerned.

10. The follow-up and action processes, following supervision missions, should be improved.

11. Incremental staffing and maintenance implications should be carefully assessed for projects which involve the upgrading and rehabilitation of health facilities.

1. PROGRAMME CONCEPTION, DESIGN, PREPARATION AND APPRAISAL

This Interim Performance Audit Memorandum is of necessity drawn on general lines to extrapolate areas for review. Some observations, therefore, pertain to one or other of the projects and not necessarily to all. Digests of each project are to be found in the annexes.

1.1 Introduction

1.1.1 By 1976, significant events had evolved during the apartheid struggle in South Africa that projected Lesotho into the vanguard of the "front-line" states in the fight for better social and economic status for the peoples of southern Africa. Lesotho had gained independence from Britain in 1966 and there was much international support at the political level. Donor aid was accordingly directed unstintingly to these states in significant amounts of which Lesotho received prime share. Coupled with this was a double-edged situation. On one hand, the policies of the dominant neighbour (South Africa) deflected Lesotho's economic growth increasing the risk of a rise in the indigent population. Lesotho's labour force had no where to look for work except to South Africa whose mines attracted around 50% of the country's male labour. On the other hand, however, this proved a significant boost to Lesotho's economy in terms of remittances from Basotho emigrant workers. An unfortunate consequence was the disruption of family life in which mothers and children were left behind at home for extremely long periods without any means of communication in most cases.

1.1.2 At the beginning of the 20th century, religious ministries started to develop health facilities, mainly hospital services. The pace of the health programme was slow at first but quickened by mid-1940s with increasing government involvement. Lesotho, then Basutoland, was a British Protectorate and it was not until four years after independence that the First Five-Year Development Plan (1stFYDP) (1970-1974) was introduced (Annex 1). A year later, ADF and WHO collaborated in reviewing the health needs of the three frontline states (Botswana, Lesotho and Swaziland). Subsequent discussions with the Government of Lesotho (GOL) resulted in a project proposal which, generally, conformed to the objectives of the 1stFYDP.

1.1.3 The Appraisal Report for this first ADF intervention in Lesotho's health sector (the Health Services Development Project) states that its mission "(was) satisfied that the project reflects the urgent needs of Lesotho in the health sector...the formal request for ADF assistance from the Government of Lesotho indicates a very high priority for this project." (Appraisal Report para 1.03). There is no reason to dispute this assertion. Later events, however, showed an appreciable reduction of the project components to just one - immunization - which merits further comment.

1.1.4 Some time elapsed before the development of a second health project (Rural Health Services Project I -RHSP I) in 1984. Although the reason may be due to the slow implementation of the previous immunization project, -the Health Services Development Project: Immunisation (or HSDPI)- yet this was probably fortuitous because the Ministry of Health's (MOH) absorptive capacity was probably weak during those early years of independence.[1] During the intervening years (1974-1984), GOL had developed a Second Five Year Development Plan (2nd FYDP) (1975-1979) and a Third Five Year Development Plan (3rd FYDP) (1980-1985). The conceptual framework for RHSP I, and the subsequent projects, RHSP II, III and IV was based on the health policies within these development plans including that of a subsequent Fourth Five Year Development Plan (4th FYDP). (Annex 1).

1.1.5 The overall design was meant to reflect a concept uniformly applied to all the projects which eventually comprised a Health Services Development Programme (HSDP). However, the design was mainly attentive to physical aspects and, to a minimal extent, capacity building. Critical areas such as, institutional strengthening of management and planning capabilities and inputs to consolidate the integration of preventive and curative care were not included in the design. These elements contribute significantly to the achievement of the project objective and sector goal as illustrated in OPEV's retrospective logical framework matrix (Annex 2) for project design and evaluation.

1.1.6 In the years 1976-1992, as the Health Services Development Programme (HSDP) unfolded, there were progressive improvements regarding timely actions on: project effectiveness after Loan Approval, project completion (planned implementation period) and total disbursement. However, difficulties continued to be experienced in the rate of disbursements and time over-run with respect to civil works that somehow did not induce cost overrun. In two instances (HSDPI and RHSP I, respectively) loan proceeds could not be fully utilized resulting in a cancellation of the undisbursed amount in the former, and transferring the latter as "savings" to RHSP II and additional upgrading works in RHSP I. (Table 2.1).

1.1.7 The planned outputs included: a) the expanded immunization programme which was successfully implemented (HSDPI of 1976) - but other project components, such as, construction and civil works for a maternity wing and teaching facilities as well as the training of nurse clinicians (a new cadre) were cancelled; b) construction of 10 and the rehabilitation of 23 (later 31) health centers (rural clinics), support to the nurse-clinician training programme and the supply of technical cooperation staff and fellowships (RHSP I). The nurse clinician programme did not utilize ADF project proceeds (PCR/RHSP I, para 3.4.2), technical assistance was provided for two instead of four years and only half of the fellowships was awarded; and c) rehabilitation of 3 district hospitals (RHSP II), 2 district hospitals (RHSP III), and 3 district hospitals (RHSP IV); also included is training of medical and nursing staff. The hospitals in

RHSP II and III are completed, commissioned and fully operational. Those under RHSP IV are well under way and the indications are that they will be completed as appraised owing to the efficient management of the Project Implementation Unit (PIU).

1.1.8 The OPEV mission visited 8 of the health centers and 6 district hospitals and generally agrees with the findings of the respective PCRs (paras: 4.1.1, HSDPI; 7.1.1, RHSP I and Study; 8.1.1, RHSP II). Essentially the projects were implemented as planned, although delays in some instances occurred because of a change in project scope/design at the request of GOL after a period had elapsed after signing (HSDPI and RHSP I) of the Loan Agreement. In the process, MOH has achieved a good country coverage of 187 health centers (rural clinics) and (to date) 5 completed upgraded and rehabilitated district hospitals (see para 1.1.7 above). ADF contributed 22 % of the health centers and by the end of its current programme would have provided upgrading and rehabilitation of 72% of the total number of government district hospitals of which 63% have been completed, commissioned and operational (para 1.1.7 above, refers); this has resulted in more beds being available than hitherto.

1.1.9 In almost all of the facilities there was satisfactory provision of telephone communication (CB radio telephone or telephone), energy sources (electricity, gas and solar) and water supply. Maintenance coverage of the facilities, though not included in the RHSP I design (that is, health centers), but in the subsequent RHSP II-IV, was more than satisfactory. Security fences were provided for all the district hospitals but for only 20% of the health centers. Major problems encountered were staff shortages and transport constraints; a very few health centers had limited services because of lack of water supply. The problem was due more to domain conflict between the village community and the center in terms of use of water source. The original siting and location of these centers had conformed, in every detail, to the criteria laid down, including adequate provision of water. Community participation which is being extolled does not necessarily convey a sense of ownership unless there is higher salience to all features essential to health provision .

1.1.10 While the physical attributes of the completed facilities were generally excellent, there were functional problems pertaining, in some instances, to flow, patient consultation and user environment. These will be dealt with under Achievements in Chapter Three.

1.1.11 On the whole, the profile of achievements in the Health Services Development Program (HSDP) shows a remarkable degree of success. However, the absence of inputs in some key areas highlights significant shortcomings. They are management (supervision, reporting and referral), training - for unmet needs relative to the health policy goals (human resources development) and management information system; these are conducive to overall efficiency and effectiveness of the health delivery system which the ADF HSDP is designed to strengthen.

1.2 The Health Policy of the Government of Lesotho (GOL)

1.2.1 The UNDP in its Country Program report (1992) states that: "(GOL's) social development objectives are based on the recognition that social progress is both a basic foundation of economic growth and the ultimate target of development efforts and that growth is not sufficient to ensure improved social conditions for the majority of the population.

Government strategy is to increase the provision of basic services, including, inter alia, health, education, housing and appropriate infrastructure, and to ensure that these services are fairly distributed among people and districts.... The Government will promote popular participation in the formulation and implementation of overall development programmes as well as improve its ability to monitor social development....... a major strategy is the elimination of poverty ..."

1.2.2 In order to assess the performance of the completed projects, OPEV thus reviews the policy environment within which the projects were developed. Lesotho's health care system evolved from a series of health policies over the years until 1986 when they were organized and formally ratified by the Government. By 1993, the GOL/MOH decided that the health policy should be reviewed and brought into line with the political philosophy of the current government. As a result, a workshop was held under the auspices of the MOH (July 28-30, 1993) in which the Minister of Health affirmed the Government's position, that "a salubrious physical and social environment is an absolute necessity of good health."[2]. To this end, the MOH will "collaborate with all those who are involved in the improvement of the environment, water, and sanitation to ensure good health" [2] - thereby emphasizing multi- and inter-sectoral participation towards the achievement of the health goal. MOH has primary responsibility for health care policies, strategies and programmes and operates about half the country's health facilities.

1.2.3 Although the workshop was considered successful in updating the health policy, the resulting strategies being conceived have yet to be put into operation. Currently, the 1986 health policy document is in force. Between 1970 and 1992, there have been four Five-Year Development Plans (1970-1974; 1975-1979; 1980-1985; 1986-1990) and currently there is a Fifth Five-Year Development Plan (1992-1996). (Annex 1). Each plan progressively carried health goals to reflect the underlying health policy; however, it was not until the fourth plan (and subsequently the fifth) that health targets began to evolve. The first two plans focussed on expanding the curative system, training doctors and nurses, establishing rural health clinics, and launching an immunization programme. At the end of the second plan, GOL adopted a health policy with primary health care as the main strategy culminating in its institutionalization nationwide during the third plan period by developing special cadres, facilities, equipment etc...

1.2.4 The health policy prime goal in Lesotho is through Primary Health Care (PHC) and the Government unequivocally states that "through PHC every Mosotho should attain a state of complete physical, mental and social well-being so that he/she can live a productive life and contribute to the socio-economic development of Lesotho."[3]

1.2.5 In terms of pursuing its goal for equity, the 1986 policy document had set four targets to ensure access to health care for every Mosotho. These are: 1) every Mosotho should be within two hours walk from the nearest health facility (patients in very difficult terrain have been known to walk for 3-5 days to the nearest health facility); 2) a fee-for-service structure should be established and enforced, based on a means test; 3) social security schemes for the very indigent should be established by the year 2000; 4) private and national insurance schemes should be established by the year 2000.

1.2.6 The GOL has passed, over the years, several pieces of legislation to support the health care delivery system and ensure minimum standards of health care and

professionalism. Many of these laws, however are now considered obsolete and need urgent revision. Examples are: Medical, Dental and Pharmaceutical Council Order 1970; Medicine Man and Herbalists Order 1978; Nurses and Midwives Council Order 1966; Natural Therapeutic Practitioners Act 1976. Technical assistance could be provided in this important area by donors.

1.2.7 Currently, the health policy embodies eight national priorities: 1) primary health care (PHC); 2) population policy; 3) community involvement; 4) accessibility of health care; 5) impact of socio-economic policies 6) ensuring reasonable standards of health care 7) protection of every Mosotho against emerging disease; and 8) rehabilitation of physically, mentally and socially disabled people.

1.2.8 Delivery of care is structured through three levels comprising primary health care at the village health post and the health center (local community level), secondary care (at district level) and tertiary care (at central level). The Appraisal Reports have described adequately the organization and structure of the (MOH). The uniqueness of this health system should be emphasized. It is a formal sharing of services delivery by both government (public) and private (NGOs) sectors in joint partnership, in accordance with the health policy; the ratio of distribution of services being around 60:40 respectively. Although the country is divided into 10 administrative districts with 1080 villages, in 1992 the health system itself comprised 19 Health Service Areas (HSA) (Annex 3) including a flying doctor service for mountainous localities inaccessible by road. Each HSA has its headquarters at one of the 19 hospitals, with MOH and the private sector each operating nine of the 18 district hospitals. In 1992, these hospitals were expected to provide referral services and technical and administrative supervision to some 148 health centers.

1.2.9 Through its health policy, the HSA concept has evolved as a pattern for administering the delivery of services at the district level where over 80% of the population lives. These are predominantly rural communities, some of which are located in virtually inaccessible mountainous areas. The important feature of the strategy is that each HSA designated district hospital is responsible for the supervision of all health centers in its catchment including the training of community health workers and traditional practitioners; each is also responsible for the implementation of PHC, the provision of secondary care hospital services, referral and technological support for the PHC network of health centers, and the implementation of all government health policies.

1.2.10 The underlying intent is decentralization of management, administration etc of health services to the district level; this would include planning, programming, monitoring, evaluation and technical support. The process has not been cohesively organized and has no decentralized budgetary capability. Only tentative elements, such as the "designation" of HSAs and the mandate (without effective tools) for carrying supervision within the system are in operation. Intersectoral health committees were introduced (IHC) to improve communication between the HSAs and the district and local systems to ensure community participation. The IHCs were abolished because they failed to function.

1.2.11 As already indicated, GOL`s health policy encompasses both MOH and the private sector which is represented by the Private Health Association of Lesotho (PHAL) and other non-governmental organizations (NGOs), e.g., the Red Cross. PHAL and the NGOs (Annex 4) receive annual subventions (though becoming limited) from GOL and, to some extent,from donor agencies (e.g., DANIDA) and their own management bodies (e.g., the church, Red Cross ...). NGOs conform to the health strategies and have fully participated in their review; they also share in the implementation of the health programme and form part of the system for administering health services. It is with some concern, therefore, that PHAL and others were not involved in any of ADF`s project/programme support.

1.3 The Projects

1.3.1 The planned sector goal of all the projects was to improve the health status of the target population. The envisaged objective throughout was to provide more and improved health care services on a sustainable basis. The HSDPI concentrated on the provision of immunization services; RHSP I on primary health care in terms of providing 10 and rehabilitating 23 rural clinics (health centers) with distribution over Lesotho's 10 districts; and RHSP II and III on the provision of secondary health care through rehabilitation of district general hospitals (RHSP II: hospitals at Mohale's Hoek, Leribe and Butha Buthe; and RHSP III: hospitals at Mafeteng and Quthing). Subsequent Loan savings from RHSP I and the RHSP Study were used to fund the rehabilitation of a further 8 clinics under RHSP I and hospital improvements under RHSP II. Planned outputs were the provision of buildings, equipment and trained medical staff. Envisaged activities included construction works, the procurement of equipment, furniture and the services of civil works consultants and contractors and the training of medical staff (Annex 2).

1.3.2 ADF supported MOH's strategy to strengthen the delivery system in terms of GOL's health policies. They are to ensure equity to correct imbalances between the rural sector (with 80% of the country's population and a mere fraction of staff and services) and that of the urban areas (Maseru in particular) to which are skewed better services and greater staff support.

1.3.3 For the four projects and the study the Borrower was the GOL and the Executing Agency the MOH. The construction of the rural clinics (health centers), provided under RHSP I proceeds, was carried out by the clinics construction team of the Ministry of Rural Development (MORD). At the commencement of RHSP I a Project Implementation Unit (PIU) was created within the MOH. The PIU then supervised the implementation of RHSP I, II, and III - thus providing continuity of experience.

1.4 Conception and Design

1.4.1 By 1974, the needs of the "front-line" states were being seriously addressed by the United Nations specialized agencies, bilateral donor agencies and NGOs. In this climate, the World Health Organization (WHO) and ADF undertook a review of those critical needs within the health sector that would require urgent attention.

1.4.2 There was recognition of the need to improve health coverage and to strengthen

the delivery network and manpower development. However, there was also one particular need that received priority consideration in terms of the extremely high rates of infant and child mortality, and the lack of a well organized preventive care programme for communicable diseases, especially relating to children. Thus the immediate concern was the control and elimination of childhood diseases which are preventable, as well as tetanus among mothers and peri-natal babies at childbirth. The strengthening of this programme (immunization) became a crucial factor in the delivery of maternal and child health and family planning (MCH-FP) services in every health center within which it (i.e., MCH) is an integral component. By implication, this satisfied part of the assumptions (see MPDE: Annex 2) for project objective relative to the first project - the Health Services Development Project: Immunization (HSDPI).

1.4.3 The development of project concept and design subsequently ensued which formed the basis of a HSDP as an evolving entity. By stages this programme eventually responded, in a certain extent, to the health policy in terms of providing: a) support for a mass preventive programme of immunization of children (ages 0-5 years) and pregnant mothers; b) strengthening inputs to expand, in a sustainable way, rural health centers (clinics) to ensure accessibility and an equitable distribution of basic health services; c) inputs to improve the quality of secondary health care hospitals in order to provide sustainable essential hospital services at the district level and a satisfactory level of referral services for the PHC network; and d) training inputs to support the development of health manpower.

1.4.4 The projects were not conceived and designed within the context of an overall sector study or plan. Nevertheless they were proposed, approved and implemented in a sequenced order of priority. There was a programme strengthening of the delivery system, deliberately, and it was indicative of a development process within the health sector. With some foresight, para 6.01 of the appraisal report for the first project, the Health Services Development Project, states : "contrary to the experience of the past, there are good indications now that planning the health sector of Lesotho will in future be done on a more systematic basis ...... the present project reflects the priorities of the Government". Currently MOH, with the assistance of WHO, is developing a formal health sector review in which the ADF Health Services Development Programme will form part of the mosaic.

1.4.5 Based on the above, the program design on which the strategy for the various projects is configured should have been considered under three aspects: 1) improving physical ambience and quality; 2) institutional strengthening; and 3) programs to be delivered.

1.4.6 There is some problem in the definition or determination of a project/program "design". Invariably it appears to relate specifically to physical structures and their related areas. This may have been due to the fact that Bank group projects were more or less devoted to construction and civil works and attendant hardware aspects such as procurement of furniture and equipment etc. However, the basic concept regarding health projects has undergone re-orientation; project design should therefore be considered as a composite of "hardware" and "software" elements, that is, in terms of infrastructure and the investing with institution-building components.

1.4.7 As a whole, the HSDP design is predicated primarily on the physical attributes of

its related projects with training of staff featuring as a weak component; no other areas were included for institutional strengthening, such as, organization and management, referrals, the integral parts of a management information system[4] and programs. Infrastructural development is important and is a basic ingredient in health coverage - to facilitate the provision of services or to provide a suitable ambience for the delivery of services. However there are certain pertinent questions in lieu: Who will provide services and how delivered? .... What programmes must be offered? ...Has the facility the institutional capacity and capability to provide sustainable services?..... These are important questions which bring into relief the point made in para 1.4.6 above and should be of prime concern to designers of health projects - in Regional Member Countries and for the staff and directorate of Bank Group Operations Departments. An illustrative example is that of malnutrition which appeared in every project document as carrying one of the highest incidence rates in the country, and yet it never featured in any of the component activities supported by the ADF projects.

1.4.8 The project/programme design took cognizance of location and siting criteria for health centers: and these were fully satisfied. The situation, however, is different in a small fraction of existing centers: water supply is unavailable or irregular, no transportation is provided in terms of logistics, outreach work and supervision. The PCR for RHSP I (paras 3.2.26 and 3.2.27) noted that geographical conditions in Lesotho should have been taken into account at appraisal to ensure that there will be added project costs in terms of air freighting building materials into extremely difficult terrain. There is merit in the comment but the design, also, should have included ecological and geographical considerations (among others) which could have helped to highlight those conditions for the appraisal team; this should merit consideration in all future health projects financed by the Bank Group.

1.4.9 The design did include some institutional strengthening in terms of support for training programs directed more to capacity building for hospital staff than for the health center; even so it was more or less a token - the original scope was much reduced after loan approval. Results showed that MOH, on the other hand, even with such modest demand was unable to fully implement the programme. It should be noted that the PIU was well organized to manage the "hardware" part of project, which it did excellently, but the absence of a section within the PIU with technical responsibility for institutional strengthening inputs indicates the overwhelming importance given to infrastructure. Failure by the design to develop project strategy for the unmet needs of organization and management, information system and capacity building has already been commented upon earlier (para 1.4.7).

1.4.10 A lesson to be derived is that project "design", as defined in para 1.4.6, is the linch-pin on which the formulation of project components through proposal, preparation and appraisal, and to a certain extent supervision, depend. The design provides the material for the Bank Group's logical framework approach which has proved an efficient tool in the Methodology for Project Design and Evaluation (MPDE). An overall design should also potentiate the direction of subsequent studies which generally set the parameters for preparation and appraisal of a project.

1.5 Preparation and Appraisal

1.5.1 All of the appraisal reports (HSDPI, RHSP I - IV) indicated clearly the direction

of GOL's health sector policy and ADF's attempt to provide projects to support selected strategies to implement the policy (paras 1.1.3 and 1.1.4). The prime health sector strategy was to improve the network and coverage of primary health care services to the rural areas and thereby increasing accessibility to all; along with this goes the provision of secondary hospital services and referral care to enhance the delivery of basic health.

1.5.2 The concentration of the appraisal to satisfy the sector strategy to provide adequate facilities presupposes that other needs, such as programs, staffing and management would automatically be satisfied: that facilities when commissioned are of necessity operational. This is not necessarily so, as experience has shown where staff shortfalls, absence of drugs, weak programs, absence of community diagnosis, absence of water supply etc constrain the effectiveness of service delivery (see recent PPARs for health sector projects in Malawi, Swaziland and Zimbabwe). Due appraisal of these needs will fully justify investments in developing facility coverage. The comments in paras 1.4.4, 1.4.5 and 1.4.6 above are equally applicable here; the appraisal therefore does not include assumptions that relate to the foregoing needs that would ensure each facility operational at an optimum. It also did not provide baseline indicators to measure achievements with respect to project objective. A retrospective logical framework (MPDE) (Annex 2) was reconstituted based on information derived from the respective appraisal reports. It provides assumptions which cover these needs which being met would lead to achievement of the sector goal to improve the health status of the population.

1.5.3 The projects were largely successful in terms of their planned outputs and they contributed significantly towards achieving improved health status of the population (that is, the sector goal), partly because of satisfactory completion of the facilities and partly due to the presence of programs and institutions already in place. Nevertheless, weaknesses in the programs and institutions required strengthening inputs to render them efficient and effective. This would have a desirable impact on the quality of services provided, thereby enhancing the achievement of the sector goal. To this end, verifiable indicators for project objective and sector goal were not provided because institutional elements, generally, were not included in the components - some indicators (baseline and verifiable), however, could have been prepared for training though minimal.

1.5.4 A section of the appraisal reports deals with the country's socio-economic background and provides analysis of, and trends in, the economy. It thus provides the setting to assess the financial feasibility of the project. The appraisal reports should use the relevant information to demonstrate the linkage between the Government's limits of affordability and anticipated cost-effective and sustainable health development. This was not evident in any of the appraisal reports under review.

1.5.5 In a few occasions project scope and design were changed (eg: HSDPI and RHSP I and II) causing delay in starting of project implementation. Fortunately, the delays did not cause cost overruns, the opposite of which usually happens. This is a recurring problem and is probably due to inadequate project preparation as most of these changes occurred after the project had been approved by the Board. Usually there is a rush from identification and/or study to appraisal without the intervening phase of preparation as a specific entity in itself. Time carefully expended in preparation (that is, desk and field work and continuous dialogue, in the

process, between ADB Group and the government) would allow all options or alternatives and all problem areas to be fleshed out, that should ensure proper appraisal of the project. This will minimize later changes in design and scope that would have been resolved during preparation. The Bank's Operations Manual provides very explicit guidelines for project preparation.

1.5.6 Project appraisal benefits from a previous sector review or study. While a study might shorten the period of preparation and reduce the time and overheads expended by Bank Group missions, yet it does not replace preparation entirely. The study[5] on which RHSP II, III and IV were based was wholly devoted to the physical aspects of the projects and presented as an architectural design. It would have been more appropriate if it had been considered within the context of "facilities planning" which includes incremental staffing needs, range of services and nature of programs responding to at-risk population needs, transport and communication needs, and functioning within a systems management.

1.5.7 ADF and GOL accepted the study (based on construction and civil works) as the end point for appraisal without much critical scrutiny. Further review (both clinical and technical) by ADF would have elicited some preparation needs still requiring attention, for example, issues relating to the disposition of functional spaces in most of the theater complexes, inadequate working areas in a few of the X-ray and laboratory sections visited, location of inter-dependent service areas in separate blocks, and inappropriate space allocations for ante-natal and family planning consultations. In this instance, further preparation work would have ensured the viable participation of the users in assessing functional adequacy regarding the layout and equipping of the facilities to be provided.

1.5.8 In the progression of appraisal reports for each succeeding project in the ADF HSDP, lessons learned (from each preceding PCR and PPAR) should be useful if tailored into the development of those reports. However, this may not be possible because the implementation of projects in the same cycle may overlap and a preceding project may have not been completed. However a section in each appraisal report should review preceding and on-going operations. Generally, lessons learned can be applied to the development of other similar projects.

1.5.9 The level of project preparation reflects the Operations Manual's statement on appraisal of a project: "Appraisal involves the review of various aspects of the project to ensure the soundness of the project, the superiority of its design to alternative means of meeting its objectives and its readiness for implementation". The various elements thus covered by the appraisal are identified as: technical, financial, economic, institutional, social distributional (e.g., women in development), environmental. It would appear that the areas which require more attention in the appraisal report are financial, economic and institutional.

2. IMPLEMENTATION

2.1 Revisions, Delays and other Difficulties

2.1.1 Revisions to appraised projects occur after Board approval, and often after

signing of the Loan Agreement. This procedure absorbs time and, at least opportunity cost, and detracts from the momentum for project execution; and in the HSDP we find:

a) the reduction of the loan amount (HSDPI) after the decision by GOL to eliminate two components and retain a third (the immunization program). This caused a reduction in the loan amount with consequent "savings" of around FUA 1.6 million - which, as part of undisbursed project proceeds, was cancelled (PCR para 3.3.1). Also, more time was expended in revising the appraised implementation strategy for the immunization program in order to utilize the WHO field experience. One wonders why this had not been thoroughly reviewed during preparation and subsequent appraisal by ADF, GOL and WHO, particularly as WHO was a principal collaborator in the concept, design and preparation of the (immunization) project (PCR 3.3.2);

b) in RHSP I, there were changes in the architectural design and structural plan etc., for two health centers in the mountainous areas resulting in unappraised/unanticipated costs. These changes were extremely desirable and justifiable, but why were they not identified during the preparatory stages of the project? (Para 1.4.7 above, refers), (PCR paras 3.2.11-3.2.12);

c) in RHSP II, there is a change in scope occasioned by higher construction costs than anticipated at appraisal; thus staff housing was eliminated - even so, there was a minor cost overrun (1.3%) which was eventually met by GOL. The question of underestimation of project costs during preparation and appraisal is offset by the fact that significant fluctuations in currency occurred with devaluation during the period (PCR paras 3.2.1 and 3.7.3).

2.1.2 Delays after signing the Loan Agreement affected almost all aspects of each project with consequent time overrun but no costs overrun in lieu. The ADF's first experience in the health sector in Lesotho - support for the immunization programme - was plagued by delays. Effectiveness was 24 months delayed because of GOL's inability to fulfill Loan conditions (PCR para 3.1.1). This contributed to the overall delay in project execution; implementation started 36 months late due to time taken in negotiating the scaling down of the project, as well as in the recruitment of the technical officer who would be responsible for training workers, establishing the programme and organizing the procurement of vaccines and equipment etc (which was also late). Implementation was virtually not completed although ADF's participation ended in 1984 after a period of 8 years from loan approval

(1976) (PCR paras 3.4.1-3.4.2); considerable difficulty was experienced by GOL in disbursement because of inability to use disbursement methods effectively (PCR para 3.4.3). In view of its limited experience with the ADB Group, it was incumbent on ADF to fully orientate GOL/MOH in Bank Group procedures.

2.1.3 The subsequent projects had very few delays: start and completion of implementation in RHSP II had a time overrun of 7 and 17 months, respectively, but with no cost implications. The initial delay was due to re-tendering after unsatisfactory response at the first tendering and subsequently to tardiness on the part of the contractor (PCR paras 3.3.4, 3.4.1, 3.4.2). Neither the PIU/MOH (which supervised diligently) nor the ADF (who gave timely responses) can be faulted for events that were beyond their control. In both RHSP I and II, there were delays in first disbursement between seven and eight months. This resulted in "savings" (Table 2.1) in RHSP I which were to supplement proceeds in RHSP II. In this instance, GOL expressed dissatisfaction at ADF's tardiness which was alleged to have slowed down implementation somewhat (RHSP II - PCR para 7.1.3).

2.1.4 Supervision was the only other major difficulty encountered although, except in the case of the immunization programme, it was offset by maintenance of excellent communication between ADF and GOL, and ADF's quick and timely responses. ADF supervision missions were tacitly split between the Loan and Project (Operations) Departments.

2.1.5 The Projects department deals with the micro aspects of a sector and is responsible for project implementation in that sector; the Loans department deals at the macro country level, covering all sectors, and therefore cannot do a detailed supervision of individual projects. Neither one can be a substitute for the other because of differing terms of reference; however whilst back to office reports were exchanged, sometimes follow-up action was limited with insufficient attention being paid to past recommendations made.

2.1.6 Thus each project was actually supervised by ADF's Projects department about two to three times during its entire life and the comment in the PCR on the immunization programme[12] is very apt (concerning the fact that of 8 supervision missions mounted, only 2 were technical supervision missions) and is equally applicable to all the projects (HSDPI - immunization -PCR para 3.8.1, RHSP I PCR para 6.1.1, RHSP II PCR para 3,5,1).

2.2 Project Costs

2.2.1 Notwithstanding the difficulties experienced in disbursing project proceeds (paras 2.1.2 and 2.1.3 above), the level of utilization of project funds was encouraging, except in the case of the first project (HSDPI), (para 2.1.1 (a) above) and Table 2.1 below. In the course of the Health Services Development Programme (HSDP), ADF made six loans to the health sector between 1976 and 1992 totalling FUA 42.43 million (UA 39.08 million). Table 2.2.

2.2.2 Between 1976 and 1991, Table 2.1 shows the level attained by the four completed projects and study (87%); 13% of total funds thus allocated to HSDPI, RHSP I -III and the Study was undisbursed. This is a significant amount which would have been rendered less so but for the large amount of undisbursed funds from HSDPI. The projects may have been implemented as planned but optimum utilization of ADF funds was not achieved. A fifth project, RHSP IV, was approved in 1992 and although two years have elapsed (1992-1994) and works are well under way[6], Table 2.1 shows no disbursement. The PCRs agree that ADF was diligent in ensuring timely communication and responses to GOL/MOH in terms of requests for assistance in project execution; but there was concern by GOL about ADF's slow pace of

disbursement.

Table 2.1
Health Services Development Programme
ADF Disbursements To Health Sector Projects: 1976-1994

	Project	Approval Year	Loan UA million	Disbursed UA million	Undisbursed UA million	Percentage Disbursed
1.	HSDPI	1976	2.30	0.36	1.94	16
2.	RHSP I	1984	5.85	4.87	0.98	83
3.	RHSP Study	1984	1.14	1.01	0.13	89
4.	RHSP II	1987	11.67	11.49	0.18	99
5.	RHSP III	1991	7.07	6.61	0.46	94
6.	RHSP IV	1992	11.05	0.00	11.05	0
			39.03	24.34	14.74	62

Table 2.2
Health Services Development Programme
ADF Loans To Health Sector Projects: 1976-1994

	Project	Approval Year	ADF	GOL	OPEC	Total
			FUA Million			
1.	HSDPI	1976	2.50	0.32	-	2.82
2.	RHSP I	1984	6.35	2.77	-	9.12
3.	Study	1984	1.34	-	-	1.24
4.	RHAP II	1987	12.67	1.59	-	14.26
5.	RHSP III	1991	7.67	0.90	2.71	11.28
6.	RHSP IV	1992	12.00	2.35	-	14.35
Totals: (FUA million)			42.43	7.93	2.71	53.07
Totals: (UA million)			39.08	7.30	2.50	48.88

2.2.3 Certain important questions arise, such as: a) was disbursement a constraint in the utilization of project funds? b) was GOLs inability to utilize funds a result of its poor absorptive capacity, weak managerial capability and institutional weakness generally? and c) did the fault lie with project appraisal for failing to compute more efficiently project cost estimates? It should be noted that the projects were completed as planned therefore the reason for funds

remaining undisbursed may lie in one or other of the foregoing scenarios.

2.2.4 The answer may lie with the first two scenarios indicated in para 2.2.3. With respect to the third, we deduce from the respective PCRs (HSDPI, RHSP I - II) that there was a fair estimation of project costs at appraisal. Costs overrun was negligible in spite of escalating costs for materials and services due to rising inflation; however, when translated into local currency it was significantly higher (RHSP II PCR para 3.7.3) This was, however, compensated for by the depreciation of the local currency (maloti/rand) against the UA. Underestimation of project costs (indexed by cost overrun) was apparent and not real. Project costs were computed at prevailing prices and currency rates at appraisal.

2.2.5 Project accounts were kept separate in all projects except in the case of the first project - the immunization programme (HSDPI). The PCR mission could not disaggregate project's expenses from MOH's general accounts and donor contributions could only be quantified in kind without the benefit of eliciting costs (HSDPI PCR paras 3.6.3-3.6.4).

2.2.6 There was nothing stated explicitly in the respective Loan Conditions that stipulated the keeping of separate project accounts within MOH. Although there was general observance of this procedure, future Bank projects should ensure the inclusion in the Loan Agreement of the terms of General Loan Conditions that stipulate that project accounts (ADF and counterpart) must be kept. They should also be made available to Bank Group staff through supervision and follow-up missions and be subjected to annual audit by (external) auditors acceptable to Bank Group and Government.

2.2.7 The interim PPAR mission was satisfied that GOL provided, with reasonable regularity, audited project accounts satisfactory to ADF. The Auditor General was also satisfied that separate project accounts were well kept. None of the project Loan Conditions had reference to project audit requirements.

2.3 Reporting and Supervision

2.3.1 One of the striking features of the HSDP was the regular submission of progress reports by MOH for all projects (PCR: HSDPI paras 3.5.1-3.5.2; RHSP I para 3.1.3; RHSP II para 3.5.1). By contrast, supervision was weak in terms of the low number of ADF missions fielded (PCRs HSDPI, para 3.8.1; RHSP I, para 6.1.1: RHSP II, para 7.1.2) but largely compensated by regular monitoring of project execution through maintenance of good communication between ADF and GOL/MOH; this situation has been

reviewed in paras 2.1.4-2.1.6 above. Supervision of construction and civil works by the PIU was exemplary throughout and proved effective in ensuring completion of works of high quality.

2.3.2 As a requirement to operational effectiveness, supervision missions should be regular and average, within resource constraints, twice a year under normal circumstances, and more if the project becomes a problem one. The presence of a Bank Group mission in the field at regular intervals lends on-the-spot support to the executing agency and government and

reinforces or instills confidence in the Bank Group.

2.3.3 Field missions acquire greater perception of project implementation issues than monitoring from the desk and they enhance follow through actions. As previously indicated in the Zimbabwe PPAR, supervision missions are not only necessary for the monitorial, advisory and technical assistance roles they play, but they also serve to preserve the linkage and dialogue between the Borrower and Bank Group during the life of the project. By this means, timely actions may be pursued to resolve issues relating to slow implementation, such as, project management, technical assistance and project related policies.

3. ACHIEVEMENTS

3.1 Outputs

3.1.1 In the HSDP covering the years 1976-1991, ADF financed, through five loans: a) an extended programme on immunization with the active participation of WHO, UNICEF and SCF; b) the construction of 10 and rehabilitation of 31 rural health centers (clinics) including equipping and furnishing; and the construction and renovation staff houses, waiting mothers'

lodges and food stores. (RHSP I).

3.1.2 Included also are: the completion of a Study for RHSP II, III and IV, and the construction, equipping and furnishing of 5 district hospitals (RHSP II and III). The above health centers which comprise 22% of the total national coverage of 187 centers have been completed, commissioned and moderately operational with certain identified constraints (see para 3.1.3 below). The completed hospitals form 56% of the government district hospitals, but when the HSDP full complement of 8 district hospitals is realized (with the completion of RHSP IV), that percentage will improve to around 90%. However, eventual coverage will be 44% of the total number of district hospitals (both MOH and PHAL). ADF contribution is therefore highly significant in strengthening facility coverage in Lesotho.

3.1.3 The completed hospitals are fully commissioned and are operational but having some key constraints which threaten quality of services - these will be amplified under Chapter 4. In a very small proportion of health centers there is the issue of inadequate or unavailable water supply, the mission feels that almost all are remediable with better administrative management between the local authority and the HSA or MOH. Until resolved, the quality and type of services will be constrained in those centers. A very commendable feature is the extensive use of solar power in all ADF facilities (centers and hospitals) with very minimal maintenance problems. The advantages have been demonstrated in energy savings, easy availability and low maintenance costs. The Bank Group should actively consider its replication in future projects.

3.1.4 There are some design issues which may lead to functional constraints as already indicated in paras 1.5.6 and 1.5.7 above. They are mostly applicable to the hospitals and, to a lesser extent, the health centers. Generally they illustrate the value of seeking user views which the mission found little evidence of. These issues may be cited as:

3.1.5 The layout of hospital facilities could have been better planned in terms of a) the handling of patients , b) the provision of space for the surgeon to write his post-operative notes without leaving the sterile zone, c) handling procedures for sterile surgical instruments and d) better logistics for the central sterilization services department (CSSD) area.

3.1.6 The space allocated for X-ray and laboratory facilities is frequently inadequate, sluice rooms are sometimes poorly located and more space is needed for mother and child care (MCH) and family planning (FP) services (hitherto shared in one room) where individual counselling and privacy are necessary. The hospital outpatient departments

combine a section which was not appraised and is of poor quality with a rehabilitated or new additional wing; the whole arrangement is unsatisfactory in terms of ambience and function.

3.1.7 The design for the mental observation units could be improved in terms of a) the provision of more secure windows and b) the use of perspex instead of unscreened glass windows and louvres. A "safe" heating system would be an advantage during winter.

3.1.8 Hospital housing areas could have been designed to achieve more

accommodation per unit of scarce land area and improved value for money, e.g., by means of the construction of apartment blocks for single family members of staff. Family houses were designed for families with two children without due recognition of the average family size in Lesotho; user views were not sought.

3.1.9 Notwithstanding the issues raised, the number of beneficiaries served by the improved coverage is significant. The principal beneficiaries[7] are children (0-14 years) and women of child bearing years (15-45 years). There were no calculations regarding potential beneficiaries but review of census data[8] has allowed projections and presumptive analyses to be made.

3.1.10 The immunization programme (HSDPI) began its national coverage in 1979 and by 1983 46% of all children (0-<5 years) were immunized against all of the six childhood diseases;[9] this compares favourably with the pre-project estimate of around 25% of children immunized against one or other of the childhood diseases.

3.1.11 By 1984, at the end of ADF support, some 310,000 children had been fully immunized, equivalent to 55% of the 0-14 years cohort, compared with 45,261 in 1974 before the programme started. In 1992, according to UNICEF,[10] the immunization rate had risen to 90% (polio 3 doses), 85% (DPT 3 doses), and 68% (measles) - Appraisal Report para 2.20 and PCR para 4.1.1). Thus, full immunization for the country has risen over time and now stands at 71%. However, certain coverage has actually decreased, for example, measles and polio 3, and efforts will need to be made to maintain existing high levels of immunization.

3.1.12 In spite of lapses, the immunisation programme, as the EPI (extended programme on immunisation), has continued in an upward trend and has achieved some measure of success in integrating this programme within the MCH-FP preventive programme in the PHC centers - also in the ante- and post-natal clinics in the district hospitals. There is a cautionary note. The sustainability of this very important programme is being jeopardized by waning of donor inputs, budgetary constraints in the MOH and problems in programme management and staff support.

3.1.13 The contribution to improved coverage is no less significant in terms of the health centers and district secondary hospitals. That programme has been in operation since 1984 and will continue through 1996, through four projects. ADF originally supported 11 NGO and 22 MOH centers in 13 out of 18 HSAs (72%); unfortunately, this distribution was not observed in selecting district hospitals for support - all were MOH facilities and because none of the NGO (PHAL) hospitals which serve over 40% of the population received any consideration, they remained in a poor state. This would lead to a situation whereby the MOH hospitals have facilities and equipment which are superior to the NGO (PHAL) hospitals. This, also, could lead to an inadequate distribution of quality services and a drift of patients from the PHAL hospitals to the MOH hospitals, thereby overloading those facilities and jeopardizing quality of care. Because of the important contributions of NGOs such as PHAL and the Red Cross, ADF should consider including NGOs as critical collaborators with the Government in health development projects.

3.1.14 Of the principal beneficiaries (para 3.1.9 above), women of child bearing years (WCBY)

comprised 46% of the female population in 1986 and that ratio has remained, more or less, constant through 1992. Over the same period, the population of children was 41% of the total population and the ratio has only increased marginally to 41.4 %. The ADF centers were distributed throughout the 10 districts of Lesotho and covered 22% of the population (para 3.1.2), thus retrospective estimation and current projections would put the total number of beneficiaries that ADF centers might have covered in 1984 at around 218,680. This number would comprise around 82,720 women of child bearing years aged 15-45 years (WCBY) and 135,960 children (0-14 years). Figures estimated for 1992 are: 261,520 of which 99,600 are WCBY and 161,920 children (0-14 years). Population growth rate was 2.6% annually, and the beneficiaries showed an increase of approximately 20% over the 8-year period. The provision of improved facilities to enhance the delivery of care is considered timely. (Annex 5).

3.1.15 The population covered by the ADF supported secondary district hospitals (1987-1992/1994) is that of the district in which each hospital is located and constitutes the number of beneficiaries. The project hospitals are sited in 8 of the 10 districts in Lesotho. In 1986 just prior to the project, the total population of the concerned area was 1.125 million and for the area of the first 5 completed hospitals, 821,400. In 1992, these figures become 1.3 million and 950,000, respectively. The associated bed state for the hospitals in 1986 totaled 419 giving an average population per bed ratio of 1,961. By 1992, following the ADF intervention, the bed state had improved by 70% to 713 with a population/bed ratio averaging 1,330. The population increase had been more than matched by increase in the bed state; this will be further enhanced by 40% following the completion of the last three hospitals (RHSP IV) in 1996.

3.2 Objective

3.2.1 The PCRs all state that the objective at appraisal was to support the health sector strategy of the government's policy by providing more and improved health care services. The retrospective MPDE logical framework matrix drawn up by OPEV, however, goes further by indicating that such services should be on a sustainable basis. The requirements are effective management, information, financial, planning and maintenance capabilities.

3.2.2 HSDP carried some institutional strengthening in terms of capacity building, although somewhat limited and overwhelmed by the construction programme; this, as indicated in earlier paragraphs (paras 1.4.6 and 1.5.2), was not enough to ensure effective and sustainable services.

3.2.3 The health centers provide basic health services through a PHC delivery system covering curative, preventive and promotive care. The preventive part is weak and the promotive is unsatisfactory in terms of outreach work. The services are mainly MCH-FP including ante- and post-natal clinics, immunization of infants and children in the expanded programme on immunization (EPI), growth monitoring, family planning and maternal deliveries. Health education is offered during clinic sessions by nursing staff but that pertaining to environmental hygiene, sanitation and motivational work is absent within the clinic program. The absence of a health assistant in almost all of the clinics reduces the linkage between the clinic and the outreach programme.

3.2.4 Nurse clinicians receive in-service training in basic laboratory tests and special procedures for screening for tuberculosis, STDs and suspected AIDS cases; slides are prepared and sent to the district hospital and patients are also referred for further investigation. Health center records are kept and reported through the information system (with no feedback) at regular intervals to the district hospital at the HSA. Each center is to be regularly supervised by a team consisting of the doctor, public health nurse (PHN) and other personnel. Referral of patients to the secondary care hospital is dependent on the availability of transport; the patient is often provided with a record book to take to the hospital. Each center has a reasonable stock of essential drugs which are dispensed under a national formulary and the supply of disposable syringes and needles is satisfactory.

3.2.5 Electric supply is maintained with a few exceptions and solar powered or gas operated refrigerators and autoclaves are provided. Telephone communication through a CB system is in operation in almost all centers and some have telephones in addition. Maintenance of all health centers is carried out effectively by PHAL.

3.2.6 There are certain areas of concern which require attention to ensure effective services output. Staff shortfalls in many health centers constrain effective service delivery; a nurse assistant with limited clinical experience often substitutes for a nurse clinician. This situation could be remedied by upgrading the skills of this cadre through a well organized in-service programme. In other instances, centers are closed for lack of staff.

3.2.7 Supervision and monitoring of health centers from the HSA is uneven, well applied in some HSAs and weak in many others. It suffers partly from shortage of personnel - the doctor, PHN, pharmacist, dentist and senior health officer, and partly from poor management orientation. The situation is further complicated in many places by a lack of transport. As a result, the management of PHC delivery becomes inefficient and is reflected down to the health post at the village level which provides first line PHC service by community health workers (CHWs) and traditional birth attendants (TBAs). These rely on the health center for supervisory, technical, referral and logistical support which, so far, has been non--existent. A weakness in the PHC strategy as implemented is the lack of

supervision and monitoring of the village health workers and very little, if any, linkage of the health post with the health center which covers the catchment area in which the posts are located.

3.2.8 The referral system has not been organized as a system. It is presumed that the health center should receive 80% of patients from the health post, and the district hospital about 30% from the health centers and around 5% will be referred to Q.E.II from the district hospitals. Quite a few patients bypass the health center for the hospital, consequently Q.E.II, supposedly a tertiary hospital, is delivering primary health care and secondary care as well. Maintenance of high quality services, sustainable at that level, in terms of trained service providers, regular supply of drugs and other important supports, would improve the credibility of the system, patient compliance and utilization rates in health centers, and district hospitals will benefit by less overcrowding of their out patient departments.

3.2.9 The purpose of the referral system is to first ensure that adequate services of acceptable quality are provided at the primary level and to screen patients for referral to the district hospitals and so on. Secondly, protocols should be established for nurses and doctors and service providers at the primary level to serve as guidelines; thirdly, a network of logistics should be in place to ensure transportation of needed cases; fourthly, an information system should be installed to provide a feedback loop; and lastly, disincentives (for example, fee surcharge) should be introduced to discourage self-referrals to secondary and tertiary levels of care. The referral system should be streamlined to ensure that most cases are first treated at the primary level efficiently and that hospital out-patients are not overloaded and that they are allowed time to deliver more sophisticated care.

3.2.10 One important anomaly noted was in reporting. All health centers are supposed to be supervised by their respective HSAs. However, MOH centers report to the MOH/HSA, while the PHAL centers report to their church body and the Red Cross center to its own principal. Accountability is compromised with regard to management control and the situation makes it difficult for decisions to be taken readily and directions to be given effectively.

3.2.11 The problem of shortage of staff has become critical at all levels, but mostly middle level cadres. There is hardly any attrition during training, but it is considerably higher after graduation. This is caused by several factors other than the urge for better inducements in South Africa. The salaries are low, there are very few incentives, especially to staff in difficult outlying areas; the conditions of service require intensive review, period of waiting to be recruited after training/graduation is often long and protracted and one of the prime causes of frustration and for leaving the country. The GOL should address these issues urgently to create job satisfaction and career development. In consonance with the foregoing, MOH requires strengthening of its human resources or manpower planning capability, as well as, its training institution for nurses and allied health staff including curriculum development appropriately tailored to identified needs such as family health/planning, community health, clinic management etc., and continuation education, which is task oriented, for health center and hospital staff; the mission understands that the World Bank and WHO and other donors have offered assistance in this area.

3.2.12 It was observed by the mission that despite the continuing high incidence of malnutrition there was not much nutrition activity in the centers visited. There were charts on the walls describing various foods, and the mission was told about a feeding program. However, there was no evidence of an intensive screening or an action oriented surveillance program and nutrition education at outreach services coordinated by, or at the centers. This is another area where donor intervention is currently focussed.

3.2.13 There are 18 general or district hospitals, 2 specialist hospitals (one for leprosy and another for psychiatric disorders) and one tertiary hospital - the Queen Elizabeth II hospital in Maseru. The district hospitals vary in size but offer, generally, an essential clinical package consisting of basic medical, surgical, obstetric and gynaecological services, and treatment for tuberculosis. The hospitals are equipped to offer diagnostic services in laboratory and X-ray procedures. They are also served by a reasonably stocked pharmacy.

3.2.14 The district hospitals comprise the secondary care level of the health system and are at the intermediate point of the referral system. They thus provide referral support to the PHC

network of health centers in terms of higher order of diagnosis and treatment. They are also designed to give technical support to the health centers. It is estimated that, in a properly managed health delivery system, 30% of health center patients may require referral to a district hospital where they can be clinically managed within a reasonable level of specialization. The district hospital itself may eventually refer around 5% of its patients to QE II for more specialized care. The system thereby eliminates overcrowding with PHC patients at the hospitals.

3.2.15 Some of the issues discussed above are applicable to the hospitals also, e.g., referrals. Attention is drawn to staff shortages being experienced in the hospitals due to a migration of trained health staff from Lesotho. Many established posts are not filled and the upgrading of the hospitals with more beds, consulting areas and additional staffing requirements have compounded the situation. The observation in para 3.3.11 above holds true.

3.2.16 Concerns regarding functional areas, such as the theatre complex, have already been noted in a preceding paragraph (para 1.5.7). Hospital equipment was procured from a wide variety of sources. A few items were supplied with parts missing. Spares are not available for some time. A more uniform and standardized approach to procurement is required. The mission found that users were not involved in the decisions regarding equipment procurement and had to accept what was being offered in terms of types,specifications and quantities - as an example, one hospital was forced to accept a load of soil waste bins far in excess of what it could use.

3.2.17 Due to the explosive increase in tuberculosis, more bed space is being taken up by cases in the hospitals. Overcrowding has resulted in some hospitals in the attempt to accommodate these patients, many of whom are being treated in general wards. As a priority

consideration, the GOL should seek donor assistance to provide special facilities at district hospitals for those patients requiring institutional care and to minimize the further spread of the infection in hospitals while developing ambulatory care and case management for selected cases. The Irish donor agency is the most active in this area.

4. OPERATIONAL PERFORMANCE

4.1 Constraints

4.1.1 There is a technical constraint which is due to staff shortfalls, equally applicable to the health centers and district hospitals. Some health centers have been closed because no staff are available; in some hospitals, coverage of wards is unsatisfactory because of few staff. The shortage of personnel has also constrained effective supervision at the HSA and health center levels, respectively.

4.1.2 Optimum effectiveness in some centers is constrained by water supply problems (para 1.6.9 above). Thus pregnant mothers are not delivered. Health assistants (HA), responsible for environmental education and other forms of health education dealing with communicable disease serve as link between the health center and its catchment area (villages). Their absence in the health centers is almost universal and mainly due to acute shortage in that cadre. In the very few centers where there is an HA, his or her work is limited by lack of transportation.

4.1.3 The period of launching ADF's first assistance in the health sector in Lesotho saw

the country's economy growing at a steady rate, stimulated by large migrant remittances from South Africa. Accordingly, development expenditures increased rapidly resulting in budgetary deficits in the 1980s. The Lesotho economy was thus characterized by increases in government revenue on the one hand, and indebtedness on the other.

4.1.4 With the reduction of remittances from South Africa (following redundancy at the mines), revenues declined significantly while recurrent expenditures, already incurred from an inflated civil service and development programs, remained high. The economy steadily declined with mounting debt consequences. A Structural Adjustment Programme (SAP) was introduced in (1988-1990) with the support of IMF and the World Bank. It was successful in reducing government expenditure and borrowing but at considerable cost to services provided and employment. Another unwelcome outcome was a rise in the poverty level by e.g., 31% in Maseru and 15% in the rest of the country since 1990. (UNICEF: Women & Children in Lesotho. GOL).

4.1.5 The satisfactory performance of the economy under SAP led to a second adjustment programme - the Extended Structural Adjustment Facility (ESAF), 1991-1994, which led to the Fifth 5-Year Development Plan (1991/2-1995/6). Under these adjustment programmes, MOH experienced budgetary cuts in recurrent expenditures with constraining effects on staff development and employment, although there was the compounding factor of staff attrition.

4.1.6 In these circumstances, GOL is actively developing, with donor assistance, such as the EU (formerly EEC), plans for resource mobilization and allocation in health, among other social sectors, which is consistent with the Bank Group's Economic Prospects and Country Programming Paper (EPCP), (RHSP II PCR para 1.2.6). Furthermore, in order to ensure an acceptable quality of health delivery, MOH's next step, after successfully expanding the desired network of facilities, is to plan for a more streamlined and efficient system through rationalization and consolidation of the service delivery system, thereby, inter alia, reducing the recurrent cost burden - an effective health planning capability will review, in this context, the development of different grades of clinics designed for the optimum use of resources because of patient utilization which varies from an average low of 15 patients daily to a high of around 150 daily; the work load of the staff also varies in lieu. A well established Health Management Information System is a necessary component in the MOH structure in achieving these ends.

4.2 Institutional Arrangements

4.2.1 The MOH has endeavoured to improve the organization and management of health services at the district level, where the implementation takes place, by developing Health Service Areas (HSA). These are geographical areas with between 38,000 and 200,000 population providing catchment for a HSA hospital. The main objective is decentralization of health services administration and management from the center and to create greater liaison between the district and local community level (paras 1.2.8-1.2.10 above, refer).

4.2.2 The MOH workshop on health policy (para 1.2.2 above) noted "that health centers in each HSA are supported technically by the HSA hospital of which there is one in each

health service area. The HSA hospital forms the second level of the referral system. It is at the HSA hospital, staffed by at least one medical doctor, that essential medicine, surgery, obstetrics and gynaecology and diagnostics are carried out. The HSA hospital supervises and coordinates all public health activities". Paras 3.2.7 and 4.1.1 above commented on the inadequacy of supervision and while the objective of the HSA is ideal, the system itself has management weaknesses.

4.2.3 The workshop further noted that "while the HSA concept has worked fairly well to standardize care and give equal authority of that level to government and PHAL institutions, its major weakness has been promoting intersectoral collaboration between health and other sectors which are based and coordinated by the District Secretary and the District Development Committee". While there is no disputing the above observation, the mission feels the more serious weakness of the HSA is MOH's failure to decentralize organization and management of the HSAs with decentralized budgetary capability.

4.2.4 The first stages of a Health Information System (HIS) has been established throughout the health delivery system. It requires institutional strengthening in terms of training of personnel, providing a fully organized information network and suitable linkages to other parts of health management system. Donor assistance is already directed in this area. The various PCR and PPAR missions have experienced considerable difficulty in retrieving needed health statistics, even for very recent years.

4.2.5 A related area is also of prime concern: The weakness of the registration system and systematic collation of vital, demographic and services data. Vital registration was organized in 1938 to collect vital data through village chiefs who recorded the events. Subsequently the Bureau of Statistics was created in 1965 and assigned the task By 1971-1973 a Demographic Sample Survey was undertaken from which evolved a modern vital registration system. The development of this capability was uneven throughout the years and health data were not easily accessible. The system has collapsed due to inadequate trained staff at district levels and lack of coordination among the agencies involved, such as, Bureau of Statistics, Ministry of Interior and the Registrar-General's Office. The developing of HIS should re-establish an effective linkage with the vital registration system

4.2.6 Because of the vital necessity for MOH to address requirements for resource mobilization, a well structured Management Information System[11] must be put in place. A critical component is a Financial Planning and Management System (FPMS) through which would be provided needed financial information for planning, policy and financing options, cost accounting, expenditure control and many more. Donor inputs in this area are selectively applied to important sections to increase financial efficiency and the process is ongoing. Results currently are not very encouraging because of unavailable personnel.

4.2.7 Much donor assistance is also directed to strengthening health planning and health services and manpower development capability. As already observed, the need for a <u>systemic plan for the critical development of appropriate health personnel is more urgent now because of the need for streamlining the system</u>. For example, the establishment list bears very little relationship to staff on post; there is patchy distribution of staff over the country - no set

pattern is followed.

4.2.8 Maintenance for the rural health centers is exemplary and is carried out by PHAL with funding support from DANIDA. The same could not be said for the hospitals, although those within the ADF supported project have fully staffed and equipped maintenance workshop units in each hospital facility. A department in the Ministry of Works is responsible for MOH hospital maintenance. The mission was not sure that there was much understanding by the department on the requirements or functions of a planned maintenance system. There was more remedial than preventive maintenance. The department suffered from budgetary restrictions and although it runs an on-the-job training program at district level for technicians, this is more or less cursory, depending on the availability of time and/or transportation.

4.2.9 Considerable donor input has gone into this area without much results; MOH needs to have a maintenance information system for preventive and remedial maintenance and forming part of a HMIS. Training of users (service providers, surgeons, nurses, laboratory technicians etc) and maintenance technicians should be part of establishing the system. Computer capability is required; improved logistics, supervision and reporting form part of the system, and each district must have a well equipped workshop.

4.3 Health Financing [12]

4.3.1 Financing of Lesotho's health services is derived from a variety of sources - government funds, government revenues (e.g., user charges..) and donor funds (which are non-sustainable). The government budget expenditure is split into two categories, namely, capital (development) and recurrent. Over the last six years GOL expenditure on health has consistently been the third largest sector allocation; this pattern, apparently, is a continuation of a trend set over the years. Notwithstanding, GOL/MOH relies heavily on donor funding to supplement provision for some services, particularly PHC, AIDS prevention and control and public health. In terms of revenue, MOH facilities and PHAL charge their patients for services although certain treatments, such as those for tuberculosis, mental disorders, epilepsy, FP, ante-natal care and immunization are free. Private doctors and traditional practitioners charge their patients varying amounts for their services. See Cost Recovery below.

4.3.2 Detailed expenditure information on MOH is difficult to obtain. The table below (Table 4.1) is based on the approved MOH budget over the period 1988-1993. In para 4.3.8 below are comparable indicators showing the extent of GOL's health investment. Sector allocations (Table 4.2) confirm the health sector's position (para 4.3.1 above) which lagged considerably behind that of the education sector.

Table 4.1
(In Millions Maloti)

MOH Budget Allocations (1988-1993)

	1988 - 1989	1989 - 1990	1990 - 1991	1991 - 1992	1992 - 1993	1993 - 1994
Administration	3.0	3.3	3.4	7.7	10.5	11.0

QE II	10.1	11.6	11.0	15.4	21.1	26.5
Districts	7.8	12.6	13.0	15.6	20.5	28.4
Mental Health	1.6	1.3	1.3	1.5	1.7	2.4
Public Health	0.8	1.5	1.6	1.7	2.0	3.0
Leprosy control	0.3	0.3	0.4	0.4	0.5	0.7
Laboratory	0.7	1.0	0.7	1.3	1.6	1.9
NHTC	1.0	0.4	0.5	0.6	1.2	2.6
TOTAL	25.3	32.0	31.9	44.2	59.1	76.6
Government Budget Total	297.9	306.2	366.6	427.5	447.3	614.6
MOH as % Total	10	10	12	11	12	13

Source: Lesotho Government: Estimates 1988/89 to 1993/1994. Ministry of Planning, Economic and Manpower Development

Lesotho Health Sector

Table 4.2

Sector Allocation (%) of Central Government Expenditure

	Sectors	1980	1991
1.	Education	15.3	21.9
2.	Health	6.2	11.5
3.	Housing, Social Welfare	1.3	5.5
4.	Economic Services	35.9	31.6

Source: World Development Report, 1993

4.3.3 The relative proportions in the budget have remained generally constant with most of the growth occurring in the last three years (1991/2, 1992/3, 1993/4). The fall in expenditure between 1989/90 and 1990/91 can be almost fully attributed to the freeze on

recruitment which accompanied the SAP. The freeze operated for only two years of the SAP and was then lifted. GOL attempted to streamline all ministries budgets to make them fit the staff in post much more closely rather than maintaining surplus funds to cover vacant posts; this caused a sharp fall (10%) in the budget for personnel emoluments in 1990/91.
Ministries can now fill posts by liaising directly with the Ministry of Public Service who will also ensure that the Ministry of Finance (MOF) releases the appropriate funds.

4.3.4 In keeping with its health policy for greater emphasis on PHC and strengthening of services at the district level, MOH seeks to reverse the trend whereby the tertiary level absorbs a considerable proportion of allocations to the health sector. Thus QE II hospital's share of the budget has gone from 40% in 1988/89 to 34.5% in 1993/9 whilst the districts' share has improved from 30.8% to 37% over the same period.

4.3.5 While GOL seeks to streamline expenditure on retention of vacancies in the Establishment List, expenditure on salaries has grown; this may be due to some success in recruiting and retaining staff or because the administrative reform programme is not working well as was expected and the civil service continues to malfunction. Drugs and dressings have shown increased expenditures but grants in the way of subventions to PHAL have been severely curtailed. The PHAL grant in 1991/92 covered all hospital staff in its institutions, including a 50% subvention for its health centers. In 1992/93, GOL funded only salaries of staff that it considered appropriate for each hospital and only on a basic grade. The subvention to PHAL as a proportion of the MOH's budget has decreased appreciably over the years. (see paras 1.2.8 and 1.2.11 above).

4.3.6 Expenditure on maintenance is still very low (0.8%) emphasizing its low priority; additional funds must be allocated to this area if MOH is to maintain its infrastructure at the acceptable level of quality.

4.3.7 A review of expenditure patterns within departments of the MOH shows that Districts and Public Health spent 99% of their budget, QE II 96%, Laboratory 94%, Administration 93%, Mental Health 91%, NHTC 83%, Operating Costs for health programmes of services 81% and Leprosy Control 57%. A serious problem in the MOH is thus highlighted which is MOH's lack of capacity to spend on its programmes rather than a shortage of funding. With the ongoing trend it was estimated that the year 1993/94 would experience greater underspending by some 20%; this must have serious implications for the delivery of health care. By contrast, there was overspending on salaries, travel and grants. Given the health care needs and various strategies indicated in the health policy, the mere identification of more funds for MOH to support various programmes is meaningless if some efforts are not made to improve the absorptive capacity of the MOH. A step in that direction is the institutional strengthening, by donors, of key sections of the Ministry, especially, in this context, financial planning and management. The objective of financial management is to improve efficiency and management of health expenditures in order to sustain programmes and services thereby enhancing resource mobilization. Financial planning and management as part of a management information system has already been commented on in an earlier paragraph, (para 4.2.6 above).

4.3.8. Cost Recovery. The prevailing economic situation is critical. This is

compounded by low morale, apathy, poor job dissatisfaction among MOH service providers, and ineffective management capacity. If this situation continues at length without redress, the quality of services will be adversely affected and gains in health status would be compromised - this has begun to be seen in the delivery of MCH. The scenario has changed from being a "front line state" (para 1.1.1 above) after the emergence of South Africa from isolation. Donor agencies are now pulling out and concentrating on South Africa. The economic and donor assistance prognosis is bleak

4.3.9 GOL/MOH is fully aware of the difficulties it faces with regard to the financing of health care and is exploiting alternative means of subsidizing government resources. Table 4.3 below gives total health expenditure for some front line states and countries in the sub-region and comparable low income economies. It shows that Lesotho's per capita health expenditure of US$ 32 had, hitherto, been the highest after Zimbabwe's in sub-Saharan Africa with a corresponding GDP of 8.4% which was the highest in the region.

Lesotho Health Sector

Table 4.3

Total Health Expenditure (1990)

	%	Per Cap	% of GDP			Aid Flows	
	Gvt.Exp.	US$	Pub.	Priv.	Tot.	Per Cap	% Health Expend
Botswana	5.1	-	-	-	-	-	-
Kenya	5.4	-	2.7	1.6	4.3	3.5	22.3
Lesotho	12.0	32.0	3.6*	4.8*	8.4	NA*	NA*(57)
Malawi	7.4	11.0	2.9	2.1	5.0	2.5	23.3
Zimbabwe	7.6	42.0	3.2	3.0	6.2	4.2	10.0
Zambia	NA	14.0	2.2	1.0	3.2	0.7	4.9

Egypt	2.8	18.0	2.6	1.0	1.6	2.2		11.6

Source: World Development Report, 1993 (except those with an *).

*Donors' figures and relevant costs information from GOL/MOH are not available. Figures are mission estimates.

4.3.10 GOL has had a cost recovery programme for some years based on charging patients for services at various health centers and hospitals. In considering options for alternative means of health financing, MOH had a cost recovery study done which was reviewed by ADF in 1988 (NCPR memo of 10/12/88). The report reviewed user charges, fee structure, revenue sources, prescription charges, health insurance, social security, medical aid, health tax etc...(RHSP II Appraisal Report, para 3.4.3). However, MOH had previously established a fee structure which was recently revised on the basis of the study, with increase of fees at the district hospitals from 10% to 30% (RHSP II PCR para 5.0.2). In the process, MOH has endeavoured to improve services quality in its health centers to reduce the flow of PHC patients to hospitals outpatients departments. To assist in this strategy, health centers now charge 50% less than hospitals; the charges are doubled at the hospital unless the patient is referred by the health center. User charges are at a flat rate and cover drugs, X-ray and laboratory services and treatment. A simplified flat rate fee is also applied to in-patients in the hospitals. PHAL facilities charge higher rates.

4.3.11 Problems arising in the scheme include weak accounting practices, leakage and poor management. The imposition of a flat rate fee is calculated to reduce leakage. It was noted that daily handling of fees collected is highly problematic in health centers in terms of security, forwarding and good ledger keeping.

4.3.12 GOL had targeted 15% of recurrent expenditure to be realized from user charges; however only 10% (1992) had been achieved. It is estimated that revenue will improve in the financial year 1993 to a level of 21% of the recurrent budget. This is based on GOL's resolve to institute better accounting practices and improve staff quality, strengthen the internal auditing system, raise the level of supervision at the HSA administration and constantly evaluate the system. As a comparison, PHAL institutions have a much higher rate of cost recovery, because of higher fees and more efficient collection; between 20% and 55% recovery was reported for 1989.

4.3.13 It became obvious to GOL that user charges alone, even with substantial increases, will not impact sufficiently on recurrent expenditure especially as it becomes apparent that it must eventually finance current donor supported projects. GOL is also experiencing rising costs from improvements from the Capital Development programmes. Accordingly, following on the results and recommendations of the cost recovery study, it has amplified cost recovery to include:

- health insurance: the scheme will be compulsory for government

employees and parastatals. By this means every person in the formal salaried sector will be a contributor and will be covered;

- voluntary scheme: applicable to private employers and mine labourers.

- community financing: whereby communities and their local bodies, including traditional practitioners are organized to participate in the financing of health programmes in their own areas.

4.3.14 There has been no assessment, as yet, regarding the revenues that would ultimately accrue from these schemes. However GOL's intention is to combine all three schemes along with user charges to have the desired impact on recurrent costs financing. The government perceives achievement of the policy goal of equity in health for all also provides a rationale for the above schemes. It noted that: relatively well-to-do patients can pay substantial health fees; private practice is on the increase especially in the urban areas; there is a continuing exodus to South Africa for medical consultations; and a significant proportion of the Lesotho population finds it difficult to afford GOL/MOH/PHAL fees..

4.3.15 Impact on Health Status: The impact on Lesotho's health status has given rise to a phenomenon in which certain diseases show a rise in incidence concurrently with others showing a decrease. Associated with this is a gradual decline in numbers per 1000 of the effective population attending the health centers irrespective of ecological zones. The reasons may be a) poverty,due to the decline of the economy - people cannot afford health care, b) the concurrent increase in user charges, (para 4.3.9 above), although these have recently been revised downwards; and c) situation most probably compounded by bad reporting from the centers - unreliability of the statistical information network.

4.3.16 Two diseases have shown a steady increase: tuberculosis and AIDS which threaten whatever gains are being made in health status. Tuberculosis had been one of the most prevalent diseases in Lesotho but this has taken even a dramatic rise (around 70%) over the last six years. This has been attributed to the impact of HIV which causes the disease AIDS. Hospital beds for tuberculosis patients are overcrowded with a demand for bed spaces. The Irish government is the principal donor agency assisting the MOH in this area.

4.3.17 In 1988 the first two cases of AIDS were reported in Lesotho. This number was doubled in each of the three following years; by 1994, however, the number had quadrupled indicating how quickly the infection is spreading. Sexually transmitted diseases (STD) has one of the highest prevalence rates in the country and is a vehicle for the HIV infection; the frequency is greatest among the 20 to 34 age cohort, with a higher proportion of young female adults, presumably because they attend ante-natal and STD clinics more frequently than men. Epidemiologic estimates for AIDS show a rate of 2% of the sexually active population, while Maseru has a rate of 5.5%. It is estimated that 60,000 persons will be infected with HIV by 1996. There is increasing donor support to the national programme for the prevention and control of AIDS.

4.3.18 In terms of MCH-FP services, there is a decline in health education sessions at the health centers on child diseases and nutrition while the attendance on FP (child spacing) is encouraging.

GOL's recent Population Policy (June 1994) has set, among its demographic and health targets, a reduction of the growth rate of 2.6% to 2.3% by the year 1996. Attendances in ante-natal clinics have declined sharply having peaked in 1988 and 1989; on the other hand, attendances in post-natal clinics is increasing and the EPI programme is performing well in some centers. The most significant improvement is acceptance of family planning in response to the IEC part of the programme; this is demonstrated by a strong increase in the use of FP devices (pill mostly and injections) over the years 1987-1992. Condom use is on the increase presumably due to AIDS awareness rather than male addiction to FP.

4.3.19 Nutritional deficiencies have become more prevalent over the decade. The rate for acute malnutrition in 1981 was 4.5% and by 1992 this figure had dropped to 2.4%.[13] However, chronic malnutrition rates increased from 19% in 1981 to 33% in 1992. The main cause for the decline in the nutritional status of children is the rise of poverty, and to some extent aggravated by drought.

4.3.20 Replicability. The HSDP is replicable by virtue of its success in improving the quality of health care facilities, thereby creating a suitable environment to enhance the delivery of services. It has also strengthened PHC delivery by consolidation of its network including ensuring referral and secondary support for that system of care - the primary focus of Lesotho's health policy. Operationally, the programme has been successful. The review of project design and institutional strengthening requirements should prove useful in future projects.

5. SECTOR GOAL ACHIEVEMENT

5.1 ADF Support

5.1.1 The envisaged sector goal of all the projects was to improve the health status of the target populations. There is explicit acceptance of the sector goal in the respective PCRs and comments in paras 3.2.1, 3.1.12-3.1.13 above are equally applicable here. The retrospective logical framework, MPDE (Annex 2) confirms the sector goal. The ADF support to the GOL programme showed purposive direction by providing investments to support the strengthening of health care delivery and so achieve the goal of improved health status.

5.1.2 Economic difficulties, continuous staff attrition and institutional weaknesses have resulted in an uneven balance in morbidity as indicated in para 4.3.14. Even so, infant mortality rate has significantly declined, life expectancy at birth has improved, as also are the crude death rate (CDR) and total fertility rate (TFR). (Annex 6). These indices prove that there is progress towards achieving the sector goal notwithstanding the various constraints. The ADF support to the programme which was directed specifically to the district and rural areas, provided a highly significant boost to health coverage for the underserved and the high risk population.

5.1.3 Despite problems involving staff shortfalls, weakness in management and planning capability, disbursement lag, initial delays and functional capacity in a few instances, the PPAR concludes that ADF has had a well done job. The overall performance is deemed satisfactory.

5.2 Other Donors Support

5.2.1 Donor funding has been essential to MOH in terms of facilitating the implementation of certain GOL/MOH policies through various programmes. PHAL relies completely on donor funding and the impending dilution of donor support presents rather a gloomy picture for that institution. Many of the most successful programmes in the MOH are donor backed and donor input has been instrumental in improving the skill and expertise of most of the staff.

5.2.2 Among the many multi-bilateral donors in the health sector is the WHO which is the technical advisor to the MOH and supports MCH-FP, PHC, health planning and management, human resources development (fellowships),community participation,water supply and sanitation and HIV/AIDS prevention and control. Other programme support is given by UNICEF: EPI, nutrition, safe motherhood and community mobilization; UNFPA: MCH-FP, IEC and population studies and data collection; World Bank in conjunction with ODA (UK), the Irish Government and the EU (EEC): FP, STD control, Second Population and Nutrition Project; EU (EEC): QE II and rural health centers upgrading, nurses training, and blood transfusion services vis-a-vis HIV/AIDS; ODA: AIDS control and rural sanitation; Irish Government: tuberculosis control, the NHTC, rural sanitation and medlab; DANIDA: assistance to PHAL, rural health.

5.2.3 Some of these projects are complementary to ADF's HSDP in not only strengthening MCH-FP at the PHC level, but in assisting to improve services at the district hospital second care level to ensure good referral support to the PHC level. Because so much donor aid is directed to so many programmes, most being complementary, GOL/MOH should strengthen its Coordination Secretariat for effective mobilization of donor resources. This should prevent duplications and overlaps, provide optimum use of resources and conserve donor inputs. MOH should consider adopting this course of action especially now that donor activity is declining. In 1992, WHO had proposed such a course and requested quarterly meetings between MOH and the donor community, but without adequate response from the MOH.

5.2.4 Non-Governmental Organizations (NGOs). Of the NGOs working in the health sector, PHAL is the largest and the most important. Nearly all the MOH programmes apply equally to PHAL hospitals and those of the government, and relations are good between PHAL and MOH at the working level. Lesotho also has smaller NGOs which are involved in providing health care. These range from internationally sponsored NGOs, like the Red Cross, Lesotho Planned Parenthood Association (LPPA) and Save the Children Fund (SCF) to various church supported agencies. Most of them belong to the Lesotho National Council of NGOs (LCN) but have independent managements. Along with the PHAL hospitals they have often pioneered new techniques and ideas and formed a viable partnership with MOH in the provision of care (Annex 4).

6. IMPACTS

6.1 Poverty, Productivity, Women, Environment

6.1.1 Due to the downturn in the Lesotho economy and the introduction of the SAP and ESAP, the percentage of indigent population is rising. Poverty is a major constraint - it potentiates disease and makes health care unaffordable.

6.1.2 Much investment which has been made towards the provision of sustainable health care is at risk of failing to achieve its objectives. The rise in unemployment, the steady decline in the productive sector and the absence of remittances from South Africa coupled with a dramatic reduction in donor activity will,inevitably, increase the likelihood of a heavy disease burden together with social deterioration in the rural population, affecting particularly the vulnerable groups (women and children). Under these circumstances, patient compliance is doubtful.

6.1.3 GOL health policy lays much emphasis on equity but the constraining factors, which are economic and psycho-social, impact adversely on an equitable access to health care which is proving unaffordable. The people may have a high salience to health but the planned benefits in terms of equity may come at too high a price under the present circumstances. Intensive resource mobilization and other measures already discussed, as well as an improved economy and job opportunities may redress the situation.

6.1.4 Between 1986 and 1992, the GDP declined by over 48%, indexing a vicious cycle in which the economy takes a downturn resulting in increase in poverty which in turn impacts adversely on the human resource, this in turn depresses productivity which in turn exacerbates the economic decline.

6.1.5 An encouraging feature in this scenario is gradual improvements in gender awareness. The UNICEF and UNFPA among other donors work actively in development programmes for women. Women carried the burden of looking after the household during the absence of their husbands at work in South African mines. Income generation programmes and the development of cooperatives are among programmes to improve the woman's self sufficiency.

6.1.6 Progress is being made in reviewing discriminatory laws pertaining to inheritance, legal rights and child care. The main constraints to women's participation in the labour force or in public life have been inhibitory conditions that do not allow them to rise to senior positions in larger organizations. Women are caught between customary law and common law; in neither system are women treated as equal to men. Under both systems a woman is a minor for most of her life. Although literacy levels are high in Lesotho, adult education specially directed to women is receiving much support. GOL policy regarding equity is being translated actively by women groups into strategies to enhance the status of women. An important contributory factor is the increasing acceptance of family planning by women of reproductive age.

6.1.7 It will be difficult to use the performance of the Health Assistant (HA) as a yardstick to assess environmental impact in the community system. There is considerable activity in community mobilization both by MOH and donors. Some programmes improve access to safe water, some deal with environmental hygiene and the disposal of solid wastes and excreta (the construction of pit latrines).

6.1.8 It is stated that though HAs are not often seen in centers, they deliver health education and help the community to adopt health practices that will enhance the environment. Available health data are not very encouraging (Annex 6) although they show marked improvement between 1983 and 1991 in terms of access to safe water; no figures are available for 1983 for comparison regarding access to adequate sanitation. The figures are generally poor when compared with those for Zimbabwe.

7. PERFORMANCE OF PARTIES

7.1 Borrower and Executing Agency

7.1.1 The Borrower is GOL and MOH is the Executing Agency for all projects in the HSDP. Lapses occurred in fulfillment of loan conditions primarily due to misinterpretation of Loan Conditions (PCR RHSP II para 7.2.1). These were eventually resolved. Implementation of the training programme and meeting Loan Conditions relating thereto proved difficult for MOH. (PCR RHSP II para 7.2.2).

7.1.2 Implementation of the training programme throughout the life of the HSDP was unsatisfactory; however, supervision of construction was good. There were problems with procurement and disbursement partly due to MOH's difficulty in following ADF procedures; these were eventually resolved satisfactorily. This is a recurring problem and some attention should be given towards orientation of Borrowers to Bank Group procedures at the start or during the life of a project. Overall management of HSDP was good. Borrower's and PIU's and performances are deemed satisfactory.

7.2 Bank Group: ADF

7.2.1 Technical supervision was infrequent but ADF maintained good communication and monitoring of progress. Technical supervision could have been more frequent as this would have enabled ADF to monitor more closely progress and to satisfy itself that project accounts were being kept properly. There was dissatisfaction from MOH regarding ADF's handling of disbursement; this persisted throughout the programme and would require review by the Bank Group. On the whole, management of the HSDP was good. ADF's performance is deemed satisfactory.

7.3 Consultants, Contractors, Suppliers

7.3.1 Consultants performed satisfactorily in relation to their terms of reference. A development plan was drawn up which led to the creation of RHSP II to IV - although the plan was largely architectural in nature (para 1.5.6 above). The cost recovery study was also satisfactory.

7.3.2 The clinics (RHSP I) were well constructed by the construction team from the MORD. The civil works carried out at the hospitals (RHSP II/III) are sound and satisfactory. The performance of contractors was satisfactory.

7.3.3 The performance of suppliers was generally satisfactory. A few items of equipment were supplied with parts missing.

8. SUSTAINABILITY AND DEVELOPMENT

8.1 Essential Factors

8.1.1 Lesotho had already introduced a cost recovery programme before the economy deteriorated. The introduction of the SAP and subsequent ESAP caused GOL to review various options to enhance cost recovery significantly. Donor financing, which carried a sizeable part of investments for health, was declining and could not be relied upon for assistance indefinitely. Under these circumstances GOL intends to establish three schemes to reinforce user charges: health insurance, voluntary insurance and community financing. PHAL and other NGOs are already part of the MOH delivery network and their contribution is already tailored within the system.

8.2.2 The main purpose for the introduction of health financing schemes (paras 4.3.12-4.3.13) is to ensure that health programmes that are provided will be sustainable. Elements which impact on sustainability are capital and recurrent costs on which the burden of acceptable quality of services rests. Sustainability will enable gains in health to be maintained at an acceptable level and, where possible, to improve on them.

8.2.3 Because of the critical economic situation and GOL's proposed remedies for sustaining health care in an efficient manner, The ADB Group should consider providing technical assistance, perhaps with some other donor support, to enable GOL to develop the schemes.

9. CONCLUSIONS, LESSONS AND RECOMMENDATIONS

9.1 Conclusions

9.1.1 The projects, namely, Health Services Development Project (HSDPI), Rural Health Services Project (RHSP) I-IV and a Study, were not conceived and designed within the context of an overall sector plan. Nevertheless they were proposed, approved and implemented in a sequenced order of priority. There was a progressive strengthening of the delivery system and it was indicative of a developmental process within the health sector. Thus between years 1976 and 1992 saw the unfolding of the Health Services Development Programme (HSDP).

9.1.2 OPEV's retrospective logical framework matrix has been used to guide the analysis throughout this review. Envisaged activities included construction works, the procurement of equipment, furniture and the services of civil works consultants and contractors and the training of medical staff. With regard to project outputs: The projects were largely implemented as planned and the facilities provided are of good quality. There are a few functional constraints from inadequate provision of water which are remediable.

9.1.3 Regarding the planned objective: being the provision of more and improved services on a sustainable basis. Buildings and equipment were provided and reasonably operational; all amenities are in place. Improved services have been provided but are constrained by transport and water supply problems.

9.1.4 The envisaged sector goal of all the projects was to improve the health status of the target populations. Although baseline indicators were not provided at appraisal, use of the

retrospective logical framework matrix (MPDE) and evidence elicited from the PCRs, enabled the PPAR mission to conclude that the HSDP contributed significantly towards achieving the sector goal. Health status has improved, but the increased prevalence of tuberculosis and the upsurge of the AIDS disease are causes for concern.

9.1.5 Already, three projects, HSDPI, RHSPI and II and the Study have been completed. RHSP III is 94% completed. The achievement of the project objective is satisfactory; that of sector goal is deemed satisfactory; and institutional performance is satisfactory. Thus overall programme performance of the HSDP is deemed satisfactory.

9.1.6 Organization and management (decentralization, referral ...), health management information system and human resources development have now to be improved to enable the MOH to plan and manage its health system efficiently.

9.1.7 The present economic climate highlights the need for rationalization of the health care delivery system in terms of greater efficiencies and resource mobilization. Also, in response to the urgent financial needs precipitated by the economic crisis, cost recovery has become a priority consideration of the MOH. The GOL/MOH is currently exploring avenues for effectively reducing the recurrent cost burden to ensure the sustainability of its programs.

9.2 Lessons

9.2.1 Key lessons learned are:

1. Improving health facilities, does not necessarily convey a sense of ownership unless the community fully comprehends the nature and extent of the benefits (para 1.1.9 above).

2. Unless budgetary and management control is decentralized, the process of decentralization is incomplete (para 1.2.10 above).

3. NGOs, especially those like PHAL, which are intimately involved with implementation of government health policies, should be also involved (by donors and government) in a coordinated project (para 1.2.11).

4. Project design is the linch-pin on which the formulation of project components through proposal, preparation and appraisal, and to some extent supervision, depend. An overall design should also potentiate the direction of subsequent studies which generally set the parameters for preparation and appraisal of a project (para 1.4.10 above).

5. Analysis of the country's socio-economic background provides relevant and useful information for appraisal in terms of assessing Borrower's affordability; it also indicates the extent of the trade-offs between cost-effective and sustainable health development (para 1.5.4).

6. Preparation of a project regarding facilities upgrading etc would benefit a good deal from active involvement of the potential users (para 1.5.7 above).

7. An efficient and well organized PIU is indispensable to satisfactory project implementation (para 2.3.1 above; HSDPI PCR, para 4.2.1).

8. Priority programmes, such as immunization of children and ante-natal mothers rely to a great extent on donor support for sustainability where the economy of the country is weak and budgetary constraints are profound. The successful experience of the ADF support (of a cost-effective package with incalculable cost-benefits) should be considered in the design of future health projects (para 3.1.10 above; HSDPI PCR, para 4.2.3).

9. The annual population increase (2.6%) between 1986-1992 was more than matched by an increase in bed space in the rehabilitated hospitals (70%) with a consequent lowering of the population to bed ratio. Improved hospital bed capacity is a requirement to meet population increments (para 3.1.15 above).

10. A well established Health Management Information System is a necessary component in MOH for effective financial planning and management, and health planning (paras 4.1.6, 4.2.7, 4.2.9 above).

11. Government's tardy fulfillment of Loan Conditions was a key factor for delays in project execution (RHSP I PCR para 7.1.3; RHSP II PCR para 8.2.3).

12. Adequate attention should be given to geographical and ecological factors at the planning stage (RHSP I PCR para 7.1.3).

13. Provision for the maintenance of facilities should be assessed and monitored throughout the project cycle, from preparation to completion (RHSP I PCR para 7.1.3; RHSP II PCR para 8.2.4).

14. Efforts to establish baseline data, from the time of preparation, should be made to enable impact measurements to be made (RHSP I PCR para 7.1.3).

15. ADF should have ensured the availability of additional manpower prior to commissioning the rehabilitated facilities. This provision should have been included in the Loan Conditions to ensure key staff support to maintain quality of care (RHSP II PCR para 8.2.3).

9.3 Recommendations

9.3.1 Recommendations for the consideration of the GOL are as follows:

1. Sustainability should be ensured by the Borrower by adequate provision in the budget for recurrent costs for high priority public health programmes, such as, immunization of children (HSDPI PCR para 3.2.1 (v)).

2. GOL/MOH should strengthen its Coordination Secretariat for effective mobilization of donor resources (para 5.2.3 above; HSDPI para 3.2.1 (vi)).

3. On-going work regarding cost-recovery should be continued because it is important that the GOL introduce alternative means for health care financing that would relieve the government of its recurrent cost burden while ensuring adequate budgetary support to sustain health services (4.3.12, 4.3.13 above). The fees structure should be arranged so as to be in accord with plans for the streamlining of the patient referral system.

4. Donor assistance should be sought such that an effective Health Management Information System can be put into place - as a planning and management aid.

9.3.2 Recommendations for the consideration of the ADB Group are as follows:

5. Project design by the ADB Group in the health sector should include institutional strengthening inputs (in terms of health information system, financial planning and management, human resources development and maintenance) to complement infrastructure, as well as, support for key programmes to at-risk populations (para 1.4.7 above).

6. ADB Group should actively consider replicating the use of solar power in future projects (para 3.1.3 above).

7. Project launching missions are desirable to minimize delays in execution due to lack of orientation of the Borrower to Bank Group procedures (RHSP I PCR para 7.2.1).

8. A logical framework matrix (MPDE) is a necessity at the project design stage (RHSP I PCR para 7.2.1).

9. Staffing of a PIU should reflect the different activities to be implemented under the project (RHSP II PCR para 8.3.1).

10. Measures should be taken throughout the execution of projects to ensure that "Other Conditions", attached to the Loan Agreement, are fulfilled. The Projects Department should report lapses to the Country Programmes Department for follow-up, following supervision missions (RHSP II para 8.3.1).

11. Incremental staff and maintenance considerations should be carefully examined for any project that involves upgrading and rehabilitation of facilities (RHSP II para 8.3.1).

Lesotho: Interim PPAR

Footnotes Supercript in the Text

1. Considerable donor activity was being generated in the health sector with investments in donor-driven projects. (reference para 1.1.4)

2. Report on Workshop on National Health and Social Welfare Policies for the Decade (1993-2003). Maseru, Lesotho July 28-30, 1993. Ministry of Health. (para 1.2.2)

3. The Situation of Women and Children in Lesotho. Ministry of Planning, Economic and Manpower Development (para 1.2.4).

4. Health Management Information System (HMIS) consists of a network comprising: a Health Information System (HIS); a Financial Planning and Management System (FPMS); and a Health Planning System (Health Services Planning and Human Resources Development). (para 1.4.7).

5. Rural Health Services Project. Terms of Reference for the Preparation of Scheme Design, Working Drawings and Tender Documents for Eight District Hospitals. Rural Health Services Project. Appraisal Report, ADF/BD/WP/33/108, Annex XVI, (para 1.5.6).

6. The PPAR mission visited Berea District Hospital (RHSP IV) which was in the mid-stages of completion. (para 2.2.2).

7. Children aged 0-4 years and 5-14 years; and women of reproductive age 15-45 years constitute over 60% of total population and comprise the most vulnerable group and therefore the greatest potential beneficiaries. Services are thus directed to mother and child (survival) or MCH as a priority. (para 3.1.9).

8. Lesotho Government Bureau of Statistics: 1976 and 1986 censuses. Population Census Report 1987, 1991, 1992. (para 3.1.9).

9. Diphtheria, whooping cough, tetanus, polio, measles and tuberculosis. (para 3.1.10).

10. The Situation of Women and Children in Lesotho. Ministry of Planning, Economic and Manpower Development. Government of Lesotho and UNICEF, July, 1994. (para 3.3.11).

11. See footnote (4) para 1.4.7. (para 4.2.6).

12. MOH: Health in Lesotho. 1993 Profile. (para 4.3).

13. MOA and MOH, 1992. (para 4.3.19).

KINGDOM OF LESOTHO
INTERIM PROJECT PERFORMANCE AUDIT REPORT
HEALTH SERVICES DEVELOPMENT PROGRAMME

LESOTHO: HEALTH POLICIES IN DEVELOPMENT PLANS

1. First 5-Year Development Plan: 1970-1974

1. To increase the number of doctors and nurses
2. To expand the number of hospital beds
3. To expand preventive services

II. Second 5-Year Development Plan: 1975-1979

1. To reduce imbalance in the distribution of health facilities
2. To proceed with capacity building to staff new rural health facilities

3. To correct imbalance between preventive and curative services through

   a) strengthening of district health teams;
   b) integration of preventive and curative services in upgraded centers;
   c) curriculum development in nursing training school to reflect policy;
   d) expansion of MCH-FP services;

III. Third 5-Year Development Plan: 1980-1985

1. To carry health services to every village through primary health care;
2. To improve and expand the national network of clinics and out patient departments;
3. To promote family planning and programmes to improve the health of mothers and children;
4. to minimize the incidence of the most prevalent communicable diseases;
5. To immunize all children against communicable diseases;
6. To upgrade curative services.

IV. Fourth 5-Year Development Plan: 1986-1990

1. To improve services at primary health care (PHC) level;
2. To upgrade district hospitals to provide essential referral services to the primary health care network as well as technical support to public health services within a Health Services Area (HSA);

3. To lower infant mortality rate to less than 80/1000;
4. To reduce child mortality by 50%;
5. To reduce case fatality:

   a) from diarrhoeal diseases in children less than 5 years old from 12% to 3%;
   b) in out-patient cases (mostly trauma) from 37% to 27%.

6. To train and mobilize 5000 village health workers;
7. To increase the number of clinics (i.e., health centers to be staffed by nurse clinicians).

KINGDOM OF LESOTHO
INTERIM PROJECT PERFORMANCE AUDIT REPORT
HEALTH SERVICES DEVELOPMENT PROJECT
NON-GOVERNMENTAL ORGANIZATIONS - NGO's

The NGOs

1. Lesotho has an extremely large range of NGOs and the Ministry of Health liaises with a significant number of them in health related matters.

2. There are two main streams of NGO activity:

a) the Private Health Association of Lesotho - PHAL. It is the largest of the NGOs involved in health provision in Lesotho.

b) the Lesotho National Council of NGOs - LCN. It comprises over 200 voluntary agencies of various sizes: among these are the Red Cross organization and the Lesotho Planned Parenthood Association - LPPA.

PHAL

3. In 1973 the Ministry of Health promoted the formal establishment of PHAL following initial efforts by the Christian Council of Lesotho, Oxfam and others. PHAL is a voluntary association of Christian churches providing not-for-profit health care services. It consists of seven member churches from different denominations which provide nine general (district) hospitals, each serving a large geographical area (Ministry of Health's designated Health Services Area), and over 70 health centers, clinics and outputs, mainly in the rural area, throughout Lesotho.

4. The principal objective of PHAL is to develop the highest level and widest distribution of health services in Lesotho through the mutual cooperation of all members, and coordination with the Government of Lesotho and especially its Ministry of Health (MOH) - Article 3 of the PHAL Constitution which was registered under the Societies Act in 1976.

5. From the objectives the following goals are delineated:

a) to improve the quality and distribution of health services while promoting the spiritual aspect of healing in all health care activities;

b) to promote primary health care (PHC) programmes throughout Lesotho toward the national goal of health for all by the year 2000;

c) to strengthen the cooperation and collaboration between PHAL and the Government;

d) to strengthen relations among member institutions and between them and the PHAL office and

e) to develop and implement an appropriate human resources development programme to complement that of the Government.

6. The Christian Medical Commission of the World Council of Churches funded the first full-time Executive Secretary in 1976. The Catholic Relief Services (CRS) initially provided

office space and secretarial services. PHAL has a formal role in the Government's programme for the delivery of health services and works with MOH to implement the health policy.

Achievements

7. Among its achievements, over the years, are:

- organization of a successful national seminar on PHC in 1978. This led to a national PHC plan of action;

- creation of the Lesotho Dispensary Asociation which took over the PHAL Drug Purchasing Programme. This has now become the Lesotho Pharmaceutical Corporation, a drug manufacturer, with PHAL having a Board seat;

- participated in the launching of the extended programme on immunization;

- jointly with the Government, supported by USAID, launched Lesotho's Rural Health Development Project to implement the Health Services Area (HSA) concept and train a new cadre of nurse- clinician to staff health centers;

- participated in the implementation of the Rural Clinic Improvement/Maintenance programme, with DANIDA support, to maintain MOH and PHAL health centers;

- assisted in the development of the National Village Health Workers Training programme.

Areas of Concern

8. The role of PHAL institutions in the delivery of health services and their relationships with GOL are under review, as a result of the deepening financial crisis affecting the whole of the health sector.

9. GOL subventions have been drastically curtailed and PHAL's funding sources are being restricted. PHAL would like to see an increase in GOL's subventions to cover the full cost of salaries and a retention allowance.

10. The sustainability of PHAL - administered programmes is in question. Although PHAL facilities offer the same range of health services, mostly better managed, there are salary differentials (PHAL with much less) between them and MOH staff. In addition, PHAL suffers from acute manpower shortage and heavy attrition of personnel because of having to recruit staff to work for excessive periods in very remote and desolate environments and under extremely trying conditions.

11. Factors impacting on PHAL's sustainability include: financial uncertainly regarding the withdrawal of bilateral and voluntary donor support; services quality affected by staff constraints, deteriotating facilities (only 8 PHAL health centers and 3 Red Cross clinics, out of a total of 33 that were rehabilitated under the ADF/MOH project and no PHAL district hospitals were included in the GOL list for ADF rehabilitation). PHAL was allocated the administration of 9 (out of 18) HSAs. In considering the fact that PHAL serves over 40% of health coverage in Lesotho, the GOL/MOH's rationalization is baffling. The present situation is causing patients to drift from PHAL facilities to MOH ones which would necessarily become overcrowded; and the downside would be PHAL catchment areas would become underserved.

The Red Cross

12. The participation of the Red Cross in health services delivery is modest in comparison with that of PHAL. It originally has 11 clinics but because of lack of funds has had to close all but four; two of these are located in remote mountainous areas where they deliver much needed services to an underserved population.

13. The Red Cross clinics or health centers offer PHC services great emphasis on health education to promote immunization, nutrition, AIDS awareness and mother and child care and family planning (MCH-FP). Its other activities are health-related and include youth programmes, protection of health and life programme, community service programme and identifying vulnerable groups in the drought relief programme.

14. The Red Cross received pilot funding from the United States Agency for International Development (USAID) and funding from the Netherlands Red Cross Association to set up

an education component for blood transfusion services. The British Red Cross also provided initial funding for a rural sanitation project in a typhoid area.

Areas of Concern

15. MOH's subvention to the Red Cross has not been readily forthcoming and the organization is in dire financial straits. If the situation continues, it will be forced to close the remaining health centers - a contingency MOH refuses to admit because of the potential loss of

coverage in highly deserving areas.

16. Funding from the Icelandic Red Cross has bridged the gap temporarily but with the exodus of major donors, e.g., Swedish Red Cross, the expectations are gloomy with regard to sustaining services through salaries, drugs etc.

Lesotho Planned Parenthood Association (LPPA)

17. LPPA is a member of the International Planned Parenthood Federation (IPPF). It is divided into 4 branches, with 8 family planning (FP) clinics and 12 outreach stations. The staff of these facilities - coordinators, clinics staff and field educators - distribute FP aids and provide information, education and communication (IEC) to motivate acceptors to FP methods and the practice of contraception. LPPA provides 45% of FP services in Lesotho. The services are based on three programmes: a) IEC, b) services, c) employment based services d) youth counselling and e) in development activities, women-in-development programmes. LPPA field educators visit groups of men in factories and industrial areas to motivate them to FP; also has a family health programme geared to students, youth in general, with provision of counselling services.

18. The LPPA received 90% of its funds from IPPF and around 10% from government. It participates in UNFPA and World Bank sponsored projects, and complements MOH's MCH-FP services and implements its family life education.

Areas of Concern

19. Areas of concern include inadequate facilites to provide services; and additional donor support for mobile teams in community work is a critical need. Already LPPA is in danger of being overstretched in the delivery of its programme in FP and is concerned that the quality of services may become diluted. Because of these constraints, impact on target groups is becoming less focussed.

Save the Children Fund (SCF)

20. SCF is British based organization supporting various activities like the expanded programme on immunization, fellowship training of physiotherapists, work with the disabled

through community based and special education; it also funds the training of motor cycle riders for community outreach work in a "rider for health" programme. SCF has been also playing a vital role in drought relief operations, particularly in the transportation of food to distribution centers.

The Christian Council of Lesotho (CCL)

21. CCL has an AIDS Education Unit that is actively engaged in IEC activities and counselling. It also provides education programmes, mass media and counselling for drugs and alcohol abuse through a unit established for that purpose. It receives funds from DANIDA and Danchurch Aid.

Other NGOs

22. There are various other NGOs with some links with the health sector. The Catholic Secretariat and Care International, for example, have begun work on AIDS prevention programmes.

ESTIMATED NUMBER OF BENEFICIARIES COVERED BY RHSP I: 1984-1992

ADF supported Health Centers (RHSP I) are distributed in all 10 Districts

	1983	1992
Base Population		
Estimated Total Population	1.5 million	1.7 million
Total Women Population	817,000	985,000
Total Children Population	618,000	736,000
Beneficiaries[1]		
WCBY (15-45 years)	376,000	453,000
Children (0-14 years)	618,000	736,000
ADF/H.C. Coverage (22%)[2]		
WCBY (15-45 years)	82,720	99,600
Children (0-14 years)	135,960	161,920
Total Beneficiaries Covered by ADF Supported H.Cs:	218,680	261,520

Data Source: GOL. Bureau of Statistics, 1987a, 1991a, 1991b, 1992.
Population Census, 1986

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1 Beneficiaries are, women of child bearing years (WCBY) aged 15-45 years and children (0-14 years). These form 60%-66% of total population in developing countries. WCBY maintained a constant ratio of 46% of all women between 1983-1992; the ratio of children to the total population varied slightly from 41% in 1993 to 41.4% in 1992.

2. These are potential beneficiaries served (1992) or could have been served (1983) by ADF supported centers. The completed facilities are 22% of the total number of health centers in the 10 districts.

KINGDOM OF LESOTHO

INTERIM PROGRAMME PERFORMANCE AUDIT
HEALTH SERVICES DEVELOPMENT PROGRAMME
DEMOGRAPHIC, MORTALITY AND MORBIDITY DATA

1. Mortality Rates (per 1000)

INDICATORS	1974	1980	1986	1992	
Infant Mortality Rate	-	-	102	75	
Under 5 Mortality Rate		-	-	140	148
Maternal Mortality (per 100,000)	-	-	-	282	
Crude Death Rate		14	-	12	11

* 282 in hospitals. National figure is unknown.

2. Demographic Data

		1974	1980	1986	1992
Population (million)		1.2	1.4	1.6	1.8
Crude Birth Rate		37	-	38	37
Total Fertility Rate		-	-	5.2	4.7
Life Expectancy at Birth (Years)	51	-	54	60	
Population Growth Rate (%)	2.3	-	2.6	2.6	

Source: UNICEF "The State of the World's Children" 1988 and 1994. (updated in Lesotho).

3. Health Personnel

		1974	1980	1986	1992
Population (million)		1.2	1.4	1.6	1.8
Number of Doctors		50	80	125	137
Number of Nursing Persons		342	412	632	688
Population: Doctor Ratio		-	-	12 800	13 905
Population: Nursing Persons Ratio	-	-	2 532	2 761	

Annex 6

4.	Percentage of Population with Access to Safe Water	1983-1986	1988-1991	1994
	Rural	11	45	-
	Urban	37	59	-
	Total	14	47	62

5.	Percentage of Population with Access to Adequate Sanitation	1983-1986	1988-1991	1994
	Rural	N/A	23	-
	Urban	N/A	14	-
	Total	N/A	22	46

6.	Percentage of Population With Access to Health Services	1985-1992
	Rural	N/A
	Urban	N/A
	Total	80

7. Child Immunisation Coverage for All Lesotho

		1974	1980	1986	1992
		%	%	%	%
-	DPT (3 doses) 31	-	69	85	
-	Measles	0	-	63	68
-	Polio (3 doses) 4	-	64	90	
-	Smallpox	31	-	-	-
-	BCG	40	-	98	-

8. Major Causes of Mortality Based on Inpatient Discharges, 1986

Signs and Symptoms
Dis. of Pulmonary Circul
Intestinal Infections
Respiratory Sys.
Cerebrovascular Disease
Other Injuries
Other Parts of Digestive
Nervous
Open Wounds and Injuries
Endocrine Diseases

9. Major Causes of Outpatient Morbidity, 1986

Respiratory System
Skin and Subcut Tissues
Digestive System
Symptoms and Ill Defined
Genito-Urinary System
Nervous System and Senses
Gonorrhea
Injur Frac. and Disloc.
Mus. Skel. System and Senses
Diarrhoea

Note 8/9: In rank order-no statistics available.

MAJOR CAUSES OF MORTALITY BASED ON IMPATIENT DISCHARGES, 1989

0-4 years		5-14 years		15+ years old	
Respiratory Tract	21	Signs and symptoms	5	Tuberculosis	138
Nutrinational Deficiencies	20	Intestinal Infection	5	Signs and Symptoms	88
Signs and synptoms	11	Other Bacterial	4	Pulmonary Circul	70
Certain Conditions Arisins in the Perinatal period	10	Late effects of Injuries	2	Cerebrovascular	48
Other Bacterial	7	Other Parts of Digestive		Other Digestive	44
Intestinal Infectious	6	Musculo-Skelatal and Connective Tissue	2	Respiratory System.	43
Musculo-skelatal Sys. and Connective Tissue	5	Other injuries	2	Hypertensive	32
Burn	4			Malignant Neoplasms	30
Congenital Anomalies	3			Urinary System	17
Other Injuries	2			Urinary Wound and Injuries	15
Metabolic Immunity	2			Blood Vessels	13
All causes	103		37		762

Source:HIS/LESOTHO