Lesotho Human Resources for Health Strategic Plan Assessment (HRH-SPA™)

A Synthesis and Prioritization of the:

Kingdom of Lesotho Ministry of Health and Social Welfare Human Resources Development & Strategic Plan 2005-2025

Government of Lesotho Ministry of Health and Social Welfare Retention Strategy for the Health Workforce 2010

Lesotho Nursing and Midwifery Strategic Plan 2011-2015

Kingdom of Lesotho Ministry of Health

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Human Resources Alliance for Africa

HRAA
HUMAN RESOURCES ALLIANCE FOR AFRICA
Strengthening Human Resources Systems for Better Health and Social Services

1. Executive Summary

In September 2003, the Government of Lesotho drafted the *Health and Social Welfare Policy* as a roadmap for the development of the health sector in Lesotho. Over the past several years, a number of important strategic documents have been developed to address the human resource challenges identified in that document. The *Lesotho Health Sector Human Resources Development & Strategic Plan 2005-2025* was drafted in 2005. In September 2010, one of the highest priority issues within the Strategic Plan was addressed by way of the *Retention Strategy for the Health Workforce 2010.* Also in 2010, the *Nursing and Midwifery Strategic Plan 2011-2015* was published.

Since their development, some elements within the three strategic plans have been wholly or partially implemented. However, due to scarce data on the cost of implementing the strategic plans' reforms and activities, limited financial support from the Government of Lesotho and development partners has been designated to implement the plans. With the goal of clarifying the financial outlay of such reforms, the Human Resources Alliance for Africa program (HRAA), led by the East, Central and Southern Africa Health Community (ECSA), was requested to cost the aforementioned plans.

In preparation for the costing activity, a prioritization activity was conducted, called the Human Resources for Health Strategic Plan Assessment (HRH-SPA™). The purpose of this activity was to identify and prioritize strategic reforms and corresponding operational activities, and further delineate the activities for costing and resource mobilization.

1.1.1 Methodology

The HRH-SPA™ methodology consists of both quantitative and qualitative data collection and analysis, employed to identify prioritized HRH reforms and the quality of operational plans associated with such reforms. The process began with the collection and review of documents contextually related to HRH such as strategic plans, annual reports, and budgets. Key HRH reforms and related activities contained within these documents were compiled into categories for prioritization. The categories were then discussed with HRH-focused and -related stakeholders, including national and subnational government representatives, professional associations and regulatory councils, teaching institutions, and development and implementing partner organizations. The stakeholders were led through a prioritization process from which HRH reform categories and corresponding activities were ranked. A discussion was facilitated to obtain qualitative contextual data to further guide the priority-setting process. The stakeholder prioritization sessions were followed up by key informant interviews to fill in any information gaps that may remain. The assessment team also worked closely with the MOH and HRH stakeholders to ensure the HRH reform categories as constructed reflected specific policy reforms. And finally, the selected reforms were deconstructed into tangible activities to ensure that they can be implemented and to sync them with existing strategic plans.

1.1.2 Results

Findings from the stakeholder working groups, key informant interviews and reference documents were synthesized to determine proposed priority reforms. Several themes emerged from the facilitated discussions within stakeholder meetings and key informant interviews:

- Due to significant disparities between urban and rural populations and health facilities, rural health care workers should be prioritized.
- Retention of health workers is a high priority, but retention initiatives will be more efficient and effective in synergy with other strategies.
- Some strategies are better addressed sequentially to maximize success.
- Addressing human resources for health challenges will require systemic change by the MOH.

Priority reforms for an initial 12-24 month period were divided into two priority areas which would have both an immediate impact and establish a foundation for further reforms: 1) Establish a rural human resources for health retention package, and 2) Develop sustainable national and district human resource systems.

Fourteen activities were prioritized for implementation for rural retention, and eight activities to develop sustainable systems:

1. Establish a rural HRH retention package
    a. Institute cost of living and hardship allowances for rural health workers
    b. Provide adequate staff housing for rural health facilities
    c. Provide communication systems for health workers in rural areas
    d. Ensure the safety of health workers in rural locations
    e. Provide transport for shopping and home leave for health workers in rural facilities
    f. Care for the health and wellness of health workers in rural areas
    g. Provide temporary replacements for rural health workers on leave through a locum tenem program
    h. Provide supportive supervision and clinical mentoring for health workers serving in rural areas
    i. Institute continuing education and training systems for all health workers
    j. Determine whether a salary adjustment is merited to align salaries with the region
    k. Increase management capacity at the Central and District Ministry of Health and Social Work levels
    l. Improve deployment systems for rapid deployment of health workers
    m. Develop flexible career progression systems for all health worker cadres
    n. Improve and require participation in performance management systems
2. Develop sustainable national and district human resource systems
    a. Integrate human resource and health management information systems
    b. Develop a sustainability plan for the emergency hiring program
    c. Strengthen the Ministry of Health and Social Work's district and central management and oversight capacity
    d. Strengthen budget and financial management capacity at the national government level
    e. Strengthen communication within the Government, particularly between Ministries
    f. Strengthen communication between the Government and health care workers
    g. Increase pre-service education capacity

h. Increase profession council capacity

1.1.3 Conclusion

The priority reform strategies and activities outlined in this report are an ambitious, but achievable, set of recommendations for the MOH to implement in the coming 12-24 months. The strategies address a priority of deep concern to the country: the loss of health workers from rural communities, and also lay a firm foundation for future human resource reforms.

In order to ensure implementation of this strategy, several additional steps will be undertaken and completed by early 2013: 1) Priority activities will be costed, and final prioritization will occur to meet realistic budget standards; 2) Recommendations will be presented to Parliament for approval; 3) A resource mobilization plan will be developed; 4) An investment strategy will be developed. Upon completion of these steps, it is expected that the MOH will be able to attract resources to support implementation of reforms, oversee implementation of activities, and develop costed strategic plans for further reforms.

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Acronyms

CE	Continuing Education
CHAL	Christian Health Association of Lesotho
COLA	Cost of Living Adjustment
DHMT	District Health Management Team
ECSA	East, Central and Southern Africa Health Community
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRAA	Human Resources Alliance for Africa
HRH	Human Resources for Health
HRH-COPR™	Human Resources for Health Costing of Operational Plan Reforms™
HRH-SPA™	Human Resources for Health Strategic Plan Assessment™
HRIS	Human Resources Information Systems
MCA	Millennium Challenge Account
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOH	Ministry of Health
MOPS	Ministry of Public Service
NEPI	Nursing Education Partnership Initiative
NHA	National Health Accounts
SWOT	Strengths, Weaknesses, Opportunities and Threats
TB	Tuberculosis
USAID	United States Agency for International Development
VOIP	Voice-over-Internet Protocol

2. Introduction

In September 2003, the Government of Lesotho drafted the *Health and Social Welfare Policy* as a roadmap for the development of the health sector in Lesotho. The policy was formulated as part of an ongoing Health Sector Reform process and an integral component of the national development strategy, as outlined in the *Government's Vision 2020 Framework*. A number of human resources-related challenges were identified in the policy and included the need to rationalize the supply of health and social welfare sector labor, implement strategies that will improve staff retention, and train available personnel appropriately to perform the tasks for which they are charged.

Over the past several years, a number of important strategic documents have been developed to address the human resource challenges identified in the *Health and Social Welfare Policy.* The *Lesotho Health Sector Human Resources Development & Strategic Plan 2005-2025* (HRH 2025) was drafted in 2005. In September 2010, one of the highest priority issues within the Strategic Plan was addressed by way of the *Retention Strategy for the Health Workforce 2010.* Also in 2010, the *Nursing and Midwifery Strategic Plan 2011-2015* was published.

Since their development, some elements within the three strategic plans have been wholly or partially implemented. However, due to scarce data on the cost of implementing the strategic plans' reforms and activities, limited financial support from the Government of Lesotho and development partners has been designated to implement the plans. With the goal of clarifying the financial outlay of such reforms, the Human Resources Alliance for Africa program (HRAA), led by the East, Central and Southern Africa Health Community (ECSA), was requested to cost the aforementioned plans. The costing is to be followed by a resource mobilization strategy in order to catalyze government and development partner buy-in for implementation of the plans.

In preparation for the costing activity, HRAA implemented an Abt Associates, Inc. Tool, the Human Resources for Health Strategic Plan Assessment (HRH-SPA™), for identifying, prioritizing and operationalizing national and subnational HRH strategies and operational plans. The HRH-SPA™ was conducted in Lesotho in August, 2012, to update the prioritization of, and current progress toward, implementation of the proposed policies, and to chart out an operationalization matrix to inform the upcoming costing. Results from the HRH-SPA™ will inform the costing process, to be carried out using a second Abt Associates tool, HRH Costing of Operational Reforms (HRH-COPR™), which will quantify the resources needed to address some of Lesotho's most pressing human resources for health challenges.

3. Purpose

The purpose of the Human Resources for Health Strategic Plan Assessment for Lesotho's Ministry of Health and Social Welfare is to identify the strategic reforms of greatest priority from the:

1. *Lesotho Health Sector Human Resources Development & Strategic Plan 2005-2025,*
2. *Retention Strategy for the Health Workforce 2010,* and
3. *Nursing and Midwifery Strategic Plan 2011-2015.*

Through this process, strategic reforms and corresponding operational activities are identified, prioritized, and further delineated for costing and resource mobilization. The end result of the HRH-SPA™ and subsequent costing and resource mobilization activities are fully operationalizable HRH reforms that will support the realization of Lesotho's *Vision 2020 and HRH 2025*.

4. Methodology

The HRH-SPA™ methodology consists of both quantitative and qualitative data collection and analysis, employed to identify prioritized HRH reforms and the quality of operational plans associated with such reforms. Step 1 of the process involves the collection and review of documents contextually related to HRH such as strategic plans, annual reports, and budgets. Key HRH reforms and related activities contained within these documents are then compiled into categories for prioritization. In Steps 2-5, the categories are discussed with HRH-focused and -related stakeholders, such as national and subnational governments, professional associations and regulatory councils, HRH technical working groups, and development and implementing partner organizations. Stakeholders are led through a prioritization process from which HRH reform categories and corresponding activities are ranked and discussion is facilitated to obtain qualitative contextual data to further guide the priority-setting process. The stakeholder prioritization sessions are then followed up by key informant interviews to fill in any information gaps that may remain. In Step 6, the assessment team works closely with the MOH and HRH stakeholders to ensure the HRH reform categories as constructed reflect specific policy reforms. And finally, in Step 7, these reforms are deconstructed into tangible activities to ensure they can be implemented and to sync them with existing strategic plans. While many operational activities are defined during the HRH-SPA™ process, in some instances where the country hasn't decided on specific activities to implement a reform, the team develops options for consideration. The selection and finalization of which activities will be implemented occurs during the HRH-COPR™ process.

4.1.1 Step One: Background Review and Construction of Priority Areas

In Lesotho, the HRH-SPA™ process began with an analysis of the *Lesotho Health Sector Human Resources Development & Strategic Plan 2005-2025,* the *Retention Strategy for the Health Workforce 2010,* and the *Nursing and Midwifery Strategic Plan 2011-2015.* Strategies, recommendations and proposed activities contained therein were extracted and synthesized into HRH reform categories (see Appendix 1 for themes identified). Findings from the three strategies were categorized in line with the overarching strategies set within the Development & Strategic Plan, and a prioritization worksheet was developed for use in the stakeholder working group sessions (see Appendix 2).

4.1.2 Step Two: Convening of Stakeholders to Identify Priorities

In-country HRH-SPA™ work was initiated with three stakeholder meetings to prioritize HRH reforms with three distinct groups of target audiences. The first stakeholder meeting was held with members of the Ministry of Health and Social Welfare Directorates which included significant participation from the Human Resource department. A second stakeholder meeting was held with representatives from the Christian Health Association of Lesotho (CHAL), nurse training institutions, professional councils, and the Nursing Education Partnership Initiative (NEPI). The final meeting was held with representatives from development and implementation partners working on HRH issues in Lesotho. A total of 46 stakeholders participated in the prioritization working groups. For a full participant list, please see Appendix 3.

Stakeholder group participants were initially introduced to the objectives and process of the HRH-SPA™. A Prioritization Worksheet was handed out (Appendix 2). Participants were requested to use the worksheet to rank the HRH reform categories from highest to lowest priority according to criteria agreed upon by the group. Prioritization criteria were as follows:

- Participant's organizational perspective
- Potential for effectiveness/impact
- Implementable/realistic
- 12-24 month timeframe
- Efficient/affordable
- Innovative
- In accordance with national priorities

Participants were also asked to mark the activities they considered most important to accomplish each HRH reform category. Once the worksheets had been completed, participants were asked to share their ranking of the reform categories. The rankings were compiled; means, modes and medians were calculated, and then presented to the group as a whole.

4.1.3 Step Three: Stakeholder Meeting Discussion

Each stakeholder group participant was asked to share the reasoning behind their selection of the top three priorities. After each stakeholder shared their opinions, a discussion was facilitated around the ranked priorities with the goal of further understanding the factors leading to the rankings, related initiatives currently underway, and key considerations for the proposed activities under each ranked priority.

4.1.4 Step Four: Synthesis of Findings

Results from the stakeholder meetings were synthesized and used to determine the top priority strategies and activities representing all stakeholders involved in this exercise. Both the numbered rankings and discussion points were considered in developing the prioritization results; discussion points could raise the priority level of a strategy higher than other strategies that ranked highly on numbers alone. Preference was given to combinations of strategies and activities which:

- Would result in efficiencies and complement one another
- Are feasible
- Could be accomplished within a 12-24 month time-frame
- Would have great impact on vulnerable communities, particularly rural communities

Figure 1: Stakeholder Input to Strategic Priority Setting

4.1.5 Step Five: Field Visits to View HRH Challenges at Rural Facilities

The HRH-SPA™ team, with representatives from the MOH, visited four rural facilities, two CHAL and two MOH, and interviewed the staff at each facility regarding rural retention preferences. Names of the facilities visited are included in Appendix 3.

4.1.6 Step Six: Presentation of Findings to Stakeholders and Key Informant Interviews

Preliminary results were then shared with a smaller MOH-HR Directorate stakeholder group, and validated by the Human Resources Director. The HRH-SPA™ team held further key informant interviews with representatives from CHAL, United States Agency for International Development (USAID), Millennium Challenges Account (MCA) and others as needed to gather addition information on current initiatives and population need (please see Appendix 3 for list of interviews). Additional documents were also collected; for a complete list of reference materials please see Appendix 4.

4.1.7 Step Seven: Moving Towards Operational Planning

The final step in the HRH-SPA™ process, which set the stage for the HRH-COPR™ process, was the identification of specific activities for implementation that were previously presented and agreed upon relative to reform areas. The three strategic plans were combed for specific activities, as well as additional policies, strategies and operational plans (for a complete list of documents referenced, please see Appendix 4). However, activities were often limited and didn't have the level of specificity required for a costing activity, or simply didn't exist. Where the required level of specificity wasn't available, the HRH-SPA ™ team developed options for the MOH to consider; as part of the HRH-COPR™ process the activity recommendations will be validated with stakeholders.

5. Findings

5.1.1 Stakeholder Meeting Strategic Priority Results

The three stakeholder meetings yielded a consensus on a strategic direction for strengthening HRH in Lesotho. Of the 46 participants, 41 submitted completed prioritization worksheets in which they ranked eight HRH reforms from most to least important, with 1 being the most and 8 the least. Although there was some variation in priority rankings between groups, the top priorities as identified and agreed upon were largely uniform. Stakeholder participants ranked "Increasing the efficiency of the prevailing labor supply" as the top priority, followed by "Increasing the equity of coverage of the prevailing labor supply," and "Instituting loss abatement strategies/retention." *Table 1* below lists reform priorities as averaged within and across each of the stakeholder sessions. Although efficiency, equity, and retention reforms attained the highest average ranking among working group participants, individual stakeholder groups also emphasized other priorities. The CHAL, Training Institutions and Professional Councils group noted that increasing the efficiency of the prevailing labor supply merited consideration as a high priority. Development and Implementing Partners, on the other hand, cited the development of monitoring, evaluation, and reporting systems as their top priority.

Table 1: Results of Individual Prioritization aggregated with and across stakeholder groups (Scale: 1 Most Important, 8 Least Important)

HRH Reforms	MOH Directorate	CHAL, Training Inst., Prof. Councils	Development/ Implementing Partners	Ave. across all groups
Increasing efficiency of the prevailing labor supply	3.18	2.86	4.19	3.46
Increasing equity of coverage of the prevailing labor supply	3.27	4.29	3.50	3.71
Institute loss abatement strategies/ Retention	3.82	3.57	6.19	4.15
Strengthen substantive training capacity	4.09	3.43	4.81	4.37
Develop National Continuing Education Program	4.64	5.07	4.63	4.66
Increase training to meet the supply gap	4.18	4.21	4.63	4.78
Linkages, collaboration and networking with key stakeholders established	6.27	5.93	4.25	5.00
M, E and reporting systems developed	5.55	6.64	3.19	5.37

Table 2 presents an alternate view of the reform prioritization results, namely the number of first and second place rankings by individual participants. Four of the reform categories received seven individual highest priority rankings each (i.e. strengthening training capacity, equity, retention, and M&E systems), with three of those obtaining several second place rankings as well. It is worth noting that while increasing the efficiency of the labor supply did not receive as many first place votes as a number of the other priorities, because of a high number of second place votes, the overall average for this reform area was the highest.

Table 2: Number of top two rankings aggregated from three stakeholder groups (Scale: 1 Most Important, 8 Least Important)

HRH Reforms	#1 Ranking	#2 Ranking
Strengthen substantive training capacity	7	6
Increase equity of coverage of the prevailing labor supply	7	5
Institute loss abatement strategies/ Retention	7	5
M, E and reporting systems developed	7	1
Increase training to meet the supply gap	5	6
Increase efficiency of the prevailing labor supply	4	11
Linkages, collaboration and networking with key stakeholders established	3	3
Develop National Continuing Education Program	2	7

5.1.2 Stakeholder Meeting Essential Activities Identification

As part of the HRH-SPA™ process in Lesotho, participants identified the activities they deemed as essential to ensure successful implementation of the aforementioned HRH reform policies. *Table 3* below displays the top four priority reform areas with the activities that received the most votes from stakeholders. The number of votes received is presented alongside each activity in parentheses (see Appendix 5 for the complete tally of activity rankings by HRH reform area).

Table 3: Prioritized activities by HRH reform area considered by stakeholders to be essential to successfully implement reform within that area

HRH Reforms	Prioritized Activities (votes)
Increase efficiency of the prevailing labor supply	• Conduct regular supportive supervision (26) • Strengthen communication systems (24) • Strengthen information systems (22)
Increase equity of coverage of the prevailing labor supply	• Develop geographic posting policy (22) • Decentralize HR management (19) • Strengthen nursing and midwifery regulatory bodies (19)

Institute loss abatement strategies/ Retention	• Improve career management and standardize promotion opportunities (29) • Increase education and training opportunities (27) • Review and increase incentives (23)
Strengthen substantive training capacity	• Establish viable human resource management information system (23) • Establish Quality Assurance Program for training institutions (20) • Refurbish and enhance training institution infrastructure (18)

5.1.3 Stakeholder Meeting Discussion

Stakeholders were asked to explain the reasoning behind the selection of their top three priorities, and discussed the activities required for successful implementation of the reforms.

The MOH Directorate group felt that:

- Lesotho needs to better equip the workers we already have, and make them more efficient.
- Lesotho needs relevant workers. Addressing the tasks/roles of existing workers can be addressed more quickly than production.
- Increasing the skills of health care workers will limit the number of referrals required and patients that get 'stuck' in the system.
- Training needs to be relevant to the job market; need to teach more practically and less theoretically.
- Lesotho needs to better monitor the labor supply it already has to inform about gaps and progress in training programs and health worker capacity.

CHAL, Professional Council and Training Institution stakeholders shared that:

- Lesotho needs to strengthen the supervision, management support, communication systems and information systems within the health sector.
- Lesotho needs to maximize the potential of the workforce we have, and make sure it is efficient.
- Distribution of health workers to rural areas is a significant challenge.
- Lesotho is always training, but not retaining. Lesotho needs strategies to limit migration.
- A quality assurance mechanism for training institutions and continuing education is needed to ensure the healthcare workers meet the needs of the society. There is a gap in both the quality and quantity of what is produced—Lesotho should focus first on the quality.
- Organizations working in the HRH field work in a haphazard manner without efficiency and collaboration.

Similarly, Development and Implementing Partners discussed that:

- Lesotho needs to do more with less.
- The focus should be on deploying appropriately the human resources Lesotho has.
- Too much work is going on in isolation; there is a need to communicate and collaborate between stakeholders.
- Lesotho needs to monitor progress to improve programming. Partners have data needed to report, but they don't have systems in place to feedback information to improve programs.

All groups felt that the strategic reform areas had significant overlaps; addressing changes in one area would likely have beneficial impact on other areas of importance. As a result, when discussing their top priorities, many participants were careful to note that, by addressing their selected strategic priorities the priorities they thought were important but hadn't prioritized would be improved.

5.1.4 Key Informant Interviews

Key informant interviews largely focused on systemic issues. Representatives from the Ministry of Health highlighted the issues of retention as a top priority, but also highlighted issues in the MOH structure, management competencies, and systems such as deployment and performance management. Representatives from USAID noted challenges in the MOH recruitment processes and communication between the MOH, MOPS, MOF and development partners. Deficiencies in pre-service education that have driven extensive in-service training were also discussed, alongside the need to expand the role of professional councils and strengthen the Government's capacity to capture on- and off-budget expenditures and investment plans. Key informants from MOH, USAID and MCA all noted challenges with recruiting scare skills to the MOH, and proposed that public-private partnerships may be the most effective mechanism implementing many activities which do not fall in the MOH's core competencies. Key informants from MOH, USAID, NEPI, MCA and CHAL also shared many initiatives that have moved forward since the development of the Strategic Plans. A list of key informants is included in Appendix 3.

5.1.5 Rural Health Facility Visits

Interviews with staff members at four rural health facilities, three owned by the Government of Lesotho, and one by CHAL, further substantiated the issues highlighted by the stakeholder working groups. (List of facilities included in Appendix 3). When asked what issues most affected their work satisfaction, health workers at these facilities reported:

- Lack of safety supplies puts them at risk
- Lack of housing for all creates inequities among staff
- The slow MOH deployment processes deter health workers from taking up MOH positions
- Lack of communication and education opportunities make health workers feel isolated
- At MOH facilities, as long as they have cell phones with airtime to communicate with their DHMT, getting transport for outreach services is not difficult. At CHAL facilities transport is difficult to obtain
- Obtaining transport by any means for personal errands, such as shopping, is extremely difficult

- Lack of electricity in homes means health workers must charge phones at the health facility
- Trainings health workers undergo should be certified and relevant to their work
- An allowance for air time for cell phones used to be in place, and made communication with the DHMT and other health workers easy, but the allowance has been taken away
- Several health workers were working without contracts, one for over six months
- Contracts for counselors had ended; the facilities were now operating without counseling support

6. Discussion

Findings from the stakeholder working groups and key informant interviews, as well as reference documents listed in Appendix 4, were synthesized to determine proposed priority reforms. Several themes emerged from the facilitated discussions within stakeholder meetings and key informant interviews:

- **Due to significant disparities between urban and rural populations and health facilities, rural health care workers should be prioritized.** Rural populations, particularly those in mountainous areas, have limited access to healthcare in Lesotho. Many individuals must travel considerable distances to health centres to access care. Because of the remote location of these health facilities, it is difficult to attract and retain staff. Health workers who are assigned to rural health facilities sometimes do not report for duty, or may not serve out their contract. Because of these challenges and the impact on rural health outcomes, interventions that will benefit rural health facilities and workers are of extremely high priority.
- **Retention of health workers is a high priority, but retention initiatives will be more efficient and effective in synergy with other strategies.** Although retention of health workers is a recognized high priority for the MOH, stakeholders repeatedly noted synergies between retention and other priorities. For example, increasing the efficiency of health workers is expected to increase job satisfaction, which in turn is expected to increase retention.
- **Some strategies are better addressed sequentially.** Participants noted that some strategies should be accomplished before others, to maximize success. For example, participants were concerned that significantly increasing training to meet the supply gap prior to instituting effective retention strategies may result in expensive training being wasted as health care workers continue to leave the country upon graduation.
- **Addressing human resources for health challenges will require systemic change.** Many of the challenges discussed by participants and key informants will require systemic change within the MOH and other Ministries to address properly. Respondents believed that retention incentives, while welcome, will not alone result in the changes desired. Changes in MOH systems are also required to adequately respond to healthcare worker needs.

6.1.1 Prioritization Principles

Based upon these themes, two principles guided the analysis of stakeholder findings and the selection of recommended priorities:

1. **Interventions should be driven by the needs of the population, particularly vulnerable rural communities.**
2. **The country must have or develop the capacity to support reforms.**

In addition, the priority reforms were formulated to be started and/or completed within a 12-24 month timeframe. Lesotho's Vision 2020 presents a broad framework of accomplishments to be

completed by 2020. Lesotho is envisioned as a healthy nation with a well-developed human resource base. The country will also have a good quality health system with facilities and infrastructure accessible and affordable to all Basotho, irrespective of income, disabilities, geographic location and wealth, and health personnel will provide quality health services and patient care.

In preparation for accomplishing Vision 2020, a 2009 Facility Accreditation Survey found that staffing at every level of healthcare delivery does not meet the minimum staffing requirements. The Survey found that the provision of even the minimum level of services required of the MOH has become compromised due to the staffing shortage at the Health Centre level and at other higher levels of the referral system. The *Human Resources Development & Strategic Plan 2005-2025* attributes the human resources crisis partly "to an inability to produce adequate numbers of professional health workers, i.e. recruitment related, and partly due to an inability to retain these professionals, once trained and deployed, i.e. retention-related. Presently there is an urgent need to recruit and retain health workers, especially at the district level. Of equal importance is the development of capacities of the existing staff throughout the health care system." The MOH defined the human resource crisis as one of eight areas of reform under the MOH Health Sector Reform Program. Further, a SWOT analysis undertaken during the formulation of the Human Resources Strategic Plan concluded that the principle constraints to the realization of the Strategic Plan defined for Human Resources for the Health and Social Welfare sector was the ability of the MOH to address the career management issues to the satisfaction of the MOPS and the ability of the sector to produce the requisite personnel and retain them in the service.

The Strategic Plans developed to address these clearly defined challenges are ambitious in defining responses to each challenge. However, in practice, it has proven impossible to implement all reforms at once, due to resource and capacity limitations. A better strategy is to develop a realistic tiered approach, where manageable reforms build upon one another within short time frames. In keeping with this strategy, the reforms selected through the prioritization process are manageable activities that can be started and/or accomplished within a 12-24 month period. Through an intentional and well-planned process, these reforms:

- Address the most pressing challenges facing the health system, such as the flow of health workers out of rural areas
- Develop a strong foundation upon which to build additional long-term reforms and future initiatives
- Are discrete, implementable activities, which are feasible within the current structure, and may be packaged to attract resource support

In addition, reforms which complemented one another and created efficiencies were prioritized. For example, deployment, career development, performance management and other reforms rely upon an integrated HRIS and HMIS system. Therefore, it is most efficient to prioritize all reforms that rely upon HRIS/HMIS so that an integrated information system that meets all HR needs can be developed concurrently, rather than in a piecemeal style. In another example the Nursing Strategic Plan listed some important reforms that would be useful for other cadres of health workers as well.

In some instances, it was more efficient to institute the reform for all cadres of health workers that could benefit, rather than only the nurse cadre. On the other hand, some reforms, while important, were de-prioritized due to a lack of efficiency. For example, increasing the production of health care workers is extremely important for the long-term viability of the health system in Lesotho. However, increasing production before addressing health worker retention issues will result in wasted education resources as the increased numbers of health workers continue to migrate at the same rate. Therefore, increased production of health workers has been identified as a secondary priority to addressing retention issues.

Finally, reforms are focused on areas of greatest need. While many of the strategies presented here, particularly systemic changes, will result in the betterment of working conditions for all health workers, population health needs clearly show that the rural areas of Lesotho have disparate health outcomes compared to the rest of the country. In the face of limited resources, and given that urban areas are direct competitors with rural areas, the retention reforms proposed focus primarily on attraction and retention of health workers in rural locations.

6.1.2 WHO Recommendations

The WHO established rural and remote health worker retention strategies in the 2010 Global Policy Recommendation, *Increasing access to health workers in remote and rural areas through improved retention.* The WHO recognizes that the needs of remote and rural health workers differ from those of other underserved areas, and recommend that countries include policies specific to rural retention needs in national health plans. The WHO recommendations encompass a broad selection of strategies, with the caveat that "the best results will be achieved by choosing and implementing a bundle of contextually relevant recommendations." Selection of interventions should be grounded in an in-depth understanding of the health workforce and of the wider context. A core requirement for retention strategies to be effective is strong human resource management systems capable of conducting workforce planning; HR recruitment, hiring and deployment practices; monitoring and supporting work environment and conditions; timely HR information systems; and performance management, leadership and staff development.

The WHO recommended interventions for attraction, recruitment and retention of health workers are categorized into four focus areas with 16 activities:

1. Education
    a. Students from rural backgrounds
    b. Health professional schools outside of major cities
    c. Clinical rotations in rural areas during studies
    d. Curricula that reflect rural health issues
    e. Continuous professional development for rural health workers
2. Regulatory
    a. Enhanced scope of practice
    b. Different types of health workers
    c. Compulsory service
    d. Subsidized education for return of service

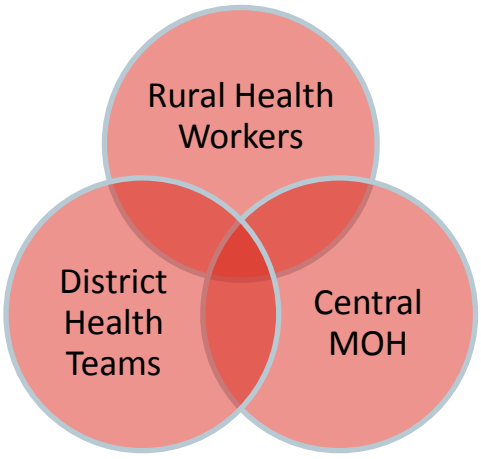
3. Financial Incentives
    a. Appropriate financial incentives
4. Professional and Personal Support
    a. Better living conditions
    b. Safe and supportive working environment
    c. Outreach support
    d. Career development programs
    e. Professional networks
    f. Public recognition measures

Many of Lesotho's proposed rural retention strategies are in line with the WHO recommendations. Prioritization of the strategies took into account the evidence cited by WHO to select reforms expected to be most effective in Lesotho's context.

6.1.3 Strategic Frameworks

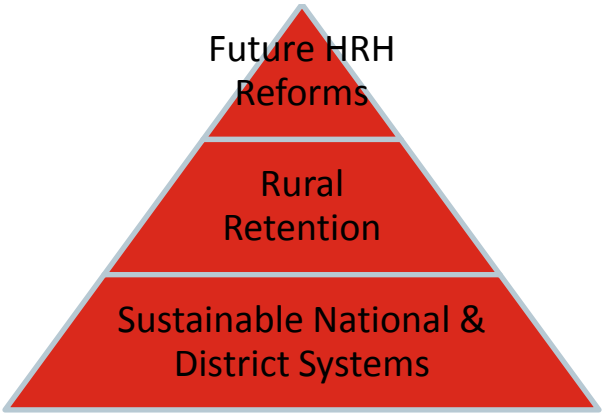
Upon evaluation of the reforms proposed in Lesotho's strategic plans, we found that no one set of recommendations was sufficient to respond to Lesotho's challenges. As recommended by the WHO, an integrated approach is required. Although the needs of rural health workers, and the attraction and retention of those health workers to rural postings, is a clear priority of the MOH, implementing the rural retention packages as proposed by the *Retention Strategy for the Health Workforce 2010* will not be sufficient to solve the retention issues. Rather, retention packages must be interconnected with greater systemic reforms for lasting impact. Therefore, the reforms proposed operate within the overlap between the rural health workers, district health teams, and the Central MOH.

Figure 2: Framework for interconnected MOH human resource reforms



In particular, the development of sustainable national and district systems will provide a strong foundation for rural retention in the short-term, and for additional reforms in the future, such as an increase in production of health providers.

Figure 3: Sustainable national and district systems as a foundation for rural retention and future reforms



While the urgent health needs of the Basotho and the health system's systemic challenges drive an understandable desire to effect wide-spread changes, we urge the MOH to act with a realistic, long-term view. An intentional and well-planned stepwise process will result in greater impact on Lesotho's health outcomes over the long-term than striving to address all challenges at once.

7. Recommendations

Priority reforms for the initial 12-24 month period are divided into two priority areas:

1. Rural human resources for health retention package
2. Sustainable national and district systems

The reforms can be further subdivided into immediate impact initiatives and foundational initiatives. Immediate impact initiatives are focused on increasing the attraction of health workers to rural health facilities, and stemming the migration from rural areas. Foundational activities focus on establishing sustainable systems that will support current and future reforms.

Table 4: Recommendations, by priority area and impact timeframe

	Rural HRH Retention Package	Sustainable Systems
Immediate Impact	• Cost of Living and Hardship Allowances • Staff Housing • Communication Systems • Safety • Transport • Caregiver Health • Locum Tenem • Supportive Supervision and Clinical Mentoring • Continuing Education and Training	• Emergency Hiring Program • Integrated HRIS & HMIS
Foundational	• Salary Adjustment Survey • Management Capacity • Deployment Systems • Career Progression Systems • Performance Management Systems	• District/Central Management/Oversight • Budget/Finance of National Government • Communication within Government • Communication between Government and Health Care Workers • Pre-Service Education Capacity • Professional Council Capacity

7.1.1 Rural Human Resources for Health Retention Package

The retention of human resources in rural health facilities owned by both MOH and CHAL is a high priority to all stakeholders. Sixty-four retention interventions were identified and ranked by key informants for the *Retention Strategy for the Health Workforce*. Since the publication of the Retention Strategy, some strategies have been implemented, particularly those which involved capital expenditures. Other strategies have had policies designed around them, but have not yet been implemented. Through the prioritization process, the following retention strategies were

selected for priority implementation within the next 12-24 months. The detailed activities required for costing and implementation of these strategies are available in Appendix 7.

Cost of Living and Hardship Allowances: Health workers assigned to rural health facilities, and particularly hard-to-reach facilities, often refuse posting or fail to report for duty. One reason frequently cited is the compensation. Health workers working in rural and hard-to-reach facilities receive the same level of compensation as those working in urban centers, despite the difficulties of the post and the higher cost of living in rural areas. Through this initiative, health workers will be paid allowances on a tiered scale:

1. Urban Health Facilities: Health workers paid base salary; no allowance
2. Rural Health Facilities: Health workers paid base salary plus small cost of living allowance
3. Hard-to-reach Health Facilities: Health workers paid base salary plus large cost of living and hardship allowance

Allowance scales will be clearly delineated and widely available so health workers are well aware of the service terms. The terms will be the same for MOH and CHAL facilities, and CHAL will be supported to ensure they can provide the benefit to their health workers. The allowance scales will be included as part of the terms of service at the facility; upon leaving the post, the health worker will no longer be eligible for the allowance. An integrated HRIS/HMIS will allow the MOH and Ministry of Public Service (MOPS) to accurately track the status of health workers and award or stop allowances in a timely manner.

> ***Action Point:*** *The MOH, in conjunction with the MOPS and CHAL, must determine the appropriate allowance scales to ensure health workers are adequately compensated. The Lesotho Nursing Directorate has proposed terms for the compensation of nursing staff in rural facilities; their proposal is included in Appendix 9.*

Salary Adjustment Survey: The salaries of heath workers in Lesotho are believed to be low in comparison to the region. As a result, health workers migrate to neighboring countries to earn higher salaries. This is a significant problem for Lesotho given its proximity to South Africa. The MOPS determines government worker salaries in Lesotho; health worker salaries cannot be changed outside of the structures established by MOPS for all government workers across sectors. However, low salary structures may be an endemic issue for the government. Anecdotally, we learned that it is difficult for the MOH to attract specialty staff, such as information technology specialists, due to low salary structures (among other issues). A salary adjustment survey is merited to determine the extent of Lesotho's disparity with the region, and, dependent upon findings, a salary adjustment may be necessary.

A salary adjustment survey and salary adjustment, if required, is a long-term process that is likely to only begin during the 12-24 month timeframe outlined. Allowances, as described previous, is a far more expeditious response to the problem of health workers leaving the country. However, short-term initiatives such as allowances must be matched with structural initiatives such as the salary survey for long-term impact.

Staff Housing: Staff housing is an important factor for the safety and well-being of health workers. Since the publication of the *Retention Strategy for the Health Workforce,* significant strides have been made in establishing housing on health facility campuses, funded by the MCA program. Each health centre, with the exception of 3-5 CHAL health facilities that are currently under review by the MOH to determine whether they should be supported to continue offering services, have had new housing units built and/or refurbished on their campuses. The housing has been designed to allow senior staff to have their families live with them, if preferred. However, for many facilities, the houses available are not sufficient for the staff assigned to the facility. Staff without housing should be supported to rent houses in nearby towns. However, many facilities are not convenient to towns, increasing the travel burden and safety risk for staff, and the housing stock available in towns are often not up to the standards provided to health workers living on the health facility campus.

Other challenges facing health workers living in rural and very hard-to-reach areas include electricity and heating of their homes, and furnishing their homes. Houses refurbished by the MCA have solar panels for electricity; maintenance contracts for the solar panels will be required. Moving personal furniture to extremely rural posts is a burden for health workers posted to very hard-to-reach areas; furnishing the houses will relieve this burden.

> ***Action Point:*** *The MOH will need to develop a housing policy that determines which cadres should be provided housing. To ensure development will meet medium- to long-term needs, the MOH should re-visit staffing norms to ensure that the staffing complement for each facility is adequate to the population's health needs, both now and 5-10 years in the future. Extremely hard-to-reach and rural health facilities should have priority for housing development.*

Communication Systems: Feeling connected to other health workers and their friends and family is another important concern for health workers assigned to rural and extremely hard-to-reach facilities. Again the MCA program has made great progress in increasing connectivity for health workers—by the end of 2012 most health facilities will have internet with Voice Over Internet Protocol (VOIP) so that health workers can complete trainings and contact the District Health Management Team (DHMT), other health providers and their families easily. For areas in which internet and VOIP is not possible, or where enhanced communication is required, cell phones and airtime should be provided and radio installed.

In addition to providing health workers with the appropriate means for communication, a protocol for a professional network should be established to guide health workers in seeking professional support from more experienced health workers. Health workers report using informal networks to garner advice; those new in their careers have fewer contacts and find it more difficult to get advice.

> ***Action Point:*** *The MOH should determine the types of health workers eligible for cell phones and the amount of airtime to be provided each month. The MOH will also need to determine an appropriate structure for a health professional network, and what communication mode is most effective for consultation between providers.*

Safety: Personal safety is another issue of concern for health workers, both those living on health facility campuses and those living in town and commuting back and forth to the facilities. Rural health facilities are frequently in highly isolated areas, which places health workers at risk. Reputable guards, armed with more than a nightstick, are required at health facilities. The rehabilitation of health facilities done by MCA has added guard huts at each facility. Health workers, particularly females, also require self-defense tools, and staff homes must have at least minimum-security precautions. Some health workers may require safe transport to and from the facilities.

> ***Action Point:*** *The MOH must determine the minimum safety-precaution package required to ensure the health workforce, particularly those in rural areas and those that live off the health facility campus, are kept safe. A standard for determining and addressing additional safety precautions required for facilities or individuals at greater-risk should be established.*

Transport: A challenge unique to health workers in some rural facilities and all hard-to-reach facilities is the ability to get transport to shop for supplies and visit their families. Without reliable transport, and with low market demand near the health facility, health workers can wait for hours for transport, or must walk long distances. A regular service, such as a chartered taxi on a designated day, to allow health workers to do their shopping or get to a more central location to catch transport to their home towns is a small, but significant benefit that will make living in rural and hard-to-reach areas easier for health workers.

> ***Action Point:*** *The MOH will need to determine the number of regular shopping trips/transport to central areas that should be allocated per facility.*

Caregiver Health: Health care workers, even under the best working conditions, face many daily stressors. In challenging work conditions, health workers are at high risk for burnout. The report, *Maximizing Human Resource Capacity in Rural District Health Systems in Lesotho* by Manafa et al., found high levels of detachment of health staff in Lesotho. Separation from families, high workload, deaths of patients, lack of resources, isolation and many other factors play a roll in provider burnout. The *HIV/AIDS Workplace Policy* addresses some aspects of caregiver health; in addition supervisors should be trained to support their staff, and health workers can develop their own innovative mechanisms for supporting one another. A policy on caring for the caregivers will provide a framework for this important consideration.

> ***Action Point:*** *The MOH should develop and cost a policy and guidelines for caring for their caregivers. Findings from the Maximizing Human Resource Capacity in Rural District Health Systems in Lesotho report may be used to inform an appropriate response.*

Locum Tenem: Common causes of provider burnout include a high workload and limited time away for rest and relaxation. In rural health facilities, staff absences due to leave, training or other causes increase the workload burden on the remaining health workers. An innovative mechanism countries such as Malawi and Nigeria have used to address this challenge is 'locum tenem,' or temporary workers who travel from facility to facility to replace workers who are on leave. This program will allow health workers in rural facilities to take their approved leaves of absence more regularly, and with less burden to their coworkers, reducing risk of burnout.

> ***Action Point:*** *The MOH will need to design the structure for locum tenem, including such considerations as how to staff the program, where the workers should be housed while at the facility, and what incentives would be required to support workers remaining mobile.*

Management Capacity: In workplaces worldwide, the capacity of managers has a direct effect on the satisfaction of their employees. In remote health facilities, nurses, or more rarely, nurse clinicians or physicians, are put in charge of managing the health centre. These health workers are trained in clinical care, and have limited or no training in management. They are overseen by DHMTs who also have limited management capacity. Building the competencies of health workers and DHMTs who will be required to play a management role is crucial for the retention, not only of the manager, but of the team they supervise. A list of training topics required by managers within the MOH and CHAL facilities is delineated on pages 58-61 of the *CE Implementation Strategy*. However, adequately building management competency requires not only training, but mentorship and supportive supervision. Central MOH and DHMT must be trained in how to mentor and provide supportive supervision to the level of managers they will be supporting.

> ***Action Point:*** *The MOH must determine an appropriate training, mentorship and supportive supervision structure focused upon management. The system will need to incorporate mechanisms to ensure mentorship/supportive supervision is provided, and a quality assurance mechanism.*

Supportive Supervision and Clinical Mentoring: Lesotho has a supportive supervision tool, but implementation of the tool has been limited. Supportive supervision and clinical mentoring are important components of a human resource management system that helps health workers feel supported and appreciated in their positions. Countrywide adoption of the supportive supervision system will require a comprehensive evaluation and revision of the existing system, and an intensive launch to emphasize the importance of the system. Supportive structures must be developed, from those for the DHMT and Local Council teams who will be providing supportive supervision and clinical mentoring, to user-friendly data systems to allow monitoring and tracking of health facilities' indicators in real time. The central MOH must hold Districts responsible for adequately supporting all facilities, including those in hard-to-reach areas.

> ***Action Point:*** *The MOH must decide an appropriate structure for supportive supervision and clinical mentorship that will support health facilities and individual providers to continue to improve their practice and work towards improved population health outcomes.*

Continuing Education and Training: Lesotho has a Continuing Education Strategy and Implementation Plan that was developed in 2010, but implementation of the plan has also been limited. A comprehensive continuing education program is crucial for ensuring the health workforce maintains up-to-date knowledge and skills, and is also used to address gaps in pre-service education and emerging diseases. Continuing education (CE) and training has been largely donor-driven in Lesotho, with healthcare workers much more likely to have received HIV and TB training than training on family planning or immunization. Training also takes healthcare workers away from their posts for extended periods of time, increasing the workload of colleagues remaining at the facility. Lesotho's continuing education program therefore has two challenges to address: 1) expanding the

continuing education program to address neglected topics, and 2) implementing innovative new methods for training which reduce time spent away from the workforce. The CE Strategic Plan delineates training priorities for all heath workers in Lesotho, however the list is quite ambitious and must be prioritized. Alternative mechanisms for delivering CE may include: a) trainees taken to local health facilities for training provided by local experts, based upon central curricula, b) trainers travel to facilities to provide CE on a regular basis, or c) trainees complete e-learning at their facility.

> ***Action Point:*** *The MOH will need to prioritize the topics into a realistic continuing education plan. The MOH should also consider alternative continuing education delivery mechanisms and select a few innovative models to pursue.*

Deployment Systems: Several groups of stakeholders decried the MOH health worker deployment system currently in place. Health workers felt that the deployment process was too slow, leaving them unemployed for months. Some moved to CHAL facilities due to the rapid hiring and deployment process. Several health workers we spoke with were working without contracts, and had not heard updates regarding their status in several months. Irish Aid has provided funding for 257 positions for two years, however, the Ministry of Finance cannot allow the payroll to grow; therefore the positions are on hold. A potential solution is abolishing the old Queen Elizabeth Hospital positions and using those abolished positions to open up space on the payroll for the 257 funded positions; a taskforce must be constituted to ensure this happens. Timely hiring and deployment of health workers is crucial to the MOH's ability to absorb funding, fill much-needed positions, and mitigate the loss of newly trained health workers or those returning to the workforce. Many countries struggle with their hiring and deployment processes; however, some have been able to streamline their processes for rapid deployment. The MOH should identify best practices to guide a modification of the deployment systems.

> ***Action Point:*** *The MOH should evaluate the deployment system to determine key bottlenecks and streamline the hiring and deployment processes.*

Career Management Systems: Career management systems help healthcare providers stay engaged throughout their careers. A strong career progression ladder gives each cadre of healthcare workers several avenues for advancement, rather than one defined path that excludes workers who have begun at a different point. Healthcare workers deployed to rural health facilities, in particular, are concerned that they may be passed over for career advancement opportunities. The MOH will need to institute systems for accurately tracking and implementing the career management system, and ensure DHMTs and healthcare workers are well aware of the processes for advancement.

> ***Action Point:*** *The MOH must work with the Professional Councils to determine appropriate career progression pathways for each cadre.*

Performance Management Systems: Lesotho's *Public Service Regulations of 2008*, and *Human Resource Policy Guidelines* have put in place a framework for the performance management systems. However, systems are unwieldy, and implementation of the performance evaluation process is extremely low. Performance evaluation can be an important feedback mechanism and

motivator for healthcare workers and a tool for the MOH in determining promotions and increasing quality of services. Currently the performance evaluation process has no consistent link to promotions, bonuses or raises. Supervisors also do not know how to use the performance evaluation process as a tool to provide constructive feedback to employees and improve performance. Increasing the implementation and effectiveness of the performance management system will require a multi-pronged approach: streamlining the process, requiring completion of the evaluation, and linking the performance evaluation to outcomes health workers can see.

> ***Action Point:*** *The MOH will need to evaluate and streamline the performance evaluation process to make implementation simpler and more relevant to the health workforce.*

7.1.2 Sustainable National and District Systems

Attracting and retaining health workers to Lesotho's most remote areas is a function not only of the Rural HRH Package, but also of the efficiency, effectiveness and sustainability of the central management and oversight systems. Fundamental to retaining health workers in demanding rural posts is strong, sustainable systems. Strengthening the national and district health systems will also form a foundation for future HRH reforms. The selected reforms below are essential for accomplishing the MOH's HRH goals. Specific activities for costing and implementation of these strategies can be found in Appendix 8.

District and Central Management and Oversight: The human resource management capacity of the government, at both the central and district levels, must be increased in order to accomplish the goals the MOH has laid out for itself. The central and district health teams require a wide range of human resource management competencies in order to oversee reforms that are currently underway, as well as successfully implement an ambitious new schedule of reforms. The reforms recommended in this report will require personnel who are skilled at developing and streamlining systems, overseeing public-private partnerships and contractors, administration, providing supportive supervision, and community management, among many other competencies. As Lesotho continues to progress in implementing reforms, even beyond those presented in this report, the demands for sophisticated management capacity will continue to increase.

> ***Action Point:*** *The MOH should conduct an assessment of their current management capacity at the central HR office, including other Heads of Programs, and in the DHMTs to determine the competencies that must be strengthened.*

Budget/Finance of National Government: The budget and finance capacity of the HR department of the MOH should be improved to increase the efficiency of funding and garner the confidence of donors. The MOH must develop capacity to accurately identify and forecast current and future HRH needs and develop appropriate budget lines. The MOH, MOF and MOPS must also develop procedures for distinguishing between on- and off-budget expenditures and manage funding to avoid duplication and increase the absorption of funding. National Health Accounts (NHA), which is practiced regularly in many countries, has not yet been implemented in Lesotho; building the capacity of the MOH and MOF to conduct NHA will increase the capacity of the government to accurately identify where health expenditures are occurring, and the sources of financing.

Action Point: *The MOH, MOF and MOPS should have a comprehensive audit completed of their financial management capacity to determine the areas which require strengthening.*

Communication within Government: Communication and coordination between departments within the MOH, MOPS, MOF and other stakeholders within the Government of Lesotho which impact HRH is a significant challenge to the impact the MOH has on their health workforce, and population outcomes. A lack of streamlined communication systems is a source of frustration for directors and managers within the government, and also for their stakeholders, including development partners. Standard operating procedures are required for collaborative planning, policy-making and budget planning. The inter-ministerial HRH technical working group, which previously was in place but was then disbanded in preparation for a larger MOH technical working group that has not yet come to fruition, should be reconstituted, and include representatives from the MOH, MOPS, MOF, Ministry of Education, Local Government Service Commission, and development partners. A strong inter-governmental planning and communications structure is vital to Lesotho's ability to attract and manage resources and meet Lesotho's Vision 2020 goals.

Action Point: *The MOH, in conjunction with relevant Ministries, must determine Standard Operating Procedures which will effectively guide collaboration towards common goals.*

Communication between Government and Healthcare Workers: A second area of communication which causes challenges for the MOH is communication between the MOH and health care workers. Individual providers need to be kept abreast of developments within the MOH, as well as on individual issues, such as contracts, deployment, rotations. The MOH has proposed updating a ministry website regularly, and the printing and distribution of a monthly newsletter. Such efforts will result in a considerable improvement in communication between the Ministry and its health workers. However, in addition, the MOH must look at communication *to* individual health workers on employment issues, as well as develop a stronger process for hearing *from* health workers for issues such as grievances and problems with contracts.

Action Point: *The MOH, in addition to continuing with plans for a website and monthly newsletter, must assess current communication systems and get stakeholder feedback on how to more effectively communicate with individual health workers.*

Human Resource Information Systems and Human Management Information Systems: In recent years, the MOH has made significant progress in introducing human resource information systems (HRIS) and health management information systems (HMIS). The HRIS was developed by the Southern African Human Capacity Development project, and has been implemented but remains in its infancy. The MOH is still expanding the system to reflect all necessary indicators, and expand the system to also track licensure of nurses and doctors. In addition, the MCA project is currently installing HMIS at the district level, and is expected to complete installation in early 2013. MCA has also piloted medical records systems in Leribe Hospital and plans to roll out the system to all hospitals. MCA is waiting for equipment to link all information systems together, and the MOH, in conjunction with International Finance Corporation, is considering a public-private partnership to maintain the systems.

This enormous progress is very promising for the efficiency of Lesotho's health systems. It is crucial that MCA's plans to link all information systems together continue for the effectiveness of the system. In addition, the recommendations in this report add a considerable number of requirements for both the HRIS and HMIS. These include the ability to support:

1. Tiered cost of living and hardship allowance
2. Staff deployment
3. Staff movement/migration/retiring
4. Performance management
5. Continuing education
6. Career progression
7. Facility vacancies
8. Registration and licensure

Action Point: *The MOH needs a comprehensive plan for information systems which integrates all existing and emerging information management needs across the health sector.*

Emergency Hiring Program: Lesotho has implemented a successful emergency hiring program which has recruited health workers from other countries, particularly Kenya. Continuation of this program should particularly focus on staffing rural and hard-to-reach areas where recruitment is challenging. In addition to recruiting non-Basotho health workers, the MOH must also develop a strategy for transitioning healthcare workers currently employed through implementing partners onto the Ministries payrolls to mitigate the loss of staff when implementing partners' contracts expire. A stop-gap measure has been provided by Irish Aid in the form of 257 positions; however, as noted above, taking advantage of this support has been challenging to the system, and the funding is in place for only two years. A long-term, feasible and sustainable strategy must be developed.

> ***Action Point:*** *Refocus the emergency hiring program to focus entirely on rural and hard-to-reach areas. Develop a strategy for absorbing implementing-partner supported positions onto the MOH's payroll.*

Pre-service Education: Lesotho currently provides training for health professionals through the National Health Training College and the National University of Lesotho. CHAL also has four nurse training programs at the Maluti, St. Josephs, Scott and Paray hospitals. Lesotho is planning to open its first physician training program in 2013. NEPI has made significant progress in supporting the upgrade of the six institutions providing nurse training. It is supporting all facilities to transition to competency-based training, and is piloting e-learning in two institutions. They are also increasing enrollment, tutors, information technology, library resources and clinical supervisors in all facilities. The work NEPI is completing is vital to improving the quality of health care delivery in Lesotho, and a strategy to ensure such changes are supported, even beyond the end of the NEPI grant, must be developed and implemented.

For the purposes of strengthening human resources, particularly in rural areas, some additional changes must be made in Lesotho's training institutions. To encourage greater enrollment of students from rural areas, who may be more willing to practice in rural areas, existing bursary

schemes should heavily favor rural candidates, and preparatory science courses should be provided to candidates from rural areas who might not otherwise be qualified to entire into a rigorous health training course. Nursing students must also be supported to become more practice-ready before deployment, particularly before deployment to rural areas where they may not have significant mentorship and support. Post-graduate preceptorship programs are needed to allow students to build practical skills, and all nursing students should be exposed to rural practice in a supportive preceptorship environment before being deployed.

> ***Action Points:*** *A strategy to support the expansion and long-term sustainability of NEPI's initiatives must be developed and implemented before the end of the NEPI grant. Initiatives to support the attraction of rural candidates to health training should be implemented, and nurses should be supported to become practice-ready, particularly for practice in rural areas, through a mandatory post-graduate preceptorship program.*

Professional Councils: Professional Councils play an important role in any countries' health system: they are crucial partners in the registration and licensure of health workers, ensuring quality, developing practice standards, and overseeing the provision of continuing education, among other roles. Professional Councils derive their authority through a Government-bequeathed statutory function. The Lesotho Medical, Dental and Pharmacy Council and the Lesotho Nursing Council do not have statutory function, but rather operate independent of the Government. The Councils were established by law to register health workers. Once registered, the Councils do not monitor health professionals' requirements, and do not require recertification. Currently the Public Health Act is being revised; this opportunity could be used to bequeath statutory function on the Councils to increase their authority to monitor health workers and act as a more comprehensive partner for the MOH. However, the Councils currently do not want to become statutory bodies, for fear of losing autonomy. One statutory body currently exists, the Higher Education Council, and is mandated to accredit and ensure the quality of health education. Significantly under-resourced, the Higher Education Council relies upon the other Councils for technical capacity.

Currently, JHPIEGO and NEPI are working with the Nursing Council to set up a database for registration, a strategic plan, and support the revision of curricula for nursing schools. Similar support is needed for the Medical, Dental and Pharmacy Council, particularly in light of the medical school opening in 2013. The MOH also desires the Councils' capacity to be expanded to support the MOH in providing quality control for health professionals.

> ***Action Point:*** *The MOH will need to negotiate with the Councils to determine an appropriate structure for expanding the mandate and capacity of the Councils to provide increased support to the MOH's HR department.*

8. Conclusion

The priority reform strategies and activities outlined in this report are an ambitious, but achievable, set of recommendations for the MOH to implement in the coming 12-24 months. The strategies address a priority of deep concern to the country: the loss of health workers from rural communities, and also lay a firm foundation for future reforms in order to meet the goals of Lesotho Vision 2020 and HRH 2025.

In order to ensure implementation of this strategy, several additional steps will be undertaken and completed by early 2013:

1. Priority activities will be costed using costing scenarios to assist with selection of appropriate implementation strategies
2. A final prioritization will be conducted to meet realistic budget standards
3. Recommendations will be presented to Parliament for approval
4. A resource mobilization plan will be developed to guide the generation of sufficient resources to allow implementation of priority activities
5. An investment strategy will be developed to increase capacity for rapid scale-up of implementation of the strategy, as well as increase absorptive capacity and develop exit strategies.

Upon completion of these steps, it is expected that the MOH will be able to attract resources to support implementation of reforms, oversee implementation of activities, and develop costed strategic plans for further reforms.

9. Appendix 1: Strategic Plan Themes

Lesotho Health Sector Human Resources Development & Strategic Plan 2005-2025	*Retention Strategy for the Health Workforce 2010*	*Nursing and Midwifery Strategic Plan 2011-2015*
Improve the efficiency of the prevailing labor supply. 1. Restructure the career ladders for cadres with a large quantitative supply gap that is driven in part by an appreciable non-technical workload. a. Nursing b. Oral Health c. Social Welfare d. Environmental Health e. Pharmacy 2. Establish a structured national CME program that adequately trains all Assistant level non-technical support occupations 3. Institute strengthened supervisory procedures for Assistant level occupations 4. Re-grade jobs such as Ward Attendant, Social Welfare Auxiliaries, Oral Health Assistants, Environmental Health Assistants, and Pharmacy Assistants whose productivity has been enhanced through in-service skills upgrading 5. Undertake critical review of desired roles and work responsibilities of the Oral Health Assistant and Health Assistant vis-a-vis the role and responsibility of the Nursing Assistant 6. Introduce a vastly improved career management system under the oversight of the Human Resources Department of the MOH that includes a revised Posting Policy and Human Resources Development Policy to ensure that the first strategy for closing the supply gap is the re-deployment of qualified personnel to jobs for which they have the requisite training and skills **Improve equity of coverage of the prevailing labor supply.** 1. Accord priority to the production and	**HRH Management Systems** 1. Supportive supervision 2. Strengthen information systems 3. Management support 4. Communication and information 5. Career management and promotion opportunities 6. Means of communication 7. Security 8. Decentralization of HR management **Policy and Planning of HRH** 1. HIV/AIDS workplace strategies **Financing HRH** 1. Review and increase allowances 2. Equalize benefits 3. Review and increase incentives 4. Housing for staff 5. Home heating 6. Equalize salaries **Educating and Training HRH** 1. Education and training	**Nursing and midwifery professional regulatory bodies strengthened.** 1. Review nursing and midwives standards of practice 2. Develop marketing and recruitment strategy 3. Train LNC and LNA secretariat in lobbying, advocacy 4. Develop strategic planning for LNC and LNA 5. Establish a service system for caring for careers 6. Strengthen LNC and LNA networking and collaboration skills 7. Develop capacity for LNC and LNA secretariat in leadership and management 8. Establish secretariat for LNC and LNA 9. Establish a licensing system for nurses and midwives 10. Develop LNA and LNC nursing and midwifery database **Monitoring, evaluation and reporting systems developed.** 1. Develop monitoring and evaluation and reporting systems **Strengthen research component in nursing and midwifery.** 1. Strengthen research capacity for nursing and midwifery

deployment of personnel required for primary health care and frontline social welfare services 2. Develop a Posting Policy that ensures that staff are distributed in a geographically equitable manner and that personnel in mountain assignments are rotated on a regular basis or are adequately compensated. 3. Institute a gate-keeping function within the HR Department that ensures that all deployment or re-deployment of personnel adhere to the guidelines of the Posting Policy **Institute loss abatement strategies.** 1. Improved career management through: a. strengthened HR Management and Administration Section of the HRD, b. development of Posting Policy that will define the criteria for promotion or re-deployment, c. implementation of the new HR policies and procedures related to direct promotion of an employee d. review and finalize the revised career ladders prescribed in the HRDSP that seek to expand avenues for career advancement e. Institute measures to eliminate structural impediments to career advancement within a cadre f. Develop and introduce an accelerated salary grade/step incrementing policy 2. Minimize attrition a. Conduct a formal benefits review to eliminate inequities b. Conduct a formal job grading/re-grading exercise that eliminates intra-sectoral pay inequities between jobs with similar qualifications c. Invest in improvements in the physical and social working environments for health and	opportunities 2. Competency-based training **Leadership of HRH System** 1. Provision of equipment and drugs 2. Improve procurement management 3. Establish statutory body for HRH	2. Integrate scientific evidence into nursing and midwifery through continuing education, pre-service training, and provision of guidelines 3. Train nurses and midwives in IT **Sustainable approach for nursing and midwifery community driven and competency-based pre-service and in-service education systems developed.** 1. Establish a national nursing and midwifery education committee 2. Review nursing and midwifery training curricula 3. Develop capacity of nursing and midwifery educators 4. Develop guidelines and preceptorship and mentorship skills training module 5. Conduct preceptorship skills courses for nurses and midwives 6. Develop guidelines and programme for creating an internship system 7. Develop policy and accreditation systems for nursing and midwifery education **Nursing and midwifery practice and services strengthened.** 1. Train nurses and midwives in leadership management skills 2. Conduct courses for training nurses and midwives in HRM 3. Train nurses and midwives in budgeting and budget management 4. Develop nurses and midwives skills in

social welfare personnel d. Create opportunities for national experts to participate in task forces and in consulting agreements on remunerative basis without having to take official leave of absence from work e. Selectively extend the mandatory retirement age to 65 for high skilled jobs f. Institute a system for hiring particularly well qualified retirees for other jobs on a contract basis g. Develop and introduce systems and procedures for managing the brain drain and minimizing its impact on the sector **Strengthen substantive training capacity.** 1. Revitalize the MOSHSW Training Committee 2. Establishment of the Quality Assurance Program for all national training institutions 3. Produce an action plan for the restructuring and strengthening of NHTC to achieve the objectives stated in the Mandala report 4. Implement NHTC-Strengthening Action Plan 5. Review status and role of all CHAL training institutions based on the Training Plan and adapt institutions as needed 6. Establish a viable and up-to-date HRMIS that builds on the HR database 7. Refurbish and enhance all training institution infrastructure as required to ensure that they are adequate to meet required production levels 8. Establish or revitalize a Health and Social Welfare Desk in the National Manpower Development Secretariat **Develop National Continuing Education Program (this is costed in the Strategy).** 1. Develop a National CE program within the MOH 2. Strengthen the HRD capacity of the		effective communication and counseling 5. Improve quality management and quality assurance systems 6. Conducting, monitoring, evaluation and reporting skills training 7. Support nurses and midwives to pursue continuing education 8. Develop policy and guidelines on task shifting 9. Strengthen mother and child health services 10. Improve TB/HIV and AIDS/STI services 11. Strengthen mental health services 12. Strengthen non communicable disease services 13. Strengthen capacity for nurses and midwives on trauma, emergency preparedness and response 14. Promote adolescent health 15. Engage communities in promoting their own health **Linkages, collaboration and networking with key stakeholders established.** 1. Improve linkages, collaboration and networking with key stakeholders

CHAL Secretariat and selected CHAL training institutions **Increase training to meet the supply gap.**		

10. Appendix 2: Strategic Plan Prioritization Worksheet

Name: **Organization:** **Position:**

Please rank the following eight key HRH reforms in order of priority, from Most Important (1) to Least Important (8).

_____ Improve the efficiency of the prevailing labor supply
_____ Improve equity of coverage of the prevailing labor supply
_____ Institute loss abatement strategies
_____ Strengthen substantive training capacity
_____ Develop National Continuing Education Program
_____ Increase training to meet the supply gap
_____ Linkages, collaboration and networking with key stakeholders established
_____ Monitoring, evaluation and reporting systems developed

Please tick the activities you consider most important for accomplishing each of the priorities:

Improve the efficiency of the prevailing labor supply

- ☐ Prioritize production and deployment of personnel for PHC and frontline social welfare
- ☐ Strengthen communication systems
- ☐ Strengthen information systems
- ☐ Provide equipment and drugs to facilities
- ☐ Conduct regular supportive supervision
- ☐ Establish a structured continuing education program
- ☐ Increase management support
- ☐ Institute strengthened supervisory procedures
- ☐ Restructure career ladders
- ☐ Re-grade jobs that have been enhanced through in-service skills upgrading
- ☐ Strengthen nursing and midwifery practice and services
- ☐ Introduce career management system
- ☐ Improve procurement management

Improve equity of coverage of the prevailing labor supply

- ☐ Decentralize HR management
- ☐ Develop geographic posting policy
- ☐ Institute gate-keeping function for deployment and re-deployment of personnel
- ☐ Equalize benefits
- ☐ Strengthen regulatory bodies

Institute loss abatement (retention) strategies

- ☐ Improve career management and standardize promotion opportunities

- Provide health care workers with reliable means of communication
- Improve security
- Establish statutory body for human resources for health
- Develop HIV/AIDS workplace strategies
- Rationalize salaries
- Review and increase allowances
- Improve housing for staff
- Ensure staff homes have heating
- Review and increase incentives
- Increase education and training opportunities

Strengthen substantive training capacity

- Revitalize MOSHW Training Committee
- Establish Quality Assurance Program for training institutions
- Restructure and strengthen NHTC
- Adapt CHAL training institutions to Training Plan
- Establish viable human resource management information system (HRMIS)
- Institute competency-based training
- Refurbish and enhance training institution infrastructure
- Establish or revitalize a Health and Social Welfare Desk in the National Manpower Development Secretariat
- Strengthen research component
- Develop sustainable approach for community-driven and competency-based pre-service and in-service education systems

Develop National Continuing Education Program

- Strengthen National Continuing Education program
- Strengthen HRD capacity of the CHAL Secretariat and selected CHAL training institutions

Increase training to meet the supply gap

- Medical doctors
- Nurses
- Oral Health
- Orthopedics
- Rehabilitation
- Radiography
- Pharmacy
- Laboratory
- Biomedical Engineering
- Nutrition/Dietician
- Health Education

- Environmental Health/Public Health Engineering
- Social Welfare

11. Appendix 3: Stakeholder Meeting Attendees, Key Informants, Health Facilities

Stakeholder Meeting Attendees:

Name	Organization	Division/Position
Allan A	EGPAF	
Malentsoe Allidi	CHAL	Executive secretary
Adline Chabeli	ICAP	NEPI nurse advisor
Mamoitheri Hanese	MOH	AHRO
Selloane Jone	LCN	Health & social development coordinator
Ntulela Khiba	CHAL – Tebellong	Administrator
Masebota Khuele	Consultant	Consultant
Moroesi Kokome	CHAL - Maluti Hospital	HR officer
Mantau Lebajoa	Seboche	HRO
Rosinah Lebina	Maluti Adv. Hospital	SNO
Manthatisi Lekau	MOH	AHRO
Mankhala Lerotholi	PSI	Acting country director
M. Maema	HRAA	Tutor
Margaret Maine	Roma College of Nursing	Deputy PNG
Mpoeetsi Makau	MOH	Head clinical nursing service
Flavia Moetsana-Poka	LNC	Registrar
Makhate Makhate	HRAA	HRIS specialist
Tseliso Makoa	LEMASO	MER officer
Sello Mapitse	MOH	HR
P. Maqhama	MOH	Financial controller
M. Matsumunyane	MCA-L	HSS manager
Tentenkie Mohapeloa	Lesotho Medical, Dental, & Pharmacy Council	Registrar
Lerato Mohlakore	CHAL	HRO
Manmuku Mokebisa	LNA	SNO
Nthabiseng Molise	MOH	NEPI coordinator
Raute Molise	LMA	Doctor
Tseleng Mokhehle	MOH	HRD
Danielle Morris	ICAP	EPIC coordinator
Itumeleng Mosala	HRAA	M&E officer
Makhetha Moshabesha	UNICEF	YAD officer
Lebohang Mothae	CHAL	Deputy executive secretary
Anaso Motseko	St. Joseph's Hospital	HRO
Victoria Nteso	Maluti SON	Principal nurse educator
K. Ntoampe	MOH-HED	Chief health educator
Morongoe Nyakare	MOH – DDC	HIV/AIDS officer

Setlaba Phalatsi	MOSD	M&E officer
Thato Ramokamale	LMA	Office secretary
Motlatsi Rangoanana	IHM	M&E specialist
Marguerite Regan	WHO	HPCO
Malefetsane Soai	Lesotho-Boston Health Alliance	Capacity strengthening officer
Shahida Tarr	NHTC	DG
Mosa Theko	MOH	AHRO
Nkoebe Theko	MOH	DPHC
Mamolitsane Thoothe	MOH	Health planner
Makopoi Tlhomola	MOH	HRM
Abraham Zerihun	CHAI	Program manager

Key Informants:

Name	Organization	Title
Moliehi Khabele	MOH	Permanent Secretary
Tseleng Mokhehle	MOH	HRD
Hilary Mwale	USAID	
Masebota Khuele	Consultant	Consultant
Sophia Mohapi	MCA	CEO
Lebohang Mothae	CHAL	Deputy Executive Secretary

Rural Health Facilities:

Name	Organization
St. Peters Health Center	CHAL
Sekameng Health Center	GoL
Mohalinyane Health Center	GoL
Mofumahali oa Rosari Health Center	CHAL

12. Appendix 4: Reference Documents

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13. Appendix 5: Stakeholder Activity Prioritization Results

Activity	Number of Votes
Strategy: Increase efficiency of the prevailing labor supply	
Prioritize production and deployment of personnel for PHC and frontline social welfare	**16**
Strengthen communication systems	**24**
Strengthen information systems	**22**
Provide equipment and drugs to facilities	**17**
Conduct regular supportive supervision	**26**
Establish a structured CE program	**16**
Increase management support	**18**
Institute strengthened supervisory procedures	**19**
Restructure career ladders	**17**
Re-grade jobs that have been enhanced through in-service skills upgrading	**14**
Strengthen nursing and midwifery practice and services	**17**
Introduce career management system	**15**
Improve procurement management	**12**
Strategy: Increase equity of coverage of the prevailing labor supply	
Decentralize HR management	**19**
Develop geographic posting policy	**22**
Institute gate-keeping function for deployment and re-deployment of personnel	**11**
Equalize benefits	**15**
Strengthen Nursing and midwifery regulatory bodies	**19**
Strategy: Institute loss abatement strategies/Retention	
Improve career management and standardize promotion opportunities	**29**
Provide HCW with reliable means of communication	**14**
Improve security	**12**
Establish statutory body for HRH (i.e. health commission, public service commission, to increase efficiency of deployment)	**13**
Develop HIV/AIDS workplace strategies	**11**
Rationalize salaries	**13**
Review and increase allowances	**18**
Improve housing for staff	**19**

Ensure staff homes have heating	**12**
Review and increase incentives	**23**
Increase education and training opportunities	**27**
Strategy: Strengthen substantive training capacity	
Revitalize MOSHW Training Committee	**11**
Establish Quality Assurance Program for training institutions	**20**
Restructure and strengthen NHTC & CHAL	**8**
Adapt CHAL training institutions to Training Plan	**14**
Establish viable human resource management information system (HRMIS)	**23**
Institute competency-based training	**16**
Refurbish and enhance training institution infrastructure	**18**
Establish or revitalize a Health and Social Welfare Desk in the National Manpower Development Secretariat	**10**
Strengthen research component	**17**
Develop sustainable approach for community-driven and competency-based pre-service and in-service education systems	**12**
Strategy: Strengthen National CE Program	
Strengthen National Continuing Education program	**25**
Strengthen HRD capacity of the CHAL Secretariat and selected CHAL training institutions	**19**
Strategy: Increase training to meet the supply gap	
Medical doctors	**26**
Nurses	**23**
Oral Health	**10**
Orthopedics	**8**
Rehabilitation	**7**
Radiography	**12**
Pharmacy	**17**
Laboratory	**17**
Biomedical Engineering	**9**
Nutrition/Dietician	**14**
Health Education	**16**
Environmental Health/Public Health Engineering	**10**

Social Welfare	**9**

**The strategies "Linkages with Stakeholders" and "M&E" did not have corresponding activities in the strategic plans, and were therefore not included on the activity prioritization worksheet*

14. Appendix 7: Rural Retention Package Priority Recommendations

Priority Intervention	Recommended Priority Activities	Activities for Costing
Cost of Living Adjustment (COLA), Hardship and other Allowances	1. Develop a 4-tier COLA & Hardship Allowance Policy: Urban, Rural, Hard-to-Reach 2. Establish other allowances - housing, transportation, utilities (water and electricity/heat), cell phone, and safety allowances. 3. Identify eligible employees using existing HRIS 4. Work with MOPS to implement tiered COLA/Hardship Allowance scale	1. Hardship/Mountain Allowance 2. Meetings to determine/refine COLA plan and implementation 3. Retention allowance 4. Call allowance 5. Housing allowance 6. Housing subsidy
Salary Adjustment	1. Hire a consultant to conduct wage study for government workers (across sectors, not just health); alternatively, consider wage study recently completed by Price Waterhouse Cooper 2. With consultant, investigate any financial discrepancies between government and non-government (CHAL) health workers, and estimate costs of standardizing benefits. 3. Cost the implications of raising wages by rate recommended by consultant	1. Consultant: wage study 2. CHAL salary adjustment up/down 3. MOH salary adjustment (25%)
Staff Housing	1. Additional staff housing built at rural facilities to meet the needs as mandated through staffing norms (built on Government or CHAL land, so only need building supplies, labor) 2. Housing allowance (described above).	1. Additional staff housing to fill MCA gap 2. Maintenance potential through PPP 3. Heating allowance—gas 4. Heating allowance—coal

Priority Intervention	Recommended Priority Activities	Activities for Costing
	3. Heating systems, including 48kg of gas half yearly and 4 bags of coal/month/nurse working at hard-to-reach health centres 4. A contract with a private firm established to maintain the existing MCA developed housing and new homes 5. Fully furnished homes for hard-to-reach facilities: List of items in nursing request for retention of nurses	5. Heating allowance—wood
Communication	1. Cell phone credit provided to Doctors, Nurses, Pharmacists in rural facilities for communication with other HCWs 2. Radio installed in facilities with spotty cell phone coverage and no internet 3. Workshop to define professional network structures held; communication to health workers about who they should contact within the network for professional support 4. A contract with a private firm established to manage internet and VOIP 5. Electricity access in homes for charging of cell phones/use of internet 6. A contract with a private firm established to maintain solar power for housing/facilities	1. Cell phone provision 2. Call credit provision 3. Radio installation 4. Stick modem 5. PC Hardware installation 6. Solar power installation 7. Maintenance of ICT 8. Satellite
Safety	1. 24-hour guard services for all rural facilities 2. Issue self-defense gadgets to female	1. 24-hour guard services with machete 2. 24-hour guard services with gun

Priority Intervention	Recommended Priority Activities	Activities for Costing
	workers, e.g. pepper spray, taser, personal alarm key chain, screecher5. Combined with flashlight (torch). Train essential self-defense tactics to female workers. 3. Set minimum standards for home alarm for staff housing and install practical security measures, e.g. burglar bars, locks, movement detectors, outdoor security lights with motion detection (when electricity is available) 4. Issue one-off free cell phones to selected categories of health workers 5. Institute sponsored taxi-service for selected health workers to get to and from work in evenings/early mornings from fixed locations	3. 24-hour guard services with dog 4. Camera installation 5. Safety gadget provision-1 (TBD) 6. Safety gadget provision-2 (TBD) 7. Safety gadget provision-3 (TBD) 8. Home safety features (e.g. burglar bars, locks, etc)
Transport	1. Monthly chartered taxi for shopping trips for rural facility staff 2. Transport subsidy to allow rural health workers to reach nearest civilization for monthly trips home/out	1. Monthly chartered taxi for shopping 2. Monthly home visit allowance
Caregiver Health	1. Convene consultative meeting to develop care for caregivers strategy, guidelines and policy; hold workshop to disseminate 2. Hire consultants to train supervisors to support health worker's emotional well-being	
Locum Tenem	1. Design locum tenem program to cover positions for health workers on leave 2. Hire mobile doctor, nurse rotation teams	1. Meetings to design program 2. Coverage (1 month) for nurses and doctors

Priority Intervention	Recommended Priority Activities	Activities for Costing
	3. Transport mobile workers between facilities 4. Identify or develop temporary housing for mobile workers	
Management Capacity	1. Hire consultants to train doctors, nurse clinicians, nurses in leadership positions in management skills 2. Hire consultants to train DHMT – district and central level - to provide supportive supervision and mentorship in management 3. Implement training programs – management, leadership, Basic computers and use of HMIS/HRIS. Full list of topics on pages 58-61 of *Continuing Education Implementation Strategy* 4. Implement supportive supervision and clinical mentorship programs 5. Strengthen supportive supervision by introducing a Performance Management System (PMS) (see below)	1. Training needs assessment 2. Leadership and management training 3. Supportive supervision training 4. Training- 10 days per nurse/doctor/etc 5. Training 1 – DHMT 6. Training 2 – DHMT
Deployment	1. Hire consultant to evaluate recruitment process and streamline 2. Hold stakeholder meetings with MOH and MOPS to find ways to realistically identify staffing needs and fill them 3. Hire outside consultants to train HR department to increase capacity in HR management 4. Improve communications between government (both district and central) and healthcare workers on providing	

Priority Intervention	Recommended Priority Activities	Activities for Costing
	timely and relevant information such as job openings, deployments, recent developments in the health sector, opportunities for trainings, etc	
Career Progression	1. Carry out situational analysis related to existing career development ladders with special emphasis on rural provider 2. Hire a consultant to design a more diversified career progression policy for all health worker cadres 3. Host two workshops for stakeholders (input and feedback) 4. Develop and update DHMT staff and community health worker career path plans. 5. Develop implementation mechanism for updated career ladder path structures 6. Hire MOH staff to manage career progression for health workers	1. Situational analysis 2. Workshop 1: inputs 3. Workshop 2: feedback 4. Implementation
Continuing Education and Training	1. Establish an office at MOH for coordinating C.E. (a staff member or 2, access to HMIS, HRIS) 2. Host workshops with stakeholders to establish C.E./training plans for all cadres 3. Council of Higher Education provided funding to ensure quality of C.E. courses and providers 4. Three training mechanisms costed: a) Trainees taken to local sites for locally taught C.E. based on central curriculum.	1. Training needs assessment (as noted above) 2. Establish package of training 3. Training mechanism—off-site 4. Training mechanism—on-site 5. Training mechanism—e-learning 6. E-learning orientation

Priority Intervention	Recommended Priority Activities	Activities for Costing
	b) Trainers coming to facilities to provide C.E. on a bi-monthly basis c) Trainees complete e-learning at their facility (resources such as computers required) 5. Consultants hired to build computer-based training platforms, independent of internet for rural facilities 6. Technical experts hired to develop trainings in neglected areas: family planning, immunization 7. Trainings provided to all providers. List of courses and audience on pages 62-68 8. Trainings held to build capacity of educators to conduct workshops and courses.	
Performance Management	1. Consultant hired and stakeholder meetings held to update performance management strategy 2. Supervisors trained in use of PMS and how to give constructive feedback 3. Employees trained through C.E. in the intent and proper form for Perf Evals 4. Position hired to manage performance evaluation process and ensure completed country-wide	1. On-going training – health centers 2. Development of DHMT committees
Supportive Supervision and Clinical Mentoring	1. Consultants hired to evaluate existing supportive supervision and clinical mentoring policies, procedures, and tools, and revise as required 2. DHMTs and Local Council trained in	1. Training – health centers 2. Mentoring (3 people for North, South and Central)

Priority Intervention	Recommended Priority Activities	Activities for Costing
	supportive supervision 3. Facility and provider staff trained in clinical mentoring 4. Data system developed for administrative supportive supervision and clinical mentoring to feed data from facilities to DHMTs monitoring and tracking 5. Data clerks hired at District level and trained to feed data back to facilities for quality assurance 6. Transport/lodging for regular visits to facilities by DHMT and Local Council team, and healthcare workers for supportive supervision and clinical mentoring activities 7. Facility supervisors trained to provide regular feedback to health workers on PMS outcomes-Transport for Central MOH to follow up on proper policy adherence at DHMT and facility levels	

15. Appendix 8: Sustainable National and District Systems Priority Recommendations

Intervention	Recommended Priority Activities	Activities for Costing
District/Central Management/ Oversight	1. Establish public-private partnership for procurement process to support the use of private partnerships to improve management capacity of district and central offices. For example: 2. Assess capacity of current central and district government 3. Train DHMT to conduct technical oversight, manage and feed data back to sites and Central 4. Train Local Government in administrative and community management 5. Train central in management oversight of Districts, facilities 6. Train central in management of contracts with private firms	1. Consultant to assess current capacity 2. Consultant to train on technical oversight
National Government Budget/Finance Oversight	1. Assess current financing procedures and data sources to estimate current and future HRH needs 2. Develop appropriate budget lines, particularly on procedures to distinguish off- and on-line budget expenditures 3. Train central on important financial functions, including forecasting, planning, on and off-budget management 4. Train Central to conduct NHA 5. The above mentioned activities may be provided through a PPP with an	1. Consultancy to assess current financing procedure and data sources to support HRH analysis 2. Consultancy to train central government and HR department on general financial functions including planning and budgeting 3. Training

Intervention	Recommended Priority Activities	Activities for Costing
	external private financial firm	
Communication within Government	1. Review inter-ministerial HRH coordinating mechanism design and objectives 2. Design SOP for collaborative planning, policy making and budget planning with government stakeholders 3. Bi-monthly meetings hold for inter-ministerial HRH TWG—health, public service, education, finance, local government, donors represented	1. Consultancy to review inter-ministerial HRH coordination 2. Consultancy to design SOP for collaborative planning, policy making and budget planning
Communication between Government and Health Care Workers	1. Consultant hired and stakeholder meetings held to establish policies and procedures for communicating with individual providers on issues such as deployment, reassignments 2. Ministry website maintained with IT person to update regularly 3. Printing and distribution of monthly newsletter 4. Staff time to write content for website and newsletter 5. Consultant hired to hold consultative stakeholder meetings and set up standardized process for health workers to report grievances, problems with contracts, etc. strengthened	1. Meetings to establish policies and procedures for communication with providers 2. Ministry website maintenance 3. Printing and distribution of newsletter 4. Hold consultative meetings to design process for health workers to report issues
HRIS + HMIS	1. Provide ongoing budgetary support to complete work on the development of the HMIS and HRIS systems. 2. Employ consultant to assess existing HRIS (developed by SAHCD) and HMIS (developed by MCA) capacity to support the above mentioned HRH reforms and any modifications to the	1. HMIS additional – support hardware/software 2. HMIS additional support – training 3. HRIS/HMIS integration and capacity building 4. HMIS/HRIS maintenance

Intervention	Recommended Priority Activities	Activities for Costing
	current budget necessary to improve these systems for: : a) Tiered COLA & Hardship Allowance b) Staff deployment c) Staff movement/retiring/migration d) Performance Management e) C.E. and training-trainees, C.E. (Technical specifications listed in CE Implementation Plan, page 106) providers, training institutions f) Career progression eligibility g) Facility vacancies h) Registration (Professional Councils) 3. Hire IT company to modify HRIS and HMIS system to meet HRH needs and link databases 4. Hire new staff and computers to utilize HRIS and HMIS to full capacity 5. Training to government staff on the use of HMIS and HRIS data 6. Contract with IT company for maintenance of systems	
Emergency Hiring Program	1. Consultants hired to develop resource mobilization plan for continuity of existing grant-funded positions 2. Existing emergency hiring plan continued, focused on rural areas 3. Private company contracted to	1. Meetings to develop plan for existing grant-funded positions 2. Cost of salary burden inherited

Intervention	Recommended Priority Activities	Activities for Costing
	manage hiring of medical staff from outside the country	
Pre-service Education	1. Existing bursaries refocused onto rural candidates 2. Preparatory science courses provided for potential rural candidates not otherwise qualified 3. Post-graduate preceptorship program in rural areas established to support nursing students to become practice-ready before deployment—mentorship and preceptorship guidelines developed, mentors trained in preceptorship and mentoring skills, preceptorship sites selected 4. Orientation course instituted for health workers coming from outside Lesotho 5. Schools supported to expand infrastructure at the schools NEPI has not done and maintain at all schools 6. Schools supported to maintain competency-based education: National Nursing and Midwifery Education Committee established to institutionalize competency-based education (TOR developed, TA recruited, Community Needs Assessment conducted, Committee trained in developing community driven and competency-based curricula) 7. Schools supported to integrate into curricula competencies that have been typically taught through in-service training	1. Bursaries for rural nursing candidates 2. Bursaries for rural midwife candidates 3. Schools supported to maintain competency-based education 4. Orientation course for non-Basotho health workers 5. Post-graduate preceptorship program 6. Infrastructure expansion at non-NEPI supported schools

Intervention	Recommended Priority Activities	Activities for Costing
	8. Schools supported to increase faculty numbers	
Professional Councils	1. Consultants hired to help develop strategic plan for Doctor/other cadre Council 2. Nursing, Doctor Councils draft practice standards; reviewed by expert 3. Consultant hired to assess Higher Education Council's needs in order to increase capacity to provide licensure function (more staff, database, development of policy and guidelines) 4. Consultant hired to assess Doctor and Nurse Councils' needs in order to oversee CE providers 5. Train secretariats in lobbying and advocacy, leadership and management 6. Consultant hired to assess and design method for Doctor and Nurses Councils to support MOH in providing quality control of health professionals 7. Council working groups develop accreditation policy for entry requirements, recruitment, certification, examinations, competencies developed, and accreditation tools developed; expert reviews policy and tools	1. Strategic plan development 2. Draft practice standards 3. Higher Education Council assessment 4. Strengthening Council oversight capacities 5. Strengthening Council's lobbying, advocacy, leadership and management capacities 6. Design of quality control support 7. Development of accreditation policy 8. CEIP Nursing launch

16. Appendix 9: Nursing Directorate Allowances Proposal

1.1 RETENTION OF NURSES IN THE HARD TO REACH AREAS

Amongst the seventy three (73) Health Centers owned by the government, thirty one (31) of them are in the very hard to reach areas and therefore less attractive to the nurses to work in such Health Centers. Among other things, it seems improper for these nurses to earn salaries exactly the same as those of nurses working in the low lands, given the difference of environment and basic facilities. (See attached PSC Minutes)

Some Health Centers are not accessible by roads and therefore making life even more difficult especially in times of emergencies.

1. Review of allowances for the 31 hard to reach Health Centers

- To earn M600.00 hardship allowance while the other 42 HC can remain at M275 as is the current practice.
- Nurse in charge of the clinic to earn M250.00 responsibility allowance
- M100.00 call allowance per call taken, which will be verified with the records by the Public Health Nurse
- **Fuel** – 48Kg of gas half yearly and 4 bags of coal per month/nurse

Hospital Based Nurses

1. Night duty allowance – 25% of one's salary/per month of night duty done
2. Call allowance – 25% of one's salary/month of call taken
3. Responsibility allowance of M250.00/month for the nurse in charge
4. Airtime – M250.00/month for the nurse in charge

Common allowances

1. Settlement allowance which should be reinforced
2. Away from home allowance of M300.00/month which will be calculated by distance (e.g. an officer who is transferred 50km from his origin/home)
3. Review of the Risk allowance for those dealing with unpredictable patients e.g Mental patients from the current M6.00 to M250.00 per month

Policy level

1. M250.00 airtime monthly for head clinical nursing services and Head Public Health Nursing services