World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2013

LESOTHO

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ABBREVIATIONS

AFRO	:	Regional Office for Africa (of WHO)
AIDS	:	acquired immunodeficiency syndrome
BCG	:	Bacille Calmette-Guerin
CCS	:	Country Cooperation Strategy
CDS	:	Communicable Diseases and Surveillance
DFID	:	Department for International Development (of United Kingdom)
DP	:	development partners
EHA	:	Emergency and Humanitarian Action
EPI	:	Expanded Programme of Immunization
EU	:	European Union
FCH	:	Family and Community Health
GDP	:	Gross Domestic Product
GFATM	:	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMP	:	Good Manufacturing Practices
GSM	:	WHO Global Management System
HIV	:	human immunodeficiency virus
HQ	:	Headquarters (of WHO)
HSD	:	Health Systems Development
IMCI	:	Integrated Management of Childhood Illness
IST	:	Intercountry Support Team (of WHO)
IVD	:	Immunization and Vaccine Development
LDHS	:	Lesotho Demographic and Health Survey
MDG	:	Millennium Development Goal
MIS	:	Management Information System
MoHSW	:	Ministry of Health and Social Welfare
MTSP	:	Medium Term Strategic Plïan
NCD	:	noncommunicable disease
NGO	:	nongovernmental organization
OPV	:	oral polio vaccine
PHC	:	primary health care
PRS	:	Poverty Reduction Strategy
RB	:	Regular budget
RH	:	Reproductive Health
SWAp	:	sector-wide approach

TB	:	tuberculosis
TT	:	tetanus toxoid
UN	:	United Nations
UNDAF	:	United Nations Development Assistance Framework
UNICEF	:	United Nations Children's Fund
USAID	:	United States Agency for International Development
WB/IDA	:	World Bank/International Development Association
WCO	:	WHO country office
WHO	:	World Health Organization

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

EXECUTIVE SUMMARY

WHO has been providing technical assistance to the government of Lesotho and its development partners for health development since October 1966. The Country Cooperation Strategy (CCS) defines the strategic framework for the work of WHO with a country and clarifies the Organization's strategic priorities in supporting the country's national health and development agenda. The Lesotho Country Cooperation Strategy (CCS) articulates strategic priorities for WHO's collaborative work in Lesotho for the period 2008-2013. The strategic priorities are rooted in WHO policies and strategies, aligned with national priorities and harmonized with the work of the United Nations and other partners in Lesotho.

The WHO global and regional policy frameworks have provided vital directions for the CCS 2008-2013. The Eleventh General Programme of Work (GPW), currently the highest policy document for WHO, provides a global health agenda that is aimed at all health agencies internationally. WHO, as the global health organ of the United Nations, contributes to this agenda by concentrating on its core functions which are based on its comparative advantage. The regional priorities have been expressed in the "Strategic Orientations for WHO Action in the African Region 2005-2009". In order to ensure effective support for all Member States of the UN, the WHO Country Focus Policy gears the operations of WHO to the needs of each country.

In the Kingdom of Lesotho, although significant political, economic and social development has been made since its independence in 1966, HIV and AIDS remain the foremost challenge to human and economic development, with a national adult HIV prevalence rate of 23% (in 2005). The country is an economically resource-poor country with a Gross Domestic Product (GDP) estimated at US$ 5 124 billion (2005) and a GDP per capita of US$ 296 (2005). The government of the Kingdom of Lesotho has acknowledged the severity of the situation and there is renewed political and financial commitment to conquer the epidemic and reverse the devastating consequences on the population of Lesotho. Other principal health development challenges that are being addressed through the MoHSW Strategic Plan 2004/5 – 2010/11 include:

(a) Reducing under-five and maternal deaths by further accelerating quality health services to children and mothers;

(b) Containing the increasing trend of major noncommunicable deseases (NCDs) and reversing the trend by addressing health risks;

(c) Ensuring equitable and sustainable access to safe water supply and sanitation, and promoting environmental and occupational health;

(d) Strengthening epidemic alert, and emergency preparedness and response to effectively tackle public health emergencies;

(e) Bolstering the health system's responsiveness for equitable access to quality health care, decentralization, human resource development and health-care financing;

(f) Coordinating the alignment and harmonization of development partners' contribution and support to the health sector.

Many development partners and donor are supporting the government in the health sector. The assistance from the development partners, including WHO's technical and financial support, over the last decade has consistently been a significant part of the health sector expenditure. On ownership and mutual accountability, WHO is supporting efforts in the country to strengthen government ownership and leadership of health sector issues, in line

with the "Paris Declaration on Aid Effectiveness, 2005". The MoHSW has developed a code of conduct that defines the expectation of the ministry and those of the partners for smooth relations and operations in the partnership and has established a number of MoHSW-partners' fora and coordination instruments. As a mechanism to strengthen the alignment and harmonization of technical and financial support as well as foster mutual accountability of government and the partner organizations, a sector-wide approach (SWAp) mechanism is in place, although it is currently in its early phases. The Lesotho UNDAF 2008-2012, which reaffirms the commitment of the UN Country Team to support the efforts of the government and people of Lesotho toward realizing Lesotho's national Vision 2020 goals, provides the framework for the harmonization of the work of UN agencies in the country.

The first WHO Cooperation Strategy (2004-2007) focused on strengthening the national health system; tackling HIV/AIDS, tuberculosis and other communicable diseases; strengthening family and community health; tackling noncommunicable diseases; and advocacy for health. WHO is working with the MoHSW and partners to make a significant difference in each of these areas and to the overall health status of the country. A review of the current CCS noted that WHO has indeed firmly established itself as the country's principal source of credible, trusted and evidence-based advice and technical support in the health sector. However, the weaknesses in the implementation of the current CCS include the limited number of staff and the limited funds available to the country office.

The development of this CCS involved extensive discussions with all key stakeholders, including the Ministry of Health and Social Welfare and the development partners in Lesotho. The overarching principles of the Country Cooperation Strategy 2008-2013 are a commitment to primary health care, the human right to health and equity. The CCS strategic agenda comprises five strategic priorities, namely**:**

(i) Strengthen the control of HIV/AIDS and tuberculosis;

(ii) Strengthen family and community health;

(iii) Enhance capacity for the prevention and control of major communicable and noncommunicable diseases;

(iv) Strengthen health systems and

(v) Foster partnerships and coordination for national health development. These strategic priorities are aligned with key national and international priorities, including the Millennium Development Goals, the Lesotho Vision 2010 and the MoHSW Strategic Plan 2004-2005 to 2010-2011.

In order to ensure effective implementation of the strategic priorities for 2008-2013, the CCS document also outlines the implications of the CCS with respect to the core competencies and knowledge management capacity requirements of the WHO country office in Lesotho, as well as the integrated programmatic and technical support needs from the WHO Intercountry Support Team, Regional Office and Headquarters.

The Country Cooperation Strategy 2008-2013 will be implemented through three consecutive biennial programme budgets and workplans. Within the framework of the WHO results-based management system, these workplans include a robust monitoring framework of intervention-specific indicators. Periodic in-depth evaluations of select programmes as well as thematic evaluations to determine their outcomes and impact on national health development will be undertaken, when necessary, in order to ensure that the WHO Country Cooperation Strategy contributes significantly to the achievement of better health for the people of Lesotho.

SECTION 1

INTRODUCTION

The Country Cooperation Strategy (CCS) defines the strategic framework for the work of WHO with a country and clarifies the proposed roles and functions of WHO in supporting the country's national health and development agenda. The document presents a basis for developing the "WHO one country plan and budget" and is used for mobilizing human and financial resources for strengthening WHO support to countries. This CCS articulates strategic priorities for WHO's collaborative work in Lesotho for the period 2008–2013.

The first WHO CCS for Lesotho was formulated for the period 2004-2007. This Second Generation CCS brings improvements in the quality of the CCS processes and document – involving better analyses of challenges and opportunities at country level, improvement in the selectivity and alignment of the strategic agenda (strategic priorities and approaches) with national priorities as well as harmonization with the priorities of partners in Lesotho. The CCS for 2008-2013 was developed through an interactive consultation and planning process involving government officials, development partners and other stakeholders.

Under the leadership of the WHO representative, the CCS development team conducted in-depth reviews and analysis of key health sector issues, including the factors that influence the health status of the Basotho, held broad consultations and conducted advocacy for the CCS 2008-2013 preparation process, and secured the active involvement of key stakeholders, including the MOH&SW, UN partners and WCO staff. The consultation process also involved the WHO Regional Office for Africa (AFRO) to ensure that country specific needs and potentials are in line with regional priorities. All efforts were also made to ensure that the strategic agenda for the work of WHO in Lesotho is aligned with key national and international development priorities, including the United Nations Development Assistance Framework (UNDAF) and the Millennium Development Goals (MDGs) (see Annex I for details of the CCS development process).

The strategic priorities and approaches which form the new strategic agenda have taken into account the demographic and epidemiological contexts, emerging health issues and changing health priorities in the country, as contained in the Lesotho Vision 2020 and the Lesotho National Health Strategic Plan 2004–2011. Additionally, the WHO Eleventh GPW 2006-2015 and the WHO Medium Term Strategic Plan (MTSP) 2008-2013 have provided new directions for the Organization's engagement with countries, and these were taken into account.

As an organization-wide reference for country work, the CCS serves as a planning, budgeting and resource allocation guide. In a two-way process, it feeds into, and takes into consideration, both the General Programme of Work and the Programme Budget. WHO will fund and operationalized the CCS for 2008-2013 through three consecutive WHO biennial budgets and workplans.

This Country Cooperation Strategy document presents an analysis of information on country health and development challenges, development assistance, aid flow and partnerships for health development, current levels of WHO cooperation and support, and the WHO policy framework including global and regional directions. It also outlines WHO's strategic priorities and the main focus that would be the focus of WHO's work during the period 2008-2013, and identifies their implications for the work of the WHO Secretariat at the country, regional and HQ levels toward contributing to the achievement of better health for the people of Lesotho.

SECTION 2

DEVELOPMENT CHALLENGES

2.1. SOCIO-DEMOGRAPHIC SITUATION

Lesotho, a small country with a surface area of 30 355km2, is landlocked and surrounded by the Republic of South Africa (RSA). It is a mountainous country more than 80% of which is 1 800m above sea level. This presents difficult topography and seasonal severe winters that are a challenge to health service delivery. Administratively, Lesotho is divided into ten administrative districts each headed by a district administrator.

Table 1 : Key Socio-economic Development Indicators

INDICATEURS	VALUE
Population Size (de jure) (1996)	1 960 069
Annual Population Growth Rate (%) (2006)	0.88
Population Urbanised (%) (1996)	17
Life Expectancy at Birth (2004)	35.2
GDP per capita (PPP, US$) (2004)	2,619
GDP (1995 constant prices) Maloti million (2005)	4529.3
GDP per capita (US$), (2005)	$ 296
GNI (2005)	$ 830.7
GNI per capita (US$) (2005)	$ 349.5
External Debt as % of GNP (2003)	44
Population below poverty line (%) (2005)	50.2
Enrolment Rate for Boys (%) (2004)	80.6
Enrolment Rate for Girls (%) (2004)	85.9
Adult Literacy Rate (%) (2002/3)	82
Human Development Index Rank (out of 177 countries) (2004)	149

Source: BOS 1996, BOS 1997, LDHS 2004

The population of Lesotho, estimated at 1.96 million, now has a declining annual growth rate (from an annual growth rate of 1.5% during the inter-censual period of 1986-1996 to 0.08% between 1996-2006). This decline in growth has been attributed in part to increasing HIV/AIDS deaths.

Politically, Lesotho has a relatively stable multi-party democracy. The country has a modified constitutional monarchy with a Prime Minister as the head of Government (with executive authority) and a King as the head of State (with no executive and legislative powers). The Parliament of Lesotho is bicameral; it has two chambers - the Assembly and the Senate. Constitutional reforms have since restored political stability; peaceful parliamentary elections

were held in 2002. Because of the improving political environment, increasing trust and recognition from international partners has enhanced opportunities for support towards health and economic development.

Lesotho is an economically resource-poor country with a Gross Domestic Product (GDP) estimated at US$ 5.124 billion (2005) and a GDP per capita of US$ 296 (2005). A large proportion of the population (76.2%) resides in rural areas where poverty is most prevalent. The economy of the country depends mainly on subsistence farming, manufacturing and remittances from migrant labour based in South African mines. The level of poverty remains high and about 50.2% of the population is living with less than $1 a day (see Table 1). This is further compounded by a high level of unemployment: about 45% (2002) unemployment rate, although the adult literacy rate is high (82%). In response to these socioeconomic challenges, the government of Lesotho has developed the *Lesotho Vision 2020* and the Lesotho *Poverty Reduction Strategy* (PRS) that guide the government's efforts toward improving the current socioeconomic situation.

2.2 BURDEN OF HIV/AIDS AND TUBERCULOSIS

HIV and AIDS remain the foremost challenge to human and economic development in Lesotho. The first case was reported in 1986 and data based on HIV sentinel surveillance surveys conducted biannually among pregnant mothers indicates that HIV prevalence has been on the rise. HIV prevalence in Lesotho remains high, with prevalence among antenatal clinic attendees of 38% in the 25–29-year-age group in 2005 (Ministry of Health and Social Welfare (Lesotho), 2005). The national adult HIV prevalence rate was 23.2% (see Table 2), the third highest in the world. HIV and AIDS accounted for 12% of all female and 11% of all male admissions in 2006. One in every three (31%) of all institutional female deaths and one in every four (25%) of all institutional male deaths in 2006 were directly linked with HIV/AIDS. Also, about one in every ten (11%) of institutional deaths in children were also directly due to HIV/AIDS[1].

Tuberculosis is a major public health problem in Lesotho. The country has the fourth highest estimated TB incidence (696 TB patients per 100 000 population) in the world (WHO Global TB report 2007). TB notification is rising at the rate of 10%-14% annually with 13 369 (all forms) and 4 024 (new smear positive) TB cases detected in 2006 – which translates to 69% case detection rate compared to WHO target of 75%. Pulmonary tuberculosis was the main cause of male admissions in Lesotho (15% of the 12 525 male admissions and 8% of all female admissions in 2006). With a TB-HIV co-infection rate of 73% and the emergence of multi-drug resistant tuberculosis (MDR-TB) in the country (60 cases on treatment as at December 2007), a huge strain has been put on the existing health infrastructure.

Table 2: Key Health and Development Indicators

INDICATEURS	VALUE
Adult (15-49) prevalence of HIV (%) (2005)	23.2
Underweight children under 5 years (%) (2004)	19.8
Infant mortality rate (per 1000 live births) (2004)	91
Under-five mortality rate (per 1000 live births) (2004)	113
Maternal mortality ratio (per 100 000 live births) (2004)	762

Source: BOS 1996, BOS 1997, LDHS 2004

[1] Source: MoHSW (2007). Health Statistical Tables 2006.

Major challenges to effective scale-up and delivery of HIV/AIDS and TB interventions include severe and acute shortage of health staff and very weak health systems (procurement and supplies management, referral, transport, supervision, monitoring and evaluation). Others are significant disparities in access to ART between different districts, inadequate patient and programme monitoring traceable to the two major challenges:- access to HIV services by TB patients and access of TB services by HIV-positive individuals concerning HIV diagnostic services; and the issue of access to CD4 count and PCR in children .

The Government has acknowledged the severity of the situation and there is renewed political and financial commitment to conquer the epidemic and reverse the devastating consequences on the population of Lesotho. A National AIDS Commission (NAC) responsible for the overall coordination of the multi-sector response to HIV/AIDS is now in place, and a National HIV/AIDS control strategy and guidelines have been developed in support of training and other capacity building efforts. The Know Your Status (KYS) initiative to encourage testing has largely been successful, though the target has not been reached. HIV-positive individuals also have access to antiretroviral drugs (ARVs). However, of the 42 000 people in need of urgent ARV, only 21 000 (50%) are on treatment.

The laboratory services for TB are being strengthened with the opening of a renovated central TB laboratory with state-of-the art capacity for TB culture and Drug Susceptibility Testing (DST) facilities at the Queen Elizabeth II hospital at Maseru. In addition, the quality assurance for lab services is being strengthened through the development of the guidelines for lab network External Quality Assurance for smear microscopy and the TB lab manual for lab staff.

Although treatment success has improved from 52% in 2003 to 67% in 2004, it still remains below WHO recommendation of 75-85%. Quality-assured TB-drugs have been secured through the assistance of the Global Drug Facility (GDF); however, the capacity to maintain a regular and uninterrupted drug supply for TB remains a challenge. In addition, lack of transport has also been noted to be a key hindrance to accessing TB and HIV/AIDS services for referred patients because transport costs are unaffordable to the majority of the population in rural areas. The coordination mechanisms between the MoHSW and NAC are weak, and there is a weakened health sector role within the multisectoral response to HIV control in Lesotho.

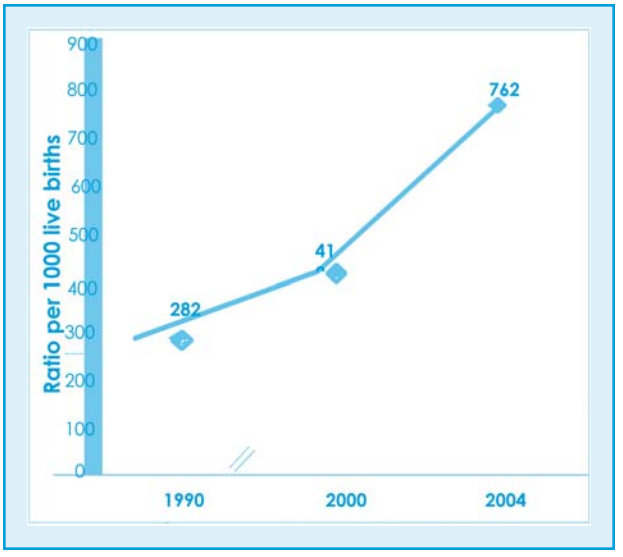
2.3 FAMILY AND COMMUNITY HEALTH

Maternal Health: Reducing the burden of maternal and under-five illnesses and deaths is vital to the socioeconomic and health development of Lesotho. The country has one of the highest maternal mortality ratios (MMR) in the African Region. The MMR has almost doubled; from 419/1000 live births in 2000 to 762/1000 live births in 2004. Inadequate maternal health services at and around birth are one of the contributing factors to high maternal mortality, along with other health system weaknesses. The leading causes of maternal mortality in Lesotho are haemorrhage, abortion, injuries, eclampsia, sepsis and obstructed labour.

Most of the above causes of morbidity and mortality affecting women are largely preventable and amenable by simple interventions. The main causes of female admissions in 2006 were abortions (12%), HIV/AIDS (12%) and pulmonary tuberculosis (8%)[2]. Anaemia, probably linked to the high rate of abortion, was one of the top ten causes of deaths, and was responsible for 3% of all deaths in 2006. A reproductive health policy has been developed. However, improving women's access to quality health services and addressing the underlying socio-cultural factors are major challenges.

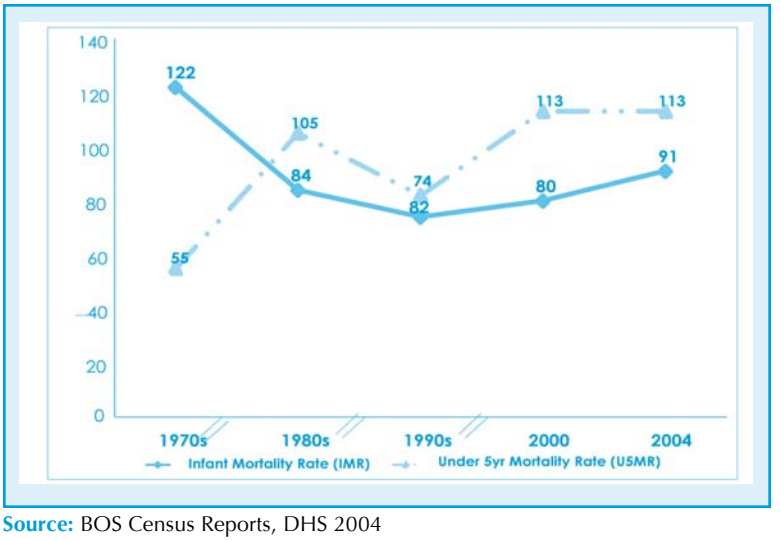
[2] Source: MoHSW (2007). Health Statistical Tables 2006.

Figure 1: Maternal Mortality rates in Lesotho, 1990-2004



Source: BOS Census Reports, DHS 2004

Figure 2: Infant and Child Mortality rates in Lesotho, 1970-2004



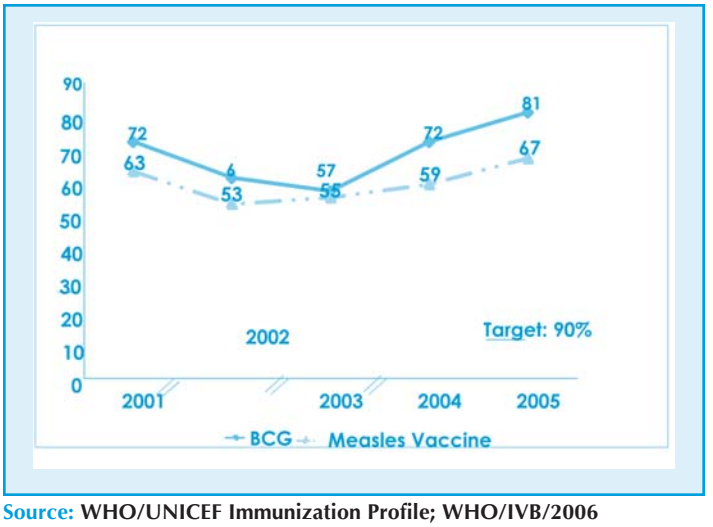
Source: BOS Census Reports, DHS 2004

Child and Adolescent Health: Adolescents (10-19 years) constitute 21.8% of the population (Morojele, 1994). They reach adulthood with little knowledge about reproductive health. The majority of youths (aged between 10 and 25 years) have no correct knowledge about sexually-transmitted infections, including HIV/AIDS, and risky sexual behaviour is common among them. The 2004 LDHS results indicate that one in five women in the 15-19 age group have had at least one birth (15 percent) or are pregnant with their first child (5 percent), and the proportion of teenagers who have begun childbearing increases from 2 percent at age 15 to 44 percent at age 19. The failure of formal and informal education in

dealing with sensitive health issues and cultural sensitivities are key factors that prevent adolescents from making full use of the health-care system. An adolescent health policy has been developed to guide interventions aimed at improving adolescent health status.

Child health status that had shown significant improvements in the 1980s is now declining: under-five mortality has doubled from 55/1000 live births in the 1970s to 113 in 2004. Infant mortality has followed a similar trend, especially in the last decade. The most frequent single cause of institutional deaths in children was diarrhoea, which accounted for 22% of all deaths followed by pneumonia (21%), malnutrition (13%) and HIV and AIDS (11%). Integrated Management of Childhood Illness (IMCI), both community-based and facility-based, is in the process of scaling up. Measures to address childcare in general and neonatal care in particular need to be institutionalized.

Figure 3: Lesotho: BCG and Measles Vaccine, 2001-2005



Source: **WHO/UNICEF Immunization Profile; WHO/IVB/2006**

2.4 IMMUNIZATION AND VACCINE-PREVENTABLE DISEASES

The immunization programme in Lesotho has been unable to meet its target of reaching at least 90% of children born every year. The trend of immunization coverage between 2001 and 1005 indicated that the national Expanded Programme on Immunization (EPI) initiative does not have the capacity to reach 90% of children with BCG (coverage rate ranged from 57% to 81%) and measles (coverage rate ranged from 53% to 67%). However, in 2005, Lesotho achieved certification standard surveillance and because the last polio case in Lesotho was in the 1980s, the African Regional Certification Commission accepted the national polio certification document.

The country needs to intensify efforts for increasing access for safe immunization and to sustain high quality surveillance against all vaccine-preventable diseases. New vaccines introduction should also be accelerated.

Reducing measles mortality and morbidity is another challenge for Lesotho as sporadic outbreaks of measles epidemic occur. However, the measles vaccine 'keep-up' campaign, targeted at children less than five years, conducted in October 2007, may substantially improve the situation. The country needs to sustain this feat by increasing routine immunization coverage against measles and providing second opportunities through periodic follow-up

campaigns. The Reach Every District (RED) approach would need to be scaled up nationwide, as a strategy to improve routine immunization coverage and integrate other maternal and child survival interventions with immunization services.

2.5 DISEASE SURVEILLANCE AND EPIDEMIC ALERT AND EMERGENCY RESPONSE

The current disease surveillance system is being strengthened and meaningful integration of communicable and noncommunicable disease surveillance is necessary at all levels. In spite of the current focus on tackling the huge burden of communicable diseases in the country, it is vital to strengthen the implementation and effectiveness of the national epidemic alert and emergency response capacity.

2.6 NONCOMMUNICABLE DISEASES – AN INCREASING BURDEN

A review of disease pattern demonstrated two epidemics – one of rapidly rising infectious diseases (mainly HIV, TB and STIs) and another of noncommunicable diseases. The major noncommunicable diseases are cardiovascular diseases, diabetes, accidents / injuries and cancers. In 2006, diabetes and hypertension were responsible for 7% of all female admissions, while diabetes, head injury and traffic accidents accounted for 8% of all male admissions. Three noncommunicable diseases (heart failure (4%), stroke (4%) and diabetes (2%) caused 10% of all institutional female deaths in 2006. Epilepsy and depression also appeared as important mental illnesses that accounted for significant hospital visits. In children, malnutrition accounted for 13% of all institutional deaths in children.

In response to the increasing prevalence of NCDs, the MoHSW, with the support of WHO and other partners, has recognized the National Hypertension, Diabetes, Mental Health and Tobacco Days as important platforms for sensitizing the public and advocating with policy-makers on the need to raise the profile of NCDs on the national development agenda. Shifting the conventional mode of addressing NCDs from the tertiary care level to primary care and with a focus on risk reduction is a necessary but difficult approach for the prevention and control of NCDs. A national mental health policy and strategic plan have been developed and a social welfare policy and strategic plan are in place. However, the capacity for effective implementation remains a challenge.

2.7 ENVIRONMENTAL HEALTH

Lesotho has been making excellent progress towards providing access to safe drinking water for all its citizens. Access to safe drinking water is about 95% in urban areas. However, access is low (56%) in rural areas. The national target for the proportion of the population without access to safe water by 2015 is 19%. The challenge of ensuring the provision of a regular supply of drinking water to the entire population (especially in rural areas where the majority of the people live) remains a daunting one. Although improved drinking water supplies have contributed to reducing diarrhoeal diseases, diarrhoea was the single most frequent cause of admissions for children below 12 years of age in 2006. Diarrhoeal diseases (some of which may be attributable to HIV/AIDS) were responsible for one in every five (22%) institutional deaths in children under 12 years of age in 2006.

Management of waste including clinical waste, solid waste and domestic and industrial wastewater is necessary at required and optimal levels to ease the substantial pressure on the environment that has also led to public health risks. Improper management of clinical waste from a rising number of hospitals is also an issue of public health concern. Only a small proportion of wastewater receives any kind of treatment prior to its discharge. The management of clinical waste including sharp wastes in facilities and other places is also a challenge that needs to be addressed.

On food safety, the capacity to effectively monitor food manufacturers and suppliers to ensure the bacteriological and chemical safety of food as well as quality assurance is limited. The importance attributed to food safety remains inadequate and consequently consumer awareness that could be brought to bear on quality of food production and supply is poor. Mass public awareness on food safety covering the gamut from "farm to fork" is required, and this will take considerable effort on the part of the authorities concerned.

2.8 HEALTH SYSTEM'S RESPONSE

With the aim of improving access to quality promotive, preventive, curative as well as rehabilitative services, the health system's response to the country's needs has improved over the years. However, meeting the entire gamut of health needs and expectations of the people, especially the poor and the disadvantaged, is a daunting challenge. The response has mainly been in terms of policy reforms, management and delivery of health services, human resource management and health financing, medicines and health technologies, information for health planning and management, and strengthening of partnerships for health.

Health System Reform: The MoHSW has put in place, as part of a broader public sector reform process, a 10-year three-phase health systems reform (HSR) programme (2000 to 2009) to redress the declining health and social welfare indicators, the declining investment in health and social welfare and the impact of the escalating HIV/AIDS pandemic on service delivery. In line with the reform process, the MoHSW developed the health and social welfare policy (2004) and the sector plan 2004-2005 to 2010-2011, within the Poverty Reduction Strategy (PRS) and the overall development framework of the country, as articulated in Lesotho's National Vision 2020. The goal of the health and social welfare sector, under Vision 2020, is to have a healthy population, living a quality and productive life by 2020. Towards these goals, the MoHSW and other stakeholders have defined an Essential Health Package (EHP) to be delivered at the different levels of care. WHO provided technical and advocacy support for each step of the health system reform process.

The priorities of government as contained in these policy tools are shown in Box 1 below.

Box 1: Government of Lesotho Health Sector Priorities

Lesotho National Vision 2020	Poverty Reduction Strategy (Health Sector priorities)	Lesotho MoHSW Strategic Plan 2004/5 – 2010/11
• Good quality and affordable health for all. • Adequate incentives to retain health rofessionals. • Traditional and modern medicines will be well integrated. • All Basotho will have access to safe drinking water and basic sanitation. • There shall be no new HIV and AIDs infections and there will be care and support for orphans and HIV infected and affected.	• Promoting access to quality and essential health care by developing clear policies. • Good quality and Improving health infrastructure, equipment maintenance and supplies. • Good quality and Improving capacity and health management systems. • Good quality and Strengthening disease prevention programmes.	• Improving maternal and child health outcomes and other public health interventions (Health Education and Promotion, Child Survival: Immunizations, Nutrition and management of common childhood illnesses, and Environmental Health). • Communicable disease control, including universal access to HIV and AIDS and STI and TB treatment, prevention, care and support, as well as major NCDs. • Sexual and Reproductive Health. • Essential clinical services, including noncommunicable disease control (diabetes, hypertension, skin infections; oral health and mental health). • Health system development, including restricting of MoHSW, development of human resources for health, health care financing and strengthening district health system through restructuring and decentralization.

Management of Service Delivery: The improving countrywide network of healthcare facilities has enhanced physical access to health services, particularly in respect of primary health care. The two major health service providers in Lesotho are the Government and Christian Health Association of Lesotho (CHAL). The network of health facilities within the country consists of 17 general hospitals, specialized hospitals, a mental hospital (Mohlomi), leprosarium hospital (Botsabelo), HIV/AIDS centre (Senkatana) and a HIV/AIDS paediatric centre (Baylor Center of Excellence). The table below shows the total number of health facilities in Lesotho by proprietor.

Table 3: Number of Health Facilities by OWNERSHIP

Proprietor	Number of Hospitals	Number of Health Centres	Total Number of Facilities
GOL	12	76	88
CHAL	8	72	80
RED CROSS	0	6	6
PRIVATE	1	30	31
GRAND TOTAL	**21**	**184**	**205**

Source: List of Health Facilities (Draft MoHSW Report: 2007)

Human resource management: A major concern of the government has been the human resource (HR) crisis, especially for health service provision in Lesotho, whereby a large number of trained clinical staff is being lost to South Africa and overseas countries. Repeated health workforce assessments also revealed an uneven distribution of the health workforce. While the majority of the population lives in rural areas, most health professionals work in urban areas or close to major cities. The MoHSW Human Resources Development and Strategic Plan (2005-2025) identifies the HR needs and gives guidelines on the interventions to be employed to attain the required HR needs.

Extensive efforts are being employed to ensure HR attraction and retention, and a more specific short-term emergency human resource plan, currently under development, will provide clear directions for immediate actions to addres the HR crisis.

Healthcare Financing: The total health expenditure was estimated at M343 per capita (WHO NHA estimates, 2005). This is far below the minimum expenditure for scaling up a set of essential health interventions in the country and prospects for its substantial increase are limited. An effective increase in the public health allocation to meet the minimum needs of the population is a challenging task.

Medicines and health technologies: In order to ensure that safe and efficacious drugs are available when needed, Drugs and Therapeutic Committees (national and district) have been established and trained. Field-testing of a training manual on management of drugs at lower levels was successfully undertaken and the revision of the training manual on the management of drugs at health centre level has been completed. The essential medicines list and standard treatment guidelines have been completed. Monitoring compliance with good manufacturing practices (GMP) in the pharmaceutical sector and monitoring the quality and safety of drugs in the market has been mandated to the National Regulatory Authority. Having a functional National Regulatory Authority equipped with essential resources and expertise is vital for meeting the challenge of ensuring compliance with GMP and post-marketing surveillance in Lesotho.

Information for health planning and management: In order to ensure adequate use of available health sector information for action, the health management information system is being strengthened. WHO supported the setting up of GIS equipment for supporting the Health Information Management Systems (HMIS).

To ensure a better future, Lesotho is striving to enhance the health status of its people by focusing on controlling a complex mix of health problems through improving the health infrastructure, reducing inequity and urban- rural differences, and fostering partnerships among relevant stakeholders. However, there are major health development challenges in the health sector (see Box 2 below), and a concerted effort by the Government and development partners will be required to overcome these challenges.

- **Reducing under-five and maternal deaths by further accelerating quality health services to children and mothers.**
- **Combating major communicable diseases including multi-drug resistant TB, and the spread of HIV/AIDS.**
- **Containing the increasing trend of major NCDs and reversing the trend by addressing health risks.**
- **Ensuring equitable and sustainable access to safe water supply and sanitation, and promoting environmental and occupational health.**
- **Strengthening epidemic alert, and emergency preparedness and response to effectively tackle public health emergencies.**
- **Bolstering the health system's responsiveness for equitable access to quality health care, decentralization, human resource development and healthcare financing.**
- **Coordinating the alignment and harmonization of development partners' contribution and support to the health sector.**

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

WHO is supporting the government within an environment of many development partners (DPs) with different types of funding mechanisms for health development. In addition, national and international NGOs are contributing significantly to the development of health in the country.

3.1 DEVELOPMENT ASSISTANCE

The assistance from the development partners over the last decade has consistently been a significant part of the health sector expenditure. The 2005-2006 and 2007-2008 Medium-Term Expenditure Framework (MTEF) plan formed the basis for current donor support to the health sector. Financial contribution from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI) constitutes an important component of the aid flow to Lesotho. GFATM funds are channeled through the Government and NGOs, whereas GAVI funds are allocated only to the government. With the approval of the TB component in Round-5, and HIV/AIDS in Round-6, the approved support from GFATM since 2004 will now be about US $9.7million. In addition, funds will be available in the country from the Vaccine Fund of the GAVI, which will enhance the responsiveness of the health system (see Table 4).

Table 4: Financial Support (US$) from Health Partners 2004/05–2006/07

Partners	2004-2005	2005-2006	2006-2007
ADB	328 555	812 012.4	1 832 405
World Bank	1 818 510	1 121 614	459 650.4
EU	331 161	No data	No data
Ireland AID	1 820 629	874 104	1 390 613
UNICEF	562 137.7	418 818	No data
WHO	209 122	400 606	3 285 714
Global Fund	4 003 794	4 463 755	1 275 373
DFID/SADC	250 955	132 211.9	No data
NORAD	No data	273 314.3	104 547
OPEC	No data	150 213	1 567 966
TOTAL	9 324 863	8 646 649	8 243 755

NB: Information based on actual annual receipt of funds; Source: 2004/05 and 2005/06 (HSR Audit reports) 2006-2007 MoHSW Budget Framework.

3.2 PARTNERSHIP AND DEVELOPMENT AID COORDINATION

Many development partners and donors are supporting the government in the health sector. Lesotho has a large NGO sector, mainly the Christian Health Association of Lesotho (CHAL), which is involved increasingly in providing primary health care. The private sector is diverse, ranging from modern facility-based state-of-the-art services to indigenous medical practitioners, village pharmacists and non-qualified practitioners. The development partners and donors support various areas of the sector's programmes and activities. A development partner and donor mapping of these areas are shown in Annex II. The major priorities of the development partners are shown in Table 5 below.

Table 5: Development Partners' Priorities

AREA OF SUPPORT	DEVELOPMENT PARTNERS
General Management (excluding HR) EU, BUMC Kellogg, ADB, MCC	WHO, Irish AID, World Bank, GLB Fund,
Decentralization	WHO, Irish AID, World Bank, MCC
Monitoring and Evaluation	WHO, Irish AID, World Bank, MCC
Medical Waste Management	WHO, World Bank, MCC
Human Resources (Also includes short-term trainings	WHO, Irish AID, UNICEF, USG, World Bank, BUMC Kellogg, ADB, UNFPA, MCC
Curative Health Care	WHO, World Bank, USG, GLB Fund, MCC
Communicable Diseases	WHO, Irish AID, USG, GLB Fund,
Noncommunicable Diseases	WHO
Disability Services	WHO, NORAD
Social Welfare Services	USG, GLB Fund, EU,
Public Health Services	WHO, UNICEF, USG, GLB Fund, EU,

On ownership and mutual accountability, WHO is supporting efforts in the country to strengthen government ownership and leadership of health sector issues, in line with the "Paris Declaration on Aid Effectiveness, 2005". The health partners are coordinated by the MOHSW through the Health Planning and Statistics Department (HPSD). The MoHSW has developed a *code of conduct* that defines the expectations of the ministry and those of the partners for smooth relations and operations in the partnership. In order to improve government ownership and leadership role, a Partners-MoHSW Forum is now in place. This government-led mechanism facilitates the exchange of information and policy dialogue between development partners and the government on all matters related to the health sector. The Forum is headed by the Permanent Secretary of the MoHSW, and includes in its membership senior-level government and development partner officials.

Other fora through which the health partners share ideas and experiences and discuss challenges include the UN Expanded Theme Group on HIV and AIDS and the AIDS Country Coordinating Mechanism (CCM) for the Global Fund to Fight AIDs, Tuberculosis and Malaria. The meetings of these fora are convened monthly. There are two co-chairs for all health partners. One chair represents the UN agencies (UNICEF, previously WHO) and the other represents the other partners (Irish AID). The MOHSW is working towards developing the terms of reference for these coordinating committees. In addition, there are other mechanisms

to coordinate resources from different agencies. The Country Coordination Mechanism (CCM) is actively involved in policy-making and monitoring of the GFATM activities and an Interagency Coordination Committee is functioning for GAVI-funded activities.

Harmonization of donor support and alignment with national plans and strategies is essential for aid effectiveness. As a mechanism to strengthen the alignment and harmonization of technical and financial support as well as foster mutual accountability of government and the partner organizations, a sector-wide approach (SWAp) mechanism is in place. Lesotho's SWAp status may be categorized as an Early SWAp. The process currently involves donor agencies and other groups in civil society, and the core elements of the Lesotho SWAp mechanism are: Common programmes of work, Agreed funding arrangements, Agreed implementation and monitoring arrangements and Institutionalized policy dialogue. Under the SWAp mechanism, 15 indicators have been identified to monitor performance of the health sector. The pooled funding arrangements are still being developed.

The engagement of WHO with the SWAp mechanism, in accordance with WHO's guidelines[3], will involve dialogue, technical assistance, convening, capacity building, and seed funds for catalytic work or innovations, as agreed with the government in WHO workplans. For all these activities, WHO's internal financial management systems will be used. In the situation where WHO has entered into specific agreement with a donor to act as a "pass through", or channel, for funds, then these may be included in a "pooling" arrangement.

The United Nations Development Assistance Framework (UNDAF), an umbrella programming mechanism of the UN Country Team in Lesotho, works in close cooperation with and has aligned its priorities to those of the government. The current UNDAF, which reaffirms the commitment of UN Country Team to supporting the efforts of the government and people of Lesotho toward realizing the long-term national Vision 2020 goals, covers the period 2008-2012. The framework is also used for monitoring progress made by Lesotho towards achieving MDG targets by 2015. The UNDAF priorities are shown in Box 3 below.

Box 3: Lesotho United Nations Development Assistance Framework Outcomes, 2008–2012

(1)	Capacity strengthened to sustain universal access to HIV/AIDS prevention, treatment, care and support and impact mitigation.
(2)	Improved and expanded access to quality basic health, education and social welfare services for all.
(3)	Increased employment, household food security and enhanced natural resource and environmental management.
(4)	Governance institutions strengthened, ensuring gender equality, public service delivery and human rights for all.

While the development community and donors remain committed to supporting the MoHSW in its health development programmes, the need for improvements in the coordination and follow-up of activities planned by different role players has been noted as a challenge.

SECTION 4

WHO POLICY FRAMEWORK: GLOBAL REGIONAL DIRECTIONS

WHO has been undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges, and to achieve the health-related MDGs. This organizational change process has, as its broad frame, the WHO corporate strategy.

4.1 GOAL AND MISSION

The mission of WHO remains "the attainment by all peoples, of the highest possible level of health" (Article 1 of WHO Constitution). WHO's global and African regional directions are encapsulated in the WHO corporate strategy, the Eleventh General Programme of Work 2006-2015, the Medium Term Strategic Plan (MTSP) and the Strategic Orientations for WHO Action in the African Region 2005-2009 which outline key features through which WHO intends to make the greatest possible contribution to health. The Organization aims at strengthening its technical and policy leadership in health matters, as well as its management capacity to address the needs of Member States including the Millennium Development Goals (MDGs).

4.2 CORE FUNCTIONS

The work of the WHO is guided by its core functions, which are based on its comparative advantage. These are:

(a) Providing leadership on matters critical to health and engaging in partnerships where joint action is needed.

(b) Shaping the research agenda and stimulating the generation, translation and dissemination of valuable knowledge.

(c) Setting norms and standards and promoting and monitoring their implementation.

(d) Articulating ethical and evidence-based policy options.

(e) Providing technical support, catalyzing change, and building sustainable institutional capacity.

(f) Monitoring the health situation and assessing health trends.

[3] WHO (2006). A guide to WHO's role in sector-wide approaches to health development; CCO/06.1.

4.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the Global Health Agenda identifies seven priority areas.

These include:

(a) Investing in health to reduce poverty;
(b) Building individual and global health security;
(c) Promoting universal coverage, gender equality, and health-related human rights;
(d) Tackling the determinants of health;
(e) Strengthening health systems and equitable access;
(f) Harnessing knowledge, science and technology;
(g) Strengthening governance, leadership and accountability.

In addition, the Director-General of WHO has proposed a six-point agenda:

(i) Health Development;
(ii) Health Security;
(iii) Health Systems;
(iv) Evidence for Strategies;
(v) Partnerships; and
(vi) Improving the performance of WHO.

The Director-General has, in addition, indicated that the success of the Organization should be measured in terms of results on the health of women and the African population.

4.4 GLOBAL PRIORITY AREAS

The global priority areas have been outlined in the Eleventh General Programme of Work. They include:

(a) Providing support to countries in moving to universal coverage with effective public health interventions;
(b) Strengthening global health security;
(c) Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
(d) Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health;
(e) Strengthening WHO's leadership at global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

The African regional priorities have taken into account, the global documents and the resolutions of the WHO governing bodies, the health-related Millennium Development Goals and the NEPAD health strategy, resolutions on health adopted by heads of state of the African Union and the organizational strategic objectives which are outlined in the Medium Term

Strategic Plan (MTSP) 2008-2013. These regional priorities have been expressed in the "Strategic Orientations for WHO Action in the African Region 2005-2009". They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion, and policy making for health in development and other determinants of health. Other objectives cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructures.

In addition to the priorities mentioned above, the Region is committed to support countries attain the health MDG goals, and to assist in tackling their human resource challenges. In collaboration with other agencies, the problem of how to assist countries source financing for the goals of the countries will be done under the leadership of the countries. To meet these added challenges, one of the important priorities of the Region is that of decentralization and the establishment of Intercountry Support Teams to further support countries in their own decentralization process, so that communities may benefit maximally from the technical support provided to them.

To effectively address the priorities, the Region is guided by the following strategic orientations:

(a) Strengthening the WHO country offices;

(b) Improving and expanding partnerships for health;

(c) Supporting the planning and management of district health systems;

(d) Promoting the scaling up of essential health interventions related to priority health problems;

(e) Enhancing awareness and response to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the expression of WHO's cooperation strategy at country level will vary from country to country depending on the country specific context and health challenges. Building on WHO's mandate and its comparative advantage, the six critical core functions of the Organization (outlined in section 1.2) are adjusted to suit each individual country needs in line with the WHO Country Focus Policy, which gears the operations of WHO to the needs of Member States at country level.

SECTION 5

CURRENT WHO COOPERATION IN LESOTHO

The approach adopted by WHO is to constantly seek opportunities for partnership which is reflected in the frequent joint programming with Government departments, other UN agencies and NGOs. Such efforts are essential to ensure harmonization of WHO work with partners having a common goal. The current WHO cooperation strategy (2004-2007) was aligned with the Lesotho Strategic Plan (2004/05 -2010/11). The CCS spelt out five principal components, as shown in Box 4 below.

Examples of the key contributions made by WHO during the first WHO Cooperation Strategy and the implementation challenges are outlined below.

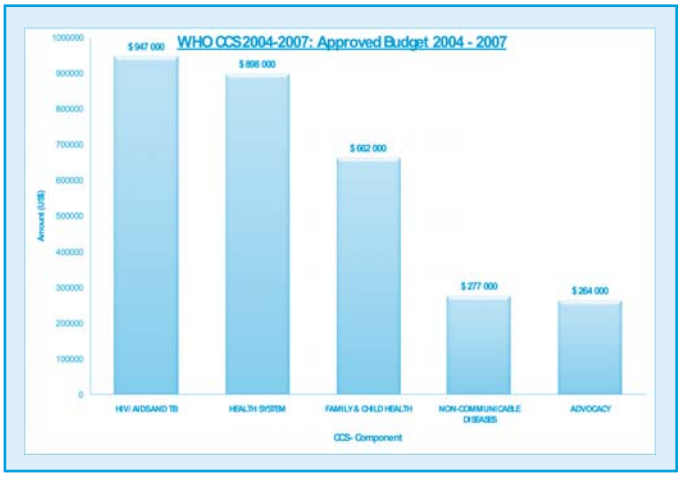
Box 4 : WHO/Lesotho CCS1 Agenda

(1)	Strengthening national health system
(2)	Tackling HIV/AIDS, TB and other communicable diseases
(3)	Strengthening family and community health
(4)	Tackling noncommunicable diseases
(5)	Advocacy for Health

5.1 CONTRIBUTIONS OF WHO COOPERATION STRATEGY 2004-2007

WHO support to Lesotho focused on HIV/AIDS, TB and health systems. For the period 2004-2007, the regular budget allocated to HIV/AIDS and TB was US$ 947 000 and the health system sub-component was allocated US$ 898 000 (see Figure 4).

Family and child health activities were allocated about US $660 000 in support of MCH, MPS, Adolescent Health and EPI activities.



Some extra-budgetary funds were also received and applied for various activities during the period that were not included in the above analyses.

MAJOR ACHIEVEMENTS IN THE FIVE CORE AREAS OF THE CCS ARE OUTLINED BELOW:

A. Strengthening the National Health System

WHO provided support in the development of research policy, the National Health Policy and Strategic Plan and strategies for strengthening health systems towards the achievement of MDGs 4, 5 and 6. Support was also provided in the development of the human resources policy.

WHO support also focused on the development of the first draft of the national medicine policy, national disability policy, mental health policy and strategic plan and formulation of draft the national health promotion policy. Development of the strategic plan for implementing the national disability policy is in progress. In the department of pharmaceuticals, Lesotho participated in the development of a training manual on management of drugs at health centre level and WHO also supported the development of the essential medicines list and standard treatment guidelines. Other support of WHO was channelled to the award of fellowships (courses) in various high-priority public health areas, as a way of increasing the number of health professionals in the country.

B. Tackling HIV/AIDS, TB and other Communicable Diseases

WHO supported the establishment of the TB and HIV Technical Task Team whose role is the development of standards and guidelines and definition of appropriate strategies to deliver TB and HIV services. Common tools have been developed for TB, HIV and AIDS to enable joint monitoring. A draft strategy for TB and HIV has been developed. A National HIV Policy 2006–2010 and National HIV Strategic Plan have also been developed and WHO provided support in these areas. In addition, WHO supported the review of national guidelines on adult and paediatric ART.

Community-based capacity building has now been integrated to include TB and HIV collaboration. District managers were trained to also manage district M&E for TB and HIV. With the support of WHO, all districts also received training on HIV prevention, treatment and care service promotion towards accelerated HIV prevention. Data managers also received training in patient monitoring.

WHO supported the ministry of health in the development of MDR strategic plan and operational guidelines. WHO's partnerships with other stakeholders resulted in resource mobilization for building the MDR-TB hospital in the country. In addition, technical support was provided to the ministry for preparatory activities for the TB drug resistance survey and for formulation of the new TB/HIV strategic plan. More support was provided to NTP for realignment of the National TB Strategic Plan 2007-2011 with the Global Plan to STOP TB. Another highlight of WHO support is in the development and submission of a successful round six Global Fund proposal.

The Know Your Status Initiative which targets 1.2 million people in Lesotho, was launched in an effort to make more people to know their status. WHO supported the development of KYS policy and guidelines. WHO also provided technical assistance in developing a strategy for communication and social mobilization.

C. Strengthening Family and Community Health

WHO supported the emergency and obstetric care (EOC) baseline study that led to the development of a maternal and newborn training manual and a Road Map on reduction of maternal and newborn morbidity and mortality. In addition, the launching of the Road Map in Lesotho was supported by WHO. It also supported the development of the adolescent health policy (which is now available in Sesotho and English), as well as the development of the reproductive health policy. The WHO PMTCT training package has been adapted and guidelines on the PMTCT and PMTC scale up plan have been developed.

To improve adolescent health, WHO supported the establishment of Adolescent Health Corners and procured equipment for some corners. WHO also supported the conduct of a baseline study on the screening of cancer of the cervix, which led to the development of RH cancers guidelines and procurement of RH equipment for RH cancer screening for the central laboratory.

In 2005, Lesotho achieved certification standard surveillance and the national polio certification document was accepted. In addition, EPI disease surveillance case definition posters covering acute flaccid paralysis (AFP), neonatal tetanus (NNT) and measles were also produced and distributed to the health facilities.

To strengthen capacity for PMTCT, WHO supported the training of health workers and community-based distributing (CBD) agents in PMTCT. Other health personnel and some community health workers were also trained in HIV and AIDs, and in counselling and IMCI. Concerning the nutrition programme, WHO supported the improvement of training modules on severe malnutrition, and the training of trainers on the use of the revised modules, as well as cascade training of district-level health workers.

D. Tackling Noncommunicable Diseases

A number of initiatives have been undertaken to tackle the noncommunicable diseases, with a focus on the determinants of health. The National Hypertension, Diabetes, Mental Health and Tobacco Days were recognized and many tobacco-free initiatives have been undertaken. WHO support was channelled towards the development of anti-smoking billboards and IEC material to improve community sensitization. A draft Tobacco Control Bill has been completed and efforts are being made to translate it into legislation. Regarding the mental health programme in Lesotho, WHO supported the formulation of a national mental health policy and strategic plan. In the areas of social welfare, support was provided in the development of a social welfare policy and strategic plan. The MOHSW Rehabilitation Centre for the Disabled is now functional and is continually being supported by WHO. Decentralization of mental health services was also strengthened through training and provision of essential mental health services to the district health management teams.

WHO also supported the development and dissemination of the Lesotho Code of Marketing of Breast Milk Substitutes. In addition, WHO provided technical and financial support to adapt and disseminate severe malnutrition protocols and ensure the nationwide celebration of the National Breastfeeding Weeks. Further support went into training of health workers in the management and control of NCDs, as well as the management of severe malnutrition.

E. Advocating for Health

WHO provided support for coordination of the work of health development partners by chairing the Health Partners' Forum and also provided technical and advocacy support to the MoHSW's health system reform agenda. In health promotion, WHO supported training of district health promotion focal points. The training was followed by the development of workplans aimed at guiding the implementation of health promotion activities in the districts.

In addition, the ministry of health was supported to prepare for the celebration of international health days such as TB, Leprosy, World Health, World No Tobacco, Mental Health, Diabetes and Hypertension and World AIDS Days. WHO supported the development of a documentary on Know Your Status campaign for the celebration of the World AIDS Day. Support was also provided for the development of oral health curriculum in Lesotho.

5.2 RESPONSIVENESS OF CCS TO CHANGING PRIORITIES IN LESOTHO

The CCS represents WHO's medium-term strategic priorities based on each country's needs. However, country priorities do change. WHO therefore has to undertake new initiatives because of changing priorities, in alignment with government and the UN Country Team. During 2004-07, examples of changes that occurred include the emergence of Avian Flu and MDR-XDR-TB, the establishment of KYS initiative and the Poverty Declaration by the Prime Minister due to drought.

These changes were challenges that needed immediate response, and WHO responded. MDR-XDR-TB and avian flu fell within the existing priority areas; the response was therefore to provide the increased focus of funding and technical support required. Lesotho was not directly affected by the avian flu but it had to be prepared. WHO facilitated the development of the Lesotho National Avian Influenza Preparedness Plan, procurement of equipment and simulation exercises. In response to the emergence of MDR-XDR-TB, the WHO country office recruited an international expert in this area into its staff.

5.3 SUPPORT FROM WHO REGIONAL OFFICE AND WHO HEADQUATERS

The WHO country office in Lesotho receives significant support from the Regional Office and HQ. Both offices supported the participation of WHO staff as well as government officials in meetings of WHO governing bodies, technical and programme review meetings, joint missions to countries, production of advocacy and training materials, and increasing information exchange. The ability of the Regional Office and HQ to respond to some of the needs of Lesotho, sometimes at very short notice, is commendable.

5.4 IMPLEMENTATION CHALLENGES

Many of WHO's achievements in Lesotho may be attributed to its strong linkage with the MoHSW. WHO has firmly established itself as the principal source of credible, trusted and evidence-based advice on health matters. The ability of the WHO country office in Lesotho to build and maintain productive partnerships with other development partners like donor agencies is another key strength that has undoubtedly supported progress towards the achievement of national health goals. The technical expertise of the staff within the country office, along with the support from the Regional Office, has bolstered the continuing achievements of WHO in the country.

However, weaknesses of the current CCS include the following: the WCO/Lesotho has very limited staff for the wide scope of activities that it performs. Second, it has limited funds and sometimes this results in a lack of bargaining power with bilateral and UN system organizations with a strong presence in the field. These and other issues are outlined in the Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis table shown in Annex III.

SECTION 6

STRATEGIC AGENDA

The mission of WHO in Lesotho, in accordance with the WHO Constitution remains "the attainment by the people of Lesotho of the highest possible level of health". The overarching principles of the Country Cooperation Strategy 2008-2013 are a commitment to primary health care (PHC), the human right to health and equity.

6.1 STRATEGIC PRIORITIES

Based on the analysis of health and development challenges, current WHO collaborative programmes, its comparative advantage, and a review of work of development partners, five *strategic priorities* have been identified. The strategic priorities fall within three WHO organization-wide strategic domains: 1: Health Security; 2: Health System Capacities and Performance; and 3: Partnerships, Gender and Equity, as shown in Box 5.

Box 5 : WHO Strategic Priorities 2008-2013

Strategic Domain	Strategic Priority
A: Health Security	I: Strengthen the control of HIV/AIDS and tuberculosis
B: Health System Capacities and Performance	2: Strengthen family and community health
	3: Enhance capacity for the prevention and control of major communicable and noncommunicable diseases
	4: Strengthen health systems
C: Partnerships, Gender and Equity	5: Foster partnerships and coordination for national health development.

The main elements of each strategic priority and the main focus in terms of WHO's focus and how each element will be implemented are elaborated below.

Domain 1: Health Security

STRATEGIC PRIORITY 1: STRENGTHEN THE CONTROL OF TB, HIV/AIDS ANDTUBERCULOSIS

In response to the burden of HIV/AIDS and Tuberculosis, which are recognized as the greatest threats to the socio-economic development of Lesotho, WHO will further enhance support for increased access to TB and HIV prevention, treatment and care services. The capacity to develop and manage partnerships for improved HIV/AIDS contol and the national capacity of MoHSW for research into TB & HIV will also be enhanced.

MAIN FOCUS

1.1: Strengthen HIV/AIDS Control

WHO will strengthen its support for the national and district capacities to scale up TB and HIV prevention, treatment, care and support services. In addition, the procurement, supply and management (PSM) system for essential medicines and health commodities will be strengthened in order to enhance the availability of anti-retroviral and anti-TB drugs. The capacity to develop and manage partnerships for HIV/AIDS will also be supported.

1.2 Strengthen Tuberculosis and MDR-TB Control

The capacity of MoHSW to monitor and evaluate TB and HIV trends and HIV interventions will be strengthened. HIV-TB programme collaboration will also be enhanced. The national capacity of MoHSW for research into TB & HIV, including MDR-TB, will also be enhanced.

STRATEGIC PRIORITY 2: STRENGTHEN FAMILY AND COMMUNITY HEALTH, INCLUDING SEXUAL AND REPRODUCTIVE HEALTH

WHO will continue to support capacity building that aims to improve the health of mothers, children, adults and the ageing population through a life-cycle development approach but with special attention to universal access to quality sexual and reproductive health, family planning and adolescent health. In line with the rights-based approach to sexual health, reproductive health needs of both genders will be addressed. A community focus and adherence to the principles of PHC remain central to WHO support. The capacity to conduct operational research and utilize evidence-based information on SRH will also be enhanced.

MAIN FOCUS

2.1 Support for increased access to maternal, newborn, child and adolescent health services ensuring continuum of care throughout the life course and across different levels of the health system, including the community

WHO will support adaptation and use of guidelines, standards and tools for enhancing skilled care for mothers and newborns, adolescent health friendly services as well as integrated management of childhood illnesses at all levels of care. Research will be conducted to formulate evidence-based policies and strategies to mobilize the participation of individuals, families and communities, and to improve access to quality services with the aim of ensuring continuum of care for safe motherhood and newborn health.

2.2 Promote diversification of health services for adolescents and adults, including reproductive health services

Support will be provided for innovative approaches for equitable access to gender-sensitive health services, including reproductive health services for both women and men, that will also include operationalization and scaling up of adolescent-friendly health services and strengthening of community-based care for healthy and active ageing. WHO will support research to address gender issues, empowerment of women and domestic violence, sexual and reproductive health care and interventions.

2.3 Support the comprehensive integration of nutrition throughout the lifecycle into the health sector framework

WHO will support effective and efficient institutionalization of nutrition programmes through strengthening synergies in service delivery as well as programme monitoring and evaluation. Research and development of technologies and interventions for micronutrient supplementation throughout the lifecycle will be strengthened. Support will also be continued for operationalization of the strategic plan for infant and young child feeding and management of severe malnutrition in health-care facilities.

STRATEGIC PRIORITY 3: ENHANCE CAPACITY FOR THE PREVENTION AND CONTROL OF MAJOR COMMUNICABLE AND NONCOMMUNICABLE DISEASES

The control of major communicable (other than HIV/AIDS) and noncommunicable diseases remain vital for health and economic development. WHO aims to support the elimination and eradication of vaccine-preventable diseases, promotion of healthy lifestyles and cost-effective interventions for the prevention and control of major NCDs, food safety and the strengthening of IDSR and epidemic alert system in the country.

MAIN FOCUS

3.1 Enhance capacity of the national immunization programme for effective prevention and control of vaccine-preventable diseases

WHO will continue to support the implementation of the national immunization programme, including the scaling up of the Reach Every District (RED) approach and the integration of other maternal and child survival interventions with immunization services. Technical support will be provided for the introduction of new cost-effective vaccines as well as the ongoing drive for effective measles control and maintenance of polio-free status. Support will also be provided towards building capacity at the district level for integrated surveillance of EPI and other priority public health outreach programmes.

3.2 Support for effective integrated disease surveillance system for communicable and noncommunicable diseases

WHO will support the strengthening of the integrated disease surveillance system including mainstreaming of existing field surveillance networks along with implementation of strategies and operational guidelines that facilitate utilization of evidence through info bases and networking.

3.3 Enhance emergency preparedness and response and implementation of International Health Regulations 2005

National capacity for surveillance will be enhanced with the development of early warning and rapid response to outbreak investigations and interventions of communicable diseases. Support will be provided for health risk assessment and building of core capacity of the government for implementing International Health Regulations (IHR) 2005 with multisectoral involvement to address diseases caused by regional and global threats.

WHO will continue to build capacity and provide logistics support for adequate response during emergencies. A broad coordinated intersectoral approach towards emergency and humanitarian action will be promoted. Support will also be provided to enhance community participation and involvement in winter and drought disaster mitigation and response.

3.4 Promote healthy lifestyles and cost-effective interventions for prevention and control of major NCDs and injuries, and for mental health promotion

The epidemic of noncommunicable diseases causes adverse effects on both health and wealth. High consumption of tobacco, changes in eating habits, increasing substance abuse, and widespread lack of physical activity and an unregulated food and beverage industry are increasingly leading to noncommunicable diseases. WHO support will focus on the promotion of healthy living, enforcement of relevant laws and generation of evidence for programmes and policies that aim to reduce lifestyle-based risks for the individual as well as for the community.

Special efforts will be made for the collection of data that will be necessary for NCD prevention. WHO's step-wise surveillance approach will be followed to generate data on risk factors for major NCDs and their disease burden and consequent deaths. Priority NCDs to be addressed include diabetes mellitus, hypertension, ischaemic heart disease, stroke, and cancers of the lungs, breast and cervix. Essential data will be disseminated in various forms.

3.5 Enhance equitable and sustainable access to safe water and sanitation, reduce environmental and occupational health risks and promote food safety

The adverse impacts of environmental determinants of health threaten the achievement of sustainable development in Lesotho. WHO's response to this challenge is to continue its multisectoral policy and programmatic advisory service to address priority environmental health issues including pollution of drinking water, inadequate sanitation, indoor air pollution and food safety. More emphasis will be put on the facilitation of evidence–based strategies for the primary prevention of pollution, and identifying and promoting sustainable technologies and approaches to prevent environmental health risks for both urban and rural communities.

WHO will promote preventive approaches to water management using the concept of Water Safety Plans to enable utilities, communities and households to maintain supplies of safe drinking water. Support will be provided to identify approaches and technologies that ensure access to safe water for vulnerable communities; and facilitate the updating of drinking water quality standards in accordance with health-based targets. Support for sanitation, including ecological sanitation, will focus on helping the government to achieve the goal of total sanitation by 2015 and ensure that this achievement is sustainable in the long term.

3.6 Enhance food safety from production through to consumption

WHO will emphasize capacity building of government institutions to develop an appropriate and effective management framework that ensures the safety of food from the production stage to consumption. Support will be provided to strengthen government capacity to monitor food safety with modern approaches and techniques; develop policy and strategies that lead to increased food safety in the public and private domains; identify successful approaches to raising awareness on the importance of food safety among diverse stakeholders; build mass awareness among the population and advise on food safety standards and regulations.

Domain 2: Health System Capacities and Performance

STRATEGIC PRIORITY 4: STRENGTHEN HEALTH SYSTEM CAPACITIES AND PERFORMANCE

WHO support will focus on enhanced functionality of the district health system, strengthened capability of MoH in collecting and analyzing financial information for decision-making and planning and strengthened human resources for health capacity at all levels. Traditional healing system as well as operational research strengthening at national and district levels will be supported. WHO will also support improved capacity of MoH to increase access to quality medicines.

WHO's aim is to support comprehensive health systems development at central, district and sub-district levels. WHO will strengthen the evidence-base for policy and planning, regulatory and organizational development through research into demand and supply-side factors, workforce skill-mix, biomedical technology, pharmaceuticals, and patient safety issues including clinical waste management. WHO will, together with partners, support the Government of Lesotho in the implementation of the Lesotho Vision 2020 health agenda and the National Strategic Health Plan 2004-2005 and 2010-2011 to ensure increased utilization levels and enhance the impact of health services.

MAIN FOCUS:

4.1 Support the planning, development and utilization of an effective and responsive health workforce

WHO will support the formulation of policies and plans for scaling up the training of nurses, midwives, health technologists and community health workers. It will develop tools for the proper utilization of the workforce, enhancing the capacity of professional regulatory bodies and associations involved in improving the quality of education and practice in partnership with the national network of public health education institutes.

4.2 Enhance national capacity to ensure access to quality essential medicines, vaccines and medical technologies

Support will be directed towards strengthening the capacity of the National Regulatory Authority in ensuring quality medicines and vaccines, monitoring the impact of the national drug policy on access to essential medicines, and promoting the rational use of drugs. Quality, safety, efficacy and rational use of traditional medicines will also be promoted. Further support will be provided for effective implementation of a policy on blood transfusions and enhancing access to quality public health laboratory services.

4.3 Strengthen country health information systems, knowledge management, health research and evidence for better decision-making

Support will be provided for strengthening the Health Management Information System. Support will also be provided for capacity building for knowledge management and modernization of health libraries, conducting needs-based quality health research, developing and managing effective health research information systems, and generating and disseminating evidence for informed decision-making.

4.4 Support alternative healthcare financing for equitable access to healthcare

Support will be provided for the development of alternative healthcare financing schemes, including social health insurance, and demand-side financing mechanisms with a view to provide policy options for effective equitable financing, while also assisting the MoHSW in its efforts to introduce and sustain health components in social safety net schemes. Support will also be provided for the generation of evidence for improvement in allocative efficiency and equity.

4.5 Strengthen the organizational and managerial capacity of the national and local health systems for delivering accessible, quality and safe care to the communities, with special focus on vulnerable groups

WHO will provide support to enhance the service mix, service quality and service responsiveness of health service delivery institutions, particularly at the district level. Support will also be provided to enhance capacity of village health. Special attention will be given to interventions that focus on eliminating demand-side barriers. Support will also be provided to address healthcare associated risks through patient safety measures such as blood safety, hand hygiene, safe injection practices, hospital waste management and other areas of facility-based quality assurance.

Domain 3: PARTNERSHIPS, ADVOCACY, GENDER AND EQUITY

STRATEGIC PRIORITY 5: FOSTER HEALTH SECTOR PARTNERSHIPS, ADVOCACY AND EQUITY

WHO will provide, within the scope of this strategic agenda, technical assistance to the MoHSW and development partners in support of the implementation of the health sector programme. In addition, WHO will continue its liaison function with respect to global alliances funds, foundations and nongovernmental organizations. Technical assistance in support of primary health care will be strengthened.

MAIN FOCUS

5.1 Assist the MoHSW to coordinate donor support for national health development

WHO will support the MoHSW to work effectively with donor partners to ensure that national health development goals and strategies are achieved. Special attention will be given to the health sector programmes, including the national health system reforms, medicines and health technologies as well as human resource development in Lesotho.

5.2 Work closely with health development partners in Lesotho to improve communications among partners and with the MoHSW

WHO will facilitate a positive dialogue among health development partners to identify key implementation and policy issues, promoting the result of the dialogue with the MoHSW and other related ministries.

5.3 Provide technical support to health development partnerships including the global funds and regional initiatives

WHO will provide the MoHSW and NGOs with technical advice required to develop project proposals to access global funds and global partnerships. Such activities will be supported through resources from HQ, and regional and country offices.

5.4 Strengthen country office presence

WHO country presence includes its physical presence as well as its integrated technical backstopping from Regional Office and Headquarters. This will be strengthened to ensure effective capacity to meet the need of the new strategic agenda contained in this CCS.

Box 6 : WHO/Lesotho Strategic Priorities and Approaches, 2008-2013

A: Health Security	I. Strengthen the control of HIV/AIDS and tuberculosis	1.1: Strengthen the control of HIV/AIDS
		1.2: Strengthen tuberculosis and MDR-TB control
	2. Strengthen family and community health	2.1: Support for increased access to maternal, newborn, child and adolescent health services ensuring continuum of care throughout the life course and across different levels of the health system, including the community
		2.2: Promote diversification of health services for adolescents and adults, including reproductive health services
		2.3: Support the comprehensive integration of nutrition throughout the lifecycle into the health sector framework
	3. Enhance capacity for the prevention and control of major communicable and noncommunicable diseases	3.1: Enhance capacity of the national immunization programme for effective prevention and control of vaccine-preventable diseases
		3.2: Support for effective integrated disease surveillance system for communicable and noncommunicable diseases
		3.3: Enhance emergency preparedness and response and implementation of International Health Regulations 2005
		3.4: Promote healthy lifestyles and cost-effective interventions for prevention and control of major NCDs and injuries, and for mental health promotion
		3.5: Enhance equitable and sustainable access to safe water and sanitation, reduce environmental and occupational health risks and promote food safety
		3.6: Enhance food safety from production through to consumption
B: Health System	4. Strengthen health systems	4.1: Support the planning, development and utilization of an effective and responsive health workforce

		4.2: Enhance national capacity to ensure access to quality essential medicines, vaccines and medical technologies
		4.3: Strengthen country health information systems, knowledge management, health research and evidence for better decision-making
		4.4: Support alternative healthcare financing for equitable access to health care
		4.5: Strengthen the organizational and managerial capacity of the national and local health systems for delivering accessible, quality and safe care to the communities, with special focus on vulnerable groups
C: Partnerships, Gender and Equity	5: Foster partnerships and coordination for national health development	5.1: Assist the MoHSW to coordinate donor support for national health development
		5.2: Work closely with health development partners in Lesotho to improve communications among partners and with the MoHSW
		5.3: Provide technical support to health development partnerships including the global funds and regional initiatives
		5.4: Strengthen WHO country presence in Lesotho – physical presence and technical backstopping from Regional Office and Headquarters

6.2 LINKAGES OF THE STRATEGIC AGENDA WITH LESOTHO GOVERNMENT, WHO AND UNDAF PRIORITIES

This Country Cooperation Strategy is rooted in WHO policies and strategies, aligned with national priorities, and harmonized with the work of United Nations and other partners in Lesotho. The strategic agenda of this CCS – comprising the strategic priorities and main focus – have strong linkages with the national health priorities of the government of Lesotho. It also has strong linkages with the six core functions of WHO and the WHO strategic objectives of the Medium Term Strategic Plan 2008-2013 (MTSP) which form the current policy, planning and implementation framework for WHO's work at the country level. Tables 6 and 7 illustrate how and where the CCS country-specific strategic priorities are linked with the Lesotho MoHSW and WHO MSTP priorities. The strategic agenda also has strong linkages with the current WHO African Regional Orientations and UNDAF/Lesotho priorities on HIV/AIDS, expanded access to quality health, strengthening public services delivery as well as the environmental management priorities of the UNDAF (see Annexes IV and V).

Table 6: Linkages Between CCS Strategic Priorities and Lesotho Government Priorities

		CCS Strategic Priorities				
S/N	MoHSW/Lesotho Priorities	(1) Strengthen the control of TB, HIV and AIDS	(2) Strengthen family and community health	(3) Enhance capacity for the prevention and control of major communicable and noncommunicable diseases	(4) Strengthen health systems	(5) Foster partnerships and coordination for national health development
1	Public health interventions (Health Education and Promotion, Child Survival: Immunizations, Nutrition and management of common childhood illnesses, and Environmental Health) Communicable Disease Control.	+++	+++	+++	+++	+++
2	(Sexually-transmitted infections, TB, HIV and AIDS).	+++	++	+++	++	++
3	Sexual and Reproductive Health Essential Clinical Services and Common.	++	+++	++	++	+++
4	Essential Clinical Services and Common illnesses (diabetes, hypertension, eye infections, skin infections; Oral Health and Mental Health).	++	++	+++	++	+++
5	Social Welfare Services (Child Welfare, Youth Services, Services for Women, Services for adults in difficult circumstances, Services for People Living with Disabilities (PWD) and Services for the elderly.	++	++	++	++	+++

Key: + + +: Very strong linkage; + +: Strong Linkage; +: Some Linkage

Table 7: Linkages Between WHO Medium Term Strategic Plan and Lesotho CCS 2008-2013 Strategic Priorities

S/N	MTSP strategic Objectives	(1) Strengthen the control of TB, HIV and AIDS	(2) Strengthen family and community health	(3) Enhance capacity for the prevention and control of major communicable and noncommunicable diseases	(4) Strengthen health systems	(5) Foster partnerships and coordination for national health development
1	To reduce the health, social and economic burden of communicable diseases.	+		+++		+
2	To combat HIV/AIDS, tuberculosis and malaria.	+++	+	+	+	+
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries.		+	+++	+	+

4	To reduce morbidity and mortality and improve health during key stages of life.		+++	++		+
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact.		+	+++		+
6	To promote health and development, and prevent or reduce risk factors for health conditions.			++		+
7	To address the underlying social and economic determinants of health.			++		+
8	To promote a healthier environment, intensify primary prevention and influenæce public policies in all sectors.			++		+
9	To improve nutrition, food safety & food security, throughout the life-course, and in support of public health and sustainable development.			++		+
10	To improve the organization, management and delivery of health services.				+++	++
11	To strengthen leadership, governance and the evidence base of health systems.				+++	+++
12	To ensure improved access, quality and use of medical products and technologies.				+++	+
13	To ensure an available, competent, responsive and productive health workforce in order to improve health outcomes.	+	+	+	+++	++
14	To extend social protection through fair, adequate and sustainable financing.				+++	++
15	To provide leadership, strengthen governance and foster partnerships and collaboration with countries.	+	+	+	++	+++
16	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively.	+	+	+	+	+++

Key: + + +: Very strong linkage; + +: Strong Linkage; +: Some Linkage

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

The strategic agenda in Section 6 has articulated the future strategic priorities, approaches and priority areas for WHO's collaborative work in Lesotho for the period 2008-13. The implementation of the strategic agenda will be based on the WHO core functions. In order to ensure effective implementation of the CCS, it is essential to outline the implications for the WHO country office in Lesotho, for the WHO Regional Office for Africa (AFRO) based in Brazzaville, as well as for WHO Headquarters (HQ) in Geneva.

7.1 IMPLICATIONS FOR WHO COUNTRY OFFICE

The implications of the CCS 2008-2013 for the WHO country office (WCO) in Lesotho will be outlined in terms of the following:

(i) Expanding the use of the Country Cooperation Strategy;
(ii) Core competencies and capacities of WCO/Lesotho team;
(iii) Integrated programmatic and technical support from regional offices and headquarters;
(iv) Effective functioning of the country office;
(v) Knowledge management and information; and
(vi) Working with organizations of the United Nations system and development partners.

(a) Expanding the use of the Country Cooperation Strategy

As the basis for developing a "one WHO country strategy, plan and budget", the WHO country office in Lesotho will ensure that the CCS will remain central to all planning and budgeting processes. The CCS will also be the basis for the WCO biennial and annual workplans, and will also be used to foster dialogue with stakeholders in Lesotho. The CCS willl be revised as required, based on appropriate consultations with all stakeholders, especially the Government of Lesotho.

(b) Core competencies and capacities of WHO country office

It is essential that the country office in Lesotho possesses the required set of competencies to effectively and efficiently perform the WHO core functions and implement the CCS. The shift in approaches and emphasis, as articulated in the strategic agenda, would mean some shift in resource allocation, in the staff profile and the development of new capacities within the country office. Building on the staff reprofiling exercise that was conducted in 2006 (with the support of AFRO), the estimated composition of staff at the country office required for successful implementation of WHO collaborative programmes under each strategic priority is provided in Table 9 below.

In order to strengthen the WCO capacity to provide essential support for the control of major communicable (beside HIV/AIDS and TB) and noncommunicable

diseases, an additional international professional expert, a Disease Prevention & Control Officer, will be required. The post of an international Administrative Officer needs to be maintained in order to ensure adequate management of the increasing resources that the WCO now has to manage.

Additional national programme officer, an Essential Drugs & Medicines (EDM) Officer, would be required to support the health system strategic approach – to provide support to the MoHSW and other partners toward ensuring the availability of safe essential drugs for Lesotho's Essential Health Package, including antiretroviral and anti-TB drugs. The officer will also focus on strengthening the capacity of the national regulatory authority to ensure effective monitoring of good manufacturing practices (GMP) and clinical trials of drugs and vaccines.

The management of information is essential for WHO support to all programmes in Lesotho. A data / information manager will be required to provide the needed competencies to the country office. The post holder will also support the WCO's broader knowledge management needs. To support the increasing programmatic administrative workload, an administrative assistant and a secretary will also be required. In striving for a strengthened WHO country presence (a platform encompassing a physical presence and technical backstopping from the regional and sub-regional levels and from headquarters), the technical support of AFRO, IST and HQ will be requested, when needed.

Table 8: Estimated Changes in Country Office Professional Staff to Fully Implement the CCS-2008-2013

CCS-2 Strategic Priority		International Professional		International Professional	
		Current	Required	Current	Required
(a)	Strengthen the control of HIV/AIDS	2	2	1	1
(b)	Strengthen family and community	0	0	1	2
(c)	Strengthen health systems	1	1	0	1
(d)	Enhance capacity for the prevention for national health development.	0	1	3	4
(e)	Foster partnerships and coordination for national health development	2	2	10	13
	Total	**5**	**6**	**15**	**21**

(c) Integrated programmatic and technical support from regional offices and headquarters

In order to implement the "one WHO country plan and budget", based on the CCS, and to respond swiftly to epidemics and other emergencies, an integrated programmatic and technical support will be required from AFRO and the WHO Intercountry Support Team for Eastern and Southern Africa (IST). The soon-to-be-operational WHO Global Management System (GSM) will support this process.

(d) Effective functioning of the country office

An enabling work environment, with increased administrative and managerial efficiency as well as adequate logistics and field security, will allow the Lesotho

WHO Country Team to carry out WHO core functions in line with the CCS. All staff will be provided the training needed to effectively utilize the GSM and the related information systems that support greater decentralization and increased accountability. Investments are required in strengthening the ICT infrastructure needed to support the increasing ICT needs.

(e) Better knowledge management

As a knowledge-based team, WCO/Lesotho will strive to make better use of its aggregate knowledge to promote better health in Lesotho. The WCO will also strive to become better at learning and knowledge sharing, and will ensure that up-to-date information on countries and WHO country offices is available and easily accessible to stakeholders. The WCO/Lesotho website will become operational. The required data/information manager will also support this process.

(f) Working with organizations of the United Nations system and development partners:

Partnerships have become a key feature of WHO's work in Lesotho. The WCO will ensure that the CCS will remain the basis for all WHO input into the UNDAF, the SWAp, PRS and other health and development processes in Lesotho. The WCO will be proactive in identifying new opportunities for synergy and harmonization of its work with that of other UN agencies and development partners. Above all, WHO Lesotho commits to providing high-quality technical support to all stakeholders toward the attainment of "Health-for-All" in Lesotho.

7.2 IMPLICATIONS FOR WHO REGIONAL OFFICE

The Regional Office will continue providing technical support to the WHO country office for implementing the strategic agenda in the areas where expertise is not available in the country. With the establishment of the Intercountry Support Teams (IST), it is expected that the IST/Eastern and Southern Africa, based in Zimbabwe, will provide more of the needed technical support, as may be necessary. Moreover, regional and IST assistance will usually be required to address emergency and humanitarian situations in order to provide timely support. The GSM will facilitate better integrated programmatic and technical support from AFRO and the Intercountry Support Team.

7.3 IMPLICATIONS FOR WHO HEADQUARTERS

WHO Headquarters, in keeping with its mandate, will continue to provide the Regional and Country Offices with global policy advice, directives on health development, and guidance on global norms and standards. In addition, it will advocate the cause of the country and take action for resource mobilization for the country at the global level.

With their broad-based networks, the Regional Office and HQ are also required to facilitate inter-country collaboration and multi-country activities for transfer of technology, sharing of experience, expertise and resources between countries within and outside the Region. This will enable WHO Lesotho to address common issues of interest as well as learn of best practices, effective strategies and approaches for health development in other countries.

While the country office has to be proactive in mobilizing resources to secure the funds required for effective implementation of the strategic agenda, support will also be needed from AFRO and HQ in mobilizing additional resources. It is essential to ensure the adequate

funding of the management and administration requirements of the WHO country office in Lesotho. As much as possible, these should be included in donor-supported projects with WHO.

7.4 RESULTS-BASED MANAGEMENT: MONITORING AND EVALUATING THE COUNTRY COOPERATION STRATEGY

The strategic agenda will be implemented through three consecutive biannual programme budgets and workplans. Within the framework of the WHO results-based management system, these workplans include a robust monitoring framework of intervention-specific indicators – which include Office-Specific Expected Results and key products. WHO's regular six-monthly monitoring of workplan implementation progress will be complemented by periodic in-depth evaluations of selected programmes to determine their outcomes and impact on national health development. Thematic evaluation of some key areas/issues will also be undertaken, when necessary.

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ANNEX - I

LESOTHO COUNTRY COOPERATION STRATEGY (2008 – 2013) DEVELOPMENT PROCESS

The exercise began with the constitution of a CCS Task Force headed by the WR/Lesotho and the engagement of a MOH&SW staff (Ms Zondy Mohapi) as the local consultant. The first Country Cooperation Strategy (CCS1) for the period 2004-2007 was reviewed to assess its implementation status and identify the gaps that need to be addressed in the second generation Country Cooperation Strategy (CCS 2008-2013) for the period 2008–2013. The findings and recommendations of the review of CCS1 together with the additional information in the documents from AFRO were utilized and reflected in the formulation of the CCS 2008-2013.

In order to improve awareness and use of the CCS 2008-2013, its development process emphasized, among others, three key issues:

(a) In-depth review and analysis of key health sector issues, including the factors that influence the health status of the Basotho;

(b) Broad consultations and advocacy for the CCS 2008-2013 preparation process, to ensure that the process was inclusive and participatory;

(c) Active involvement of key stakeholders, especially the MOH&SW, UN partners and WCO staff;

In reviewing CCS1, the initial step was to acquaint ourselves with and understand the contents of a number of documents which specified the priorities of WHO at global, regional and country levels and those that indicated the health priorities of Lesotho for the period covered by the CCS1. Other documents included several progress reports of the health sector and WHO country office and reports on policies and guidelines of the health sector. The review of CCS1 was supplemented by face-to-face interviews and the administration of a structured questionnaire. The interviews were carried out with all WHO country office technical staff and stakeholders who included MOH&SW programme officers, line ministries, UN agencies, academic institutions, development partners, nongovernmental organizations (NGOs) and the private sector, both profit-making and not-for-profit.

The questionnaire gathered information that assessed the CCS1 development process, knowledge about the CCS, the CCS 2004-2007 appropriateness in reflecting health priorities at global, regional and country levels, the implementation process, achievements and gaps thereof. To get a broader picture of the new priorities, an additional review of relevant documents was undertaken. These documents included, the budget framework of Lesotho's health sector for 2007-2008 to 2009-2010, Lesotho national health priorities and strategic plan for 2004-2005 to 2010-2011 which highlight the priorities for this period, Vision 2020, the Lesotho Poverty Reduction Strategy, health–related Millennium Development Goals, WHO global and regional strategic plans/directions, The Medium Term Strategic Plan 2008-2013 of WHO and the United Nations Development Assistance Framework 2008-2012 of Lesotho. The priorities gathered from these documents, together with the gaps and recommendations from the review of CCS 2004-2007, defined the priority areas of CCS 2008-2013.

The CCS 2008-2013 development process involved extensive discussions with the Ministry of Health and Social Welfare, the Multi-Agency Task Force, UN agencies and development partners in both public and private sectors in Lesotho. The WR met with the CCS Multi-Agency Task Force to inform them of and acquaint them with the CCS 2008-2013 development process. There were broad consultations and advocacy for the preparation of the CCS 2008-2013, taking into consideration the global health challenges and targets, the WHO HQ and regional strategic plans and national health priorities. We took the opportunity of the Health Sector Review Forum where the MoH&SW, multilateral and bilateral organizations, NGOs, the private sector and civil society were represented to present the CCS 2008-2013 process and priorities.

During the WHO staff retreat at the end of 2007, top senior staff in the MoH&SW, directors and programme managers were again consulted and the draft CCS 2008-2013 document given to them for comments and inputs. The comments from the MoH&SW and other partners were incorporated into the draft document. This was followed by several discussions and consultations internally within the WCO/Lesotho to fine-tune and strengthen the document. The draft CCS 2008-2013 document was also shared with heads of UN agencies for comments. All these consultations provided the needed alignment with the national health priorities.

We would like to acknowledge with gratitude the immense invaluable contributions of the consultants, namely Dr A. Onyeze from the AFRO/ICST/ESA and Ms Z. Mohapi from the MoH&SW. We express our gratitude to the Regional Office and Headquarters for their orientation in the finalization of the document.

ANNEX - II

DEVELOPMENT PARTNERS / DONORS MAPPING: HEALTH PARTNERS CONTRIBUTION TO 2007/08 BUDGET

Development Partners / Donors Mapping: Health Partners contribution to 2007/08 Budget

PROGRAMMES & SUB-PROGRAMES	IRISH AID	WHO	UNICEF	IDA	USG	GLB FUND	EU	BUMC Kellogg	ADB	NORAD	UNFPA	GOL	MCC (2008)
GENERAL MANAGEMENT													
1. Administration				X				X	X			X	
2. Improving General Management including QA	X			X								X	
3. Improving Financial Management	X			X								X	
4. Human Resource including TA support	X			X	X	X	X	X	X			X	
5. Policy, Planning, Monitoring and Evaluation		X		X		X						X	
6. Infrastructure Development & Maintenance				X			X		X			X	
7. Acquisition and Maintenance of Equipment	X			X			X	X	X			X	
8. Short term training including W/shops	X			X		X	X	X	X	X		X	
9. Health Sector Financing				X								X	
10. Research		X										X	
DECENTRALIZATION													
1.Financial Management				X									
2. Strengthen DHMTs and service delivery	X			X								X	X
3.Salaries (Includes TA)	X			X								X	X
4. Training	X	X		X									X
5. M& E	X			X									
6. Pharmacy services in districts				X								X	
7. Office Space Rental	X												
8. Office Space permanent		X		X									
9. Equipment				X									X
10. Transport (Vehicles)				X									X
11. H/C Infrastructure													X
PROGRAMMES & SUB-PROGRAMES	**IRISH AID**	**WHO**	**UNICEF**	**IDA**	**USG**	**GLB FUND**	**EU**	**BUMC Kellogg**	**ADB**	**NORAD**	**UNFPA**	**GOL**	**MCC (2008)**
MONITORING AND EVALUATION AT CENTRAL LEVEL													
1. Human Resource	X			X								X	X
2. Equipment				X									X
3. IDSR		X											
4. Training	X												X
5. Strengthen Processes of M&E				X									X
6. DHS	X											X	X
7. Research												X	X
MEDICAL WASTE MANAGEMENT													
1. Incinerators				X									X
2. Protective Clothing				X									
3. Human Resource/TA				X								X	X
4. Training		X		X									
4. Policies and Plans													X
HUMAN RESOURCES													
1. TA HPSD	X												
2. TA ICT				X									
3. DHIO				X									
4. M&E	X			X								X	
5. District Accountants				X									
6. Short term Training	X			X							X	X	
7. Long Term Training	X	X						X					
8. NHTC			X						X			X	X
9. Nurses	X											X	
10. Doctors (Prospective)	X	X						X				X	
CURATIVE HEALTH CARE													
1.Patient Care												X	
2. Referrals outside Lesotho												X	
3. Pharmaceutical Services		X		X	X	X						X	
4. Laboratory Services + Infrastr.					X	X						X	X
5.Safe blood												X	X
PROGRAMMES & SUB-PROGRAMES	**IRISH AID**	**WHO**	**UNICEF**	**IDA**	**USG**	**GLB FUND**	**EU**	**BUMC Kellogg**	**ADB**	**NORAD**	**UNFPA**	**GOL**	**MCC (2008)**
COMMUNICABLE DISEASE													
1. TB Prevention & Control					X	X						X	
2. HIV & AIDS/STI Prevention & Contro	X	X			X	X						X	

ANNEX - III

SWOT ANALYSIS FOR IMPLEMENTING THE CCS

The possible strengths, weaknesses, opportunities and threats have been identified for implementation of the CCS as reflected in the table below.

Strenghts	Weaknesses
• Broad consultations during development of CCS1. • Team spirit within WHO country office since 2006. • Consultative leadership style of the current WR office. • Adherence to recruitment policy enabled recruitment of competent staff. • The reprofiling, posts established and competent staff recruited	• Inadequate marketing of the CCS and POA to stakeholders • CCS not sufficiently being used as a planning tool. • Weak monitoring within the country. • Overloaded staff members due to thin staffing of the office. • Lack of coordination and follow-up on implementation of the plans by different role players • Inadequate funding and technical resource to support implementation of the plans • Inadequate communication programmes and between programmes and the WCO • Regular reviews/monitoring of CCS implementation by all partners have not been formalized. • Inadequate availability of WHO technical staff at the country level
Opportunities	**Threats**
• Easy access to international technical expertise(AFRO,HQ) • Clear monitoring mechanisms from AFRO and HQ. • Partnering opportunities with other UN agencies to support the health sector. • Availability of clear guidelines and tools for development and implementation of CSS and for ensuring compliance with WHO regional and global priorities. • Availability of multi-professional human resource base within the UN system.	• Inadequate commitment of the MOHSW to WHO operations. • Perceptions that WHO is a funding institution • Lack of ownership of the CCS from other key role players in health. • Human resource crisis in health sector.

ANNEX - IV

LINKAGES BETWEEN AFRO PRIORITIES AND STRATEGIC OBJECTIVES AND CCS STRATEGIC PRIORITIES WHO-LESOTHO CCS STRATEGIC PRIORITIES

		WHO-Lesotho CCS Strategic Priorities				
S/N	AFRO Regional Priorities & Strategic Objectives	(1) Strengthen the control of TB, HIV and AIDS	(2) Strengthen family and community health	(3) Enhance capacity for the prevention and control of major communicable and noncommunicable diseases	(4) Strengthen health systems	(5) Foster partnerships and coordination for national health development
1	A more structured engagement by WHO at the national health policy level.	+	+	+	++	+++
2	Strengthening WHO's role in supporting the development of national health systems.	+	+	+	+++	++
3	Working with Member States and partners to support the scaling up of public health programmes.	+++	++	++	++	++
4	Ensuring that in times of crisis all affected populations, displaced people, have access including to essential healthcare.		+++	+	+	
5	Harmonizing WHO efforts with those of the United Nations and, where appropriate, with other development partners in line with the priorities of the Member States.	++	++	++	++	+++

ANNEX - V

LINKAGES BETWEEN AFRO PRIORITIES AND STRATEGIC OBJECTIVES AND CCS STRATEGIC PRIORITIES

		WHO-Lesotho CCS Strategic Priorities				
S/N	Lesotho UNDAF Priorities	(1) Strengthen the control of TB, HIV and AIDS	(2) Strengthen family and community health	(3) Enhance capacity for the prevention and control of major communicable and noncommunicable diseases	(4) Strengthen health systems	(5) Foster partnerships and coordination for national health
1	Capacity strengthened to sustain universal access to HIV/AIDS prevention, treatment, care and support and impact mitigation.	+++	++	++	++	++
2	Improved and expanded access to quality basic health, education and social welfare services for all.	++	++	+++	+++	+++
3	Increased employment, household food security and enhanced natural resource and environmental management.	+	+	++	+	+
4	Governance institutions , strengthened ensuring gender equality, public service delivery and human rights for all.	++	++	++	++	++