Document of
The World Bank

Report No.: 55417

PROJECT PERFORMANCE ASSESSMENT REPORT

LESOTHO

HEALTH SECTOR REFORM PROJECT
(CR. 3376)

HIV AND AIDS CAPACITY BUILDING AND TECHNICAL ASSISTANCE PROJECT
(H113)

June 29, 2010

Sector Evaluations (IEGSE)
Independent Evaluation Group

Currency Equivalents (annual averages)

Currency Unit = Maloti

2000	US$1.00	6.94 maloti
2001	US$1.00	8.61 maloti
2002	US$1.00	10.54 maloti
2003	US$1.00	7.56 maloti
2004	US$1.00	6.46 maloti
2005	US$1.00	6.36 maloti
2006	US$1.00	6.77 maloti
2007	US$1.00	7.05 maloti
2008	US$1.00	8.26 maloti
2009	US$1.00	8.47 maloti

Abbreviations and Acronyms

AfDB	African Development Bank
AIDS	Acquired immune deficiency syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral drugs
BCC	Behavior change communication
BCP	Basotho Congress Party
CBO	Community-based organization
CCM	Country Coordinating Mechanism
CHAL	Christian Health Association of Lesotho
DCA	Development Credit Agreement
DCI	Development Cooperation Ireland
DfID	Department for International Development
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DOTS	Directly observed therapy short course
ESW	Economic and sector work
EU	European Union
FMIS	Financial Management Information System
GFCU	Global Fund Coordination Unit
ICR	Implementation Completion Report
ICT	Information communication technology
IDA	International Development Association
IEG	Independent Evaluation Group
HCTA	HIV and AIDS Capacity Building and Technical Assistance Project
HIV	Human immunodeficiency virus
HMIS	Health Management Information System
HPSU	Health Planning and Statistics Unit
SACU	Southern Africa Customs Union
HSRP	Health Sector Reform Project
KYS	Know Your Status
LAPCA	Lesotho AIDS Programme Coordinating Authority
LCD	Lesotho Congress for Democracy
LCN	Lesotho Council of Non-governmental Organizations
MCC	Millennium Challenge Corporation
M&E	Monitoring and evaluation
MOFDP	Ministry of Finance and Development Planning
MOHSW	Ministry of Health and Social Welfare
MOPS	Ministry of Public Service
MOU	Memorandum of understanding
MTCT	Mother-to-child transmission
MTEF	Medium-term expenditure framework
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NDSP	National Drug Supply Organization
NDP	National Development Plan
NGO	Nongovernmental organization
NHTC	National Health Training Center
OVC	Orphans and vulnerable children
PAD	Project Appraisal Document
PLWHA	People living with HIV/AIDS
PPAR	Project Performance Assessment Report
PEPFAR	President's Emergency Program for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
QEII	Queen Elizabeth II Hospital
RBF	Results-based financing
UNAIDS	Joint United Nations Programme on HIV/AIDS

STI	Sexually transmitted infection	UNDP	United Nations Development Programme
SWAp	Sector-wide approach	UNFPA	United Nations Family Planning Association
TB	Tuberculosis	UNICEF	United Nations Children's Fund
TOR	Terms of reference	VCT	Voluntary counseling and testing
TWG	Technical working group	WHO	World Health Organization

Fiscal Year

Government: 1 April – 31 March

Director-General, Evaluation	:	Mr. Vinod Thomas
Director, Independent Evaluation Group (World Bank)	:	Ms. Cheryl Gray
Manager, Sector Evaluations (IEGSE)	:	Ms. Monika Huppi
Task Manager	:	Ms. Martha Ainsworth

IEGWB Mission: Improving development results through excellence in evaluation.

About this Report

The Independent Evaluation Group assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEGWB annually assesses about 25 percent of the Bank's lending operations through field work. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons.

To prepare a Project Performance Assessment Report (PPAR), IEGWB staff examine project files and other documents, interview operational staff, visit the borrowing country to discuss the operation with the government, and other in-country stakeholders, and interview Bank staff and other donor agency staff both at headquarters and in local offices as appropriate.

Each PPAR is subject to internal IEGWB peer review, Panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible Bank department. IEGWB incorporates the comments as relevant. The completed PPAR is then sent to the borrower for review; the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

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Outcome: The extent to which the operation's major relevant objectives were achieved, or are expected to be achieved, efficiently. The rating has three dimensions: relevance, efficacy, and efficiency. *Relevance* includes relevance of objectives and relevance of design. Relevance of objectives is the extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). Relevance of design is the extent to which the project's design is consistent with the stated objectives. *Efficacy* is the extent to which the project's objectives were achieved, or are expected to be achieved, taking into account their relative importance. *Efficiency* is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. The efficiency dimension generally is not applied to adjustment operations. *Possible ratings for Outcome:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Risk to Development Outcome: The risk, at the time of evaluation, that development outcomes (or expected outcomes) will not be maintained (or realized). *Possible ratings for Risk to Development Outcome:* High Significant, Moderate, Negligible to Low, Not Evaluable.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry of the operation and supported effective implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of supported activities after loan/credit closing, toward the achievement of development outcomes. The rating has two dimensions: quality at entry and quality of supervision. *Possible ratings for Bank Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower (including the government and implementing agency or agencies) ensured quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development outcomes. The rating has two dimensions: government performance and implementing agency(ies) performance. *Possible ratings for Borrower Performance:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

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This report was prepared by Judyth Twigg, Consultant, who assessed the project in October 2009. Marie-Jeanne Ndiaye provided administrative support.

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Principal Ratings

Health Sector Reform Project (Cr. 3376-LSO)

	*ICR**	*ICR Review**	*PPAR*
Outcome	Satisfactory	Moderately Satisfactory	Moderately Unsatisfactory
Institutional Development Impact**	Modest	Substantial	———
Risk to Development Outcome	———	———	Substantial
Sustainability***	Likely	Likely	———
Bank Performance	Satisfactory	Satisfactory	Satisfactory
Borrower Performance	Satisfactory	Satisfactory	Moderately Unsatisfactory

HIV/AIDS Capacity Building and Technical Assistance Project (H113-LSO)

	*ICR**	*ICR Review**	*PPAR*
Outcome	Satisfactory	Moderately Satisfactory	Moderately Satisfactory
Risk to Development Outcome	Substantial	Substantial	Substantial
Bank Performance	Satisfactory	Satisfactory	Satisfactory
Borrower Performance	Satisfactory	Moderately Satisfactory	Moderately Satisfactory

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible Bank department. The ICR Review is an intermediate IEGWB product that seeks to independently verify the findings of the ICR.
**As of July 1, 2006, Institutional Development Impact is assessed as part of the Outcome rating.
***As of July 1, 2006, Sustainability has been replaced by Risk to Development Outcome. As the scales are different, the ratings are not directly comparable.

Key Staff Responsible

Health Sector Reform Project (Cr. 3376-LSO)

Project	*Task Manager/Leader*	*Division Chief/ Sector Director*	*Country Director*
Appraisal	Julie McLaughlin	Dzingai Mutumbuka	Pamela Cox
Supervision	Julie McLaughlin	Dzingai Mutumbuka	Fayez Omar
Completion	Muhammad Ali Pate	Dzingai Mutumbuka	Ritva S. Reinikka

HIV/AIDS Capacity Building and Technical Assistance Project (H113-LSO)

Project	*Task Manager/Leader*	*Division Chief/ Sector Director*	*Country Director*
Appraisal	Julie McLaughlin	Dzingai Mutumbuka	Pamela Cox (Acting)
Supervision	Feng Zhao	Dzingai Mutumbuka	Ritva S. Reinikka
Completion	Feng Zhao	Christopher Thomas	Ruth Kagia

Preface

This is a Project Performance Assessment Report (PPAR) for Lesotho's Health Sector Reform Project (HSRP, US$20.4 million) and HIV and AIDS Capacity Building and Technical Assistance Project (HCTA, US$5.0 million). HSRP was the first phase of a planned three-phase Adaptable Program Loan designed to support a ten-year government Health Sector Reform Program (2000-2009). Project plans included co-financing by the government and an array of other development partners, including the African Development Bank, European Union, Republic of Ireland, UNICEF, and the World Health Organization. HSRP was approved on June 30, 2000, became effective on January 31, 2001, and closed on June 30, 2005. Total actual costs were US$19.53 million, or 95 percent of the original estimate; of the IDA credit of US$6.5 million, US$6.16 million, or 94.8 percent, was actually disbursed. The closing date for the project was extended once, by fifteen months, to allow additional time for achievement of triggers to move to Phase II.

HCTA, a first-of-its-kind project, was explicitly designed to enhance country capacity to absorb a significantly larger amount of resources offered by another donor (the Global Fund to Fight AIDS, Tuberculosis, and Malaria). It was approved on July 6, 2004, became effective on January 31, 2005, and closed as scheduled on December 31, 2008. The grant was 98 percent disbursed.

This report was prepared by Judyth Twigg, IEG consultant. The findings are based on a review of project files; the projects' mid-term reviews and Implementation Completion and Results Reports; documents related to Lesotho's Global Fund grants; published and unpublished literature on health status and health reform in Lesotho; and health statistics and documents released by the Government. Interviews were conducted with some of the project task managers; other World Bank managers, staff, and consultants who worked on the project; officials from the Ministry of Health and Social Welfare, Ministry of Finance and Development Planning, and other government agencies; health providers; representatives of key non-governmental organizations; and other donors. During a two-week mission to Lesotho in October 2009, government and health sector personnel, World Bank staff, and donors were interviewed in Maseru and the districts of Leribe and Thaba-Tseka. A list of those consulted is in Annex A. IEG would like to express appreciation to those interviewed and to the World Bank Lesotho Liaison Office staff, particularly Theresia Rasethuntsa, Masekeleme Sekeleme, and Ligo Mohibe, who helped make appointments, arranged for transportation, and assembled key documents.

Following standard IEG procedures, copies of the draft PPAR were sent to Government officials and agencies for their review and comments, but no comments were received.

Summary

The $20.4 million **Health Sector Reform Project** (HSRP, 2000-2005) was designed as the first phase of a three-phase adaptable program loan (APL) to support a ten-year Health Sector Reform Program (2000-2009) whose objective was to achieve a "sustainable increase in access to quality preventive, curative, and rehabilitative health care services in Lesotho." The objectives of the HSRP were to assist Lesotho in achieving a sustainable increase in access to quality preventive, curative, and rehabilitative health care services, including: (a) strengthening the capacity of the Ministry of Health and Social Work (MOHSW) to develop, carry out, and monitor the Program; and (b) expanding the capacity of the public sector to respond to HIV/AIDS. The project's focus was to enable the MOHSW to collect and analyze information, formulate and assess sectoral strategies for improving equity, quality, and access, meet international standards for financial management, monitor progress against a stated workplan towards measurable targets, evaluate strategies, and attract and retain qualified staff. Further, by project's end the Government of Lesotho was to have established partnerships with non-governmental organizations undertaking activities to prevent the transmission of HIV and mitigate the impact of HIV/AIDS.

The closing date for the project was extended once, by fifteen months, to June 30, 2005, to allow additional time for achievement of triggers to move to Phase II. During the life of the project, the MOHSW improved its capacity to plan, implement, monitor, and evaluate comprehensive health sector reform strategies in the areas of service delivery, health financing, human resources, drug supply, and infrastructure development. Implementation of a ten-year health sector policy inaugurated in 1999 continued on track, and development partners worked together through what was termed a sector-wide approach. Shortcomings included the failure to: (a) fill vacant positions with appropriately skilled personnel; (b) establish a Health Management Information System (HMIS) that would manage the required information and evidence to report health sector reform program indicators; and (c) build capacity of several MOHSW departments and in the districts to implement the reform program and strengthen service delivery. Policies and guidelines for HIV/AIDS were developed, but prevention and targeting of high-risk groups received insufficient attention. Overall, health system development did not lead to improvement in service delivery during the lifetime of the project, and health outcomes improved modestly, at best. The major reason for this disconnect was the persistent problem in human resources and capacity.

The outcome of the HSRP is rated **Moderately Unsatisfactory**, based on the Substantial relevance of its objectives, Modest relevance of design, Modest achievement of both objectives, and Modest efficiency in meeting those objectives. The Risk to Development Outcome is rated **Substantial**. The project resulted in institutional capacity strengthening in the MOHSW, especially in the Health Planning and Statistics Unit, but questions lingered about the extent to which the gains from the project were fully institutionalized, given problems with staff turnover.

Bank performance is rated **Satisfactory**, with important attention to the need to market reforms and address issues with politicization of the civil service, but insufficient focus on the risks posed by human resource challenges. Borrower performance is rated **Moderately Unsatisfactory**, with the MOHSW having been transformed into a more professional organization with increased commitment to reform, but with staffing and financing issues a continued obstacle.

The objective of the $5 million **HIV and AIDS Capacity Building and Technical Assistance Project** (HCTA, 2004-2008) was to increase Lesotho's capacity to use effectively the resources

provided through a $29 million Global Fund grant to support the implementation of HIV and AIDS programs within its territory. The project provided technical assistance to build capacity in the Ministry of Health and Social Work, the Ministry of Finance and Development Planning, National AIDS Commission, and civil society organizations. The HCTA project design was uniquely different from previous World Bank HIV/AIDS projects, with its exclusive focus on using the Bank's comparative advantage to complement and enable the absorption of much more substantial Global Fund resources. This innovative design reflected a new partnership model never before attempted by the Bank in the health sector and was well adapted to the country situation.

The project closed as scheduled on December 31, 2008. It greatly improved the capacity of the Ministries of Health and Finance and the National AIDS Commission to manage and disburse Global Fund resources, but few resources were used to strengthen the capacity of civil society organizations beyond the largest umbrella NGOs. Ninety-two percent of all posts at the National AIDS Commission were filled. Annual reports on all key HIV/AIDS program indicators were produced and disseminated each year of the project, although monitoring and evaluation systems remain weak. Lesotho's Round 2 Global Fund grant was 99 percent disbursed by the end of the HCTA project. Key informants repeatedly offer the same bottom-line analysis: in the absence of the Bank's intervention, the Global Fund's Round 2 grant to Lesotho would have been cancelled. Almost half of grant funding was disbursed through civil society organizations, and almost all of the grant-funded civil society subprojects received a satisfactory rating from the Global Fund with respect to achieving output targets.

Nevertheless, improvements in the efficacy with which the funds were used were modest. On the one hand, there were major achievements in the procurement and distribution of drugs through the National Drug Supply Organization, promising to improve the availability of drugs and efficacy of treatment programs. However, only three percent of project resources were used to strengthen the capacity of civil society and there was little emphasis on building civil society's technical capacity to provide interventions. Positions at the Ministry of Health and Social Work, which were key to improving the technical capacity and effective use of funds, were not filled due to high staff turnover; the vacant staff positions, particularly the inability to staff the behavior change communication unit, were a serious setback for the country's ability to formulate and implement an effective HIV prevention campaign. While the project increased the capacity to mobilize additional resources for the national program, as exemplified by additional grants from the Global Fund (Rounds 5, 6, 7, and 8) and the United States Government through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR), the capacity to use these funds effectively to prevent HIV and mitigate its impact remains weak and was only modestly enhanced by the project.

The outcome of the HCTA is rated **Moderately Satisfactory.** The project's objectives were highly relevant, though the design was only modestly so. The project substantially achieved the objective of raising the capacity to use Global Fund resources, but the capacity generated to use the resources effectively was modest. The project was substantially efficient in meeting those objectives.

The Risk to Development Outcome is rated **Substantial**. The project's contribution to the country's ability to absorb Global Fund and other donor resources has proven its effectiveness in attracting additional resources. While donor funds are no guarantee of sustainability, the increase in financing creates favorable conditions for maintaining and improving upon capacities that

were created, particularly in the presence of a partner such as the Bank who has focused attention on capacity-building imperatives. International technical assistance, however, is a short-term solution to a long-term problem. It is not clear that the Government adequately planned for absorption of technical assistance provided by the project to facilitate permanent improvements in local capacity. Institutionalizing the systems created or supported by the project remains a concern.

Bank performance is rated **Satisfactory.** The Bank's role was catalytic, supporting innovations in institutional capacity development to increase adequacy of procedures and systems as well as individual capabilities. Some shortcomings remained, however, including failure to focus on the well-known problem of human resource retention, targeting of capacity-building at national-level institutions at the expense of the district level and below, and failure to take advantage of opportunities to explore synergies between HIV/AIDS and TB. Borrower performance is rated **Moderately Satisfactory**, with high levels of commitment throughout and appropriate development of policy documents and strategies to develop the national response to HIV/AIDS, but failure to respond to high staff turnover and to Bank exhortations about the need to focus attention on HIV/AIDS prevention.

Lessons

The experience with the two projects has generated the following lessons:

- **The Bank needs to pay greater attention to political economy factors that can influence project implementation and performance. Even issues that are seemingly resolved can re-emerge unexpectedly.** For example, there are current political controversies swirling around the National AIDS Commission, with continuing rumors that it is about to be dissolved. Given that the Commission's initial creation was viewed by many as simply a quick political fix, intended to placate public outcry over increasing number of AIDS-related illnesses and deaths, it is not surprising that it remains a source of controversy, in many cases merely a tool in ongoing power struggles.

- **Health sector reform does not and cannot take place in a vacuum.** In the case of the HSRP, the lack of a macroeconomic support program to push for difficult policy issues outside the purview of the MOHSW probably constrained or delayed actions, particularly in the areas of decentralization of services and upgrading the salaries and benefits of health workers (civil service salaries being a system-wide issue). Lack of progress or clarity on "upstream" issues – most importantly, setting the rules of the game for an eventual fiscal devolution to local authorities – meant that "downstream" activities within the health sector itself had to be deferred, or redesigned to fit within the purview of only the health sector.

- **Sustainable human resources retention requires long-term planning, ownership, and most of all, innovation.** Like many countries in the region, shortage of skilled manpower is one of the main challenges facing the Government of Lesotho. Levels of remuneration, while important, are not the primary issue. Staff in rural areas cite a variety of more compelling factors that make it difficult for them to attract qualified personnel: neglect by senior management and headquarters offices, who virtually never spend time outside Maseru conferring with service providers at the health facilities themselves; housing and security; and most importantly, lack of resources, especially equipment and vehicles/fuel, that would make it possible for staff to perform their main task – saving lives – effectively. It is also not

clear that an exclusive focus on supply-side issues is appropriate in the human resources area. If all staff worked to full capacity, the situation would be improved greatly, but existing approaches have not focused on the productivity and duplication sides of the equation.

- **HIV/AIDS programs must be balanced with attention to, and integration with, other key health priorities.** There is near-universal agreement that HIV has crowded out other important health challenges in Lesotho. The HCTA's focus on Global Fund resources may have exacerbated this problem, with its exclusive concentration not only on HIV, but on Global Fund-financed HIV interventions; Government attention, largely because of the significant dollar amounts involved, remains with the Global Fund grant, and opportunities to integrate both Global Fund activities and HIV-related activities with the health sector in general have been missed. Bank projects could have encouraged integration of HIV with other health services, including those for TB, reproductive health, and orphans and vulnerable children.

- **As more resources are becoming available to finance HIV programs, it is the Bank's comparative advantage to focus on system strengthening projects like the HSRP and HCTA.** The Bank's hands-on implementation support remains much needed, given the Global Fund's status as a grant-providing agency that offers limited implementation support. Continued Bank support for strengthening of implementation systems can help remove capacity bottlenecks and speed up the pace of implementation of other partners' HIV and health sector reform programs. This approach is also an effective way to invest limited Bank resources, as compared to a much costlier expenditure on more mainstream interventions. Building capacity and filling gaps uses the Bank's comparative advantage, particularly in system and fiduciary strengthening, in a way that complements, rather than competes with, other partners' financing. In short, the Bank's approach to health and HIV/AIDS in Lesotho has accomplished a lot with relatively little money. In the current environment, with a number of global initiatives providing substantial resources toward improving health, nutrition, and population outcomes, the Bank's approach in Lesotho could serve as a valuable lesson to be extended to other priority development areas.

Vinod Thomas
Director-General
Evaluation

1. Country and Health Background

1.1 Lesotho (formerly Basutoland) has endured periods of political turbulence, including seven years of military rule, since gaining independence from Great Britain in 1966. Constitutional government was established in 1993 (Central Intelligence Agency 2009). In 1998 contested elections resulted in widespread protests and riots, prompting brief but intense intervention by South African and Botswanan military forces under the auspices of the Southern African Development Community. Constitutional reforms restored relative political stability, with peaceful parliamentary elections in 2002, but National Assembly elections in 2007 were once again hotly contested. Although aggrieved political parties continue to demonstrate distrust of the results, the last three years have been dominated by relative peace and consensus (Owusu-Ampomah, Naysmith, and Rubincam 2009).

1.2 Lesotho is small, mountainous, and landlocked, bordered on all sides by South Africa and heavily influenced in all spheres by its only neighbor. It has a population of about two million, about a quarter of whom live in urban areas. Predominantly Christian, the vast majority of the population is of Basotho ethnicity. Forty percent of women and 28 percent of men have secondary education or higher. With boys frequently tending livestock part- or full-time, and then transitioning to mine work as adults, women tend to be more educated and to occupy the majority of mid-level public and private sector white-collar jobs. Access to basic services in rural areas is low. Fewer than one percent of rural residents have access to electricity in their households, only 37 percent travel fewer than 15 minutes to a water source, and half have no access to sanitation facilities (World Bank 2009b).

1.3 Real per capita economic growth averaged 3.3 percent over 1991-2007, above average for sub-Saharan Africa. Lesotho reached the status of lower-middle income country in 2005. Extreme income inequality persists, with a Gini coefficient of 0.63 and more than half of the population living below the poverty line of US$1.50 per day (Owusu-Amoman, Naysmith, and Rubincam 2009; World Bank 2007).

Health Conditions

1.4 Lesotho's relatively strong economic development in recent decades was mirrored by improvement in the state of its human capital until the late 1990s, when the impact of the AIDS epidemic became evident. Lesotho has the third highest reported adult HIV prevalence rate in the world, at 23.2 percent, surpassed only by Swaziland and Botswana (NAC 2008a). That figure has remained steady for the last several years. Approximately 18,000 people, or one percent of the entire population, die annually of AIDS-related complications (Cohen 2009). As a result, Lesotho has experienced a dramatic recent decline in life expectancy: in 2007 life expectancy had dropped from its peak of 60 years in the early 1990s by about 15 years and was lower than in the 1960s (Figure 1-1). Infant and under-five mortality rates increased steadily in the late 1990s, consistent with the timing of pediatric deaths due to HIV/AIDS, but have declined since the early 2000s to pre-AIDS levels (Figure 1-2) (World Bank 2009b).

Figure 1-1: Life Expectancy, 1980-2009

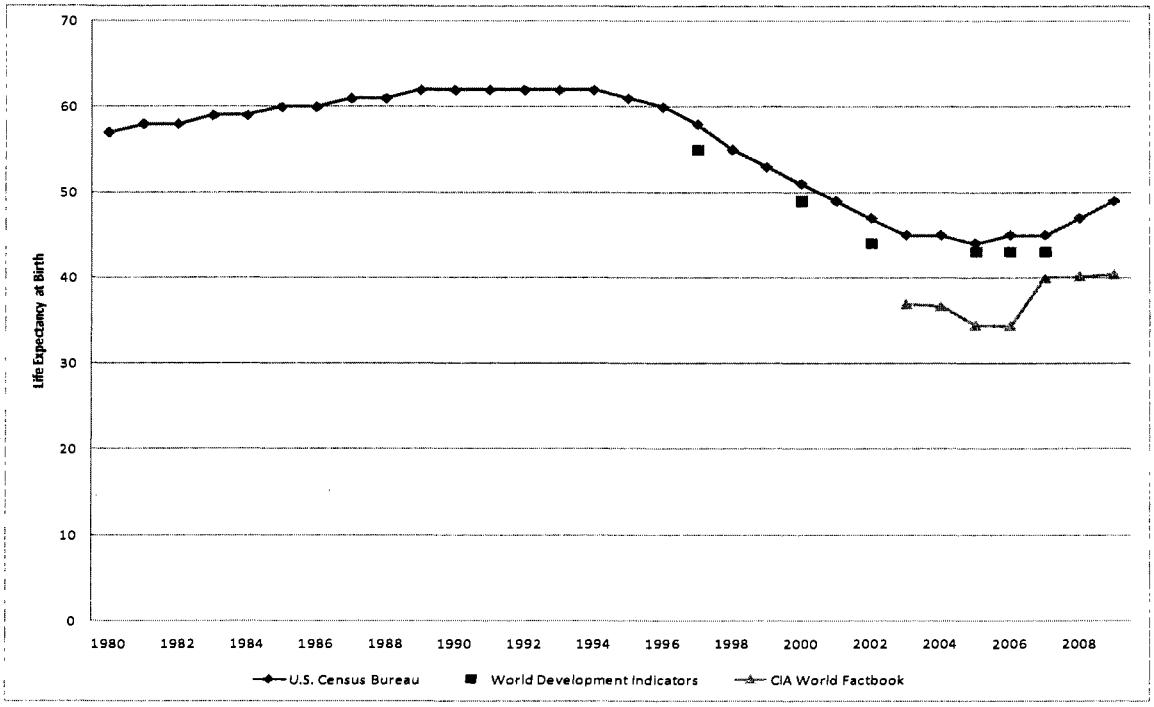
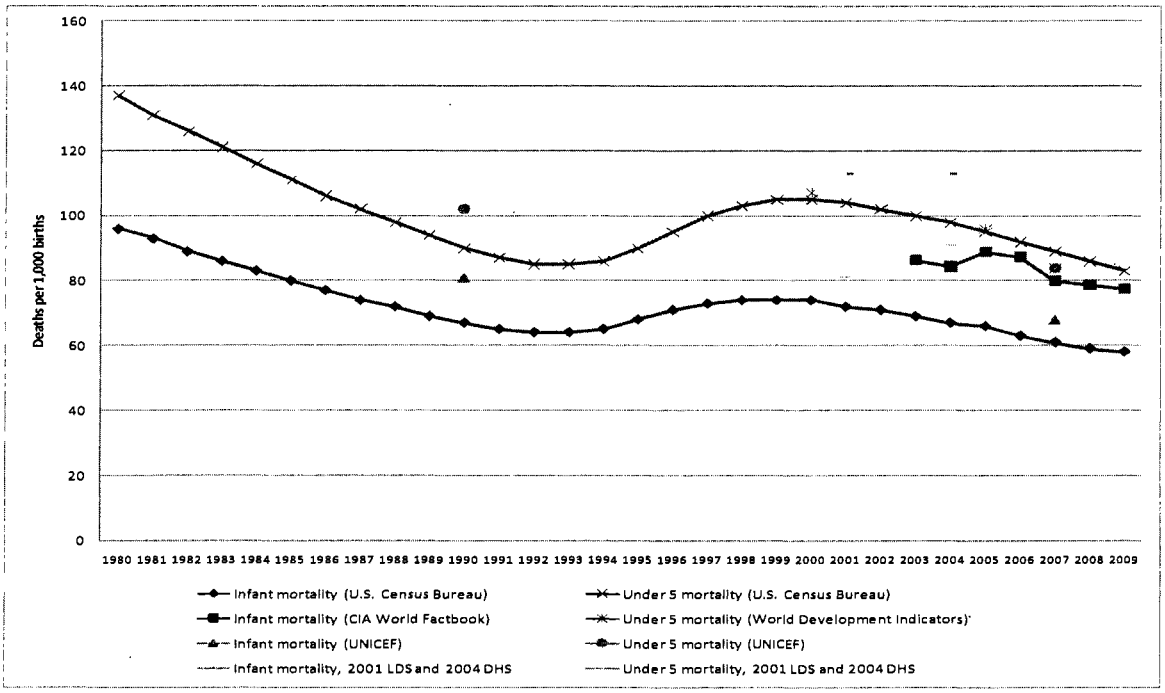


Figure 1-2: Infant and Under 5 Mortality Rates, 1980-2009



1.5 The total fertility rate has declined from 4.9 per woman in the 1990s to 3.5 in 2005 (World Bank 2009b). The strong influence of the Catholic Church on government policy has prevented further development of family planning interventions (Adair 2009; Tuoane,

Madise, and Diamond 2004). Because of its temperate climate, Lesotho is almost entirely free from the tropical diseases, including malaria, that are prevalent in most of sub-Saharan Africa (Shonubi 2005). Measles immunization coverage rates have remained steady at over 80 percent, and more than half of children with diarrhea receive oral rehydration solution (up from 29 percent in 2000). The share of women reporting exclusive breastfeeding more than doubled from 15 to 36 percent between 2000 and 2004. However, the percentage of underweight children worsened between 1996 and 2004, from 16 to 20 percent, with the highest prevalence among the poorest income quintiles.

1.6 Lesotho also has the fifth highest tuberculosis (TB) incidence rate in the world, with 513 cases per 100,000 people (Seung 2009). Tuberculosis is the leading cause of death for those with HIV and AIDS (80 percent of HIV patients are co-infected), the number of deaths from TB having tripled since 1990 (World Bank 2009c). Multidrug-resistant and extensively-drug-resistant TB are suspected to be rising. Although accurate data on drug resistance are not available, ten percent of smear-positive patients are estimated to have multidrug resistance (Satti 2008).

Health System

1.7 Lesotho's health system is managed by the Ministry of Health and Social Welfare (MOHSW). Service delivery takes place mainly through the MOHSW and faith-based organizations, the largest of these being the Christian Health Association of Lesotho (CHAL), which operates about half of the country's health facilities. Public and CHAL facilities generally cover distinct geographic areas, and so while they offer the same services they do not compete with or substitute for one another, as purchasers generally do not choose between the two types; they simply go to whatever facility is located in their geographic area. The health system is divided into four levels: tertiary and specialized hospitals, district hospitals, health centers and clinics, and village health workers. Only the MOHSW provides tertiary services in the form of the national referral hospital, Queen Elizabeth II (QEII) Hospital, with particularly critical cases referred to Bloemfontein, South Africa, about a ninety-minute drive from Maseru (Babich 2008). About 2,600 traditional healers also provide services, some outside the realm of biomedical interventions (Lievens and Manu 2008b).

1.8 The country has ten health districts (Macro International 2008). Health service delivery in each district is overseen by district health management teams, headed by district medical officers. Generally, each district has at least one hospital and a number of primary care facilities, but there is some concentration of facilities in the capital and the lowlands districts nearest the capital (World Bank 2009b). On average, there are 9.5 primary facilities and just over one hospital per 100,000 population. Lesotho has only 0.75 annual outpatient visits per capita, well below the World Health Organization (WHO) norm of 3.5 and significantly below that for South Africa (2.3)(World Bank 2009b). Given the magnitude of the HIV pandemic, it is unlikely that service demand accounts for this low utilization; monetary costs, transport costs, long waiting times, and staff shortages are likely constraining factors (Lievens and Manu 2008b). Transportation is particularly burdensome for the Basotho who live in inaccessible mountain regions with few roads and sometimes extreme weather (floods, snowstorms, and high winds), although the Lesotho Flying Doctors Service

uses single-engine planes and helicopters to reach the most critical cases in these areas (Furin, Shutts, and Keshavjee 2008; Shonubi 2005).

1.9 The Government is moving forward with an aggressive process of decentralization that will impact health service delivery at both facility and community levels (PEPFAR 2009). The Local Government Act of 1997 devolved responsibility for health service provision and management to district governments and community councils. Responsibility for primary level health facilities is currently being gradually transferred to the Ministry of Local Government and Chieftainship, with MOHSW maintaining responsibility for secondary and tertiary hospital services.

Box 1-1: Human Resources in the Health Sector

Lesotho's human resource situation is commonly defined as a perpetual crisis. The health sector is no exception. The pull factor from the geographically contiguous and economically stronger South Africa is continuous and substantial. There are about 90 doctors in all of Lesotho, and 80 percent of those are from other African countries, many marking time in Lesotho while waiting for certification in the South African medical corps (Médicins sans Frontières 2009). The shortage of physicians makes nurses even more valuable, but those are also in short supply: from 1994 to 2004 the number of employed nurses fell by 15 percent, halving the rate of nurses and midwives per 1,000 population at a time when the country's burden of disease was substantially increasing (World Bank 2009b). Only a small minority of the country's health centers say they have a full contingent of staff. In 2006/07, 87 percent of all approved health worker posts in the country were actually filled, but these numbers varied widely across categories: the National Health Training Center filled 99 percent of its positions, but primary health facilities had a vacancy rate of 33 percent (Lievens and Manu 2008b). Salary rates, while higher than those in other poor sub-Saharan Africa countries, are uncompetitive with South Africa, the Middle East, the United Kingdom, and other Western countries, where many Basotho nurses go.

Lesotho does not have its own medical school. The National Health Training Center produces 60 new nurses a year, and the Christian Health Association of Lesotho (CHAL) nursing schools an additional 70 nurses and nursing assistants, but studies indicate an immediate need for about 600 nurses. The Government has considered a variety of options to address this problem, including extra pay allowances to selected health workers using Global Fund grants, but it is unclear whether these would create disincentives to health workers who are not beneficiaries of this scheme.[a] Overall, the human resource reform thrust has been too focused on filling vacant slots, with little attention to staff incentives other than pay enhancements.

International partners (including the Bank) have long recognized the magnitude of the human resource challenge, but little has been done effectively to address it. For example, the US Millennium Challenge Account has committed US$140 million to new and improved health facilities across the country, but there are no plans to train or recruit the additional estimated 600 health care workers that will be needed to staff these structures (Médicins sans Frontières 2009). The Bank's recent public-private partnership project, which is assisting with the construction of a new referral hospital to replace the aging Queen Elizabeth II facilities, will need about 1,000 staff, with only 600 of those to come from the existing hospital. The new facility will have to hire the additional 400 health workers largely from outside Lesotho; it is uncertain how these plans will be perceived by the health workers in place. A concept note issued collectively by health donors (Health Development Partners 2008) noted the apparent lack of commitment of senior management in the Ministry of Health and Social Work to implementation of its Human Resources Development and Strategic Plan. A recently-constituted Technical Human Resources Working Group on Health, composed of key representatives of Government and donors, is currently formulating new short- and long-term strategies to address the human resources problem.

a.The Round 8 Global Fund grant includes support for health staff in CHAL facilities, in an effort to reduce inequities in pay among health personnel.

1.10 One of the pervasive problems of Lesotho's health sector is its human resource crisis (Box 1-1). Although the ratio of physicians per 1,000 population has doubled since the 1990s, it remains among the worst in the region (World Bank 2009b). The shortage of doctors makes medical support staff such as nurses even more valuable, but they are also in short supply, with 600 vacant nursing positions waiting to be filled (IRIN 2009).

1.11 Given the country's severe human resource constraints, effectiveness and efficiency remain major challenges to the health system. With outpatient contact levels low and average 2007 occupancy rates of Government and CHAL hospitals 38 and 42 percent, respectively, it is reasonable to question whether scarce human resources are being deployed effectively. The only hospital reaching a bed occupancy rate of 75-80 percent is the QEII, but the quality of its care is reported to be below standard (Naylor and others 2008).

World Bank and Other Donor Support

1.12 Lesotho has historically received a relatively small amount of overall donor assistance. This is partly attributable to the limited financial management and monitoring capacity of the Government, and also a decline in donor interest after the end of South Africa's apartheid regime in 1994 and the civil unrest after the 1998 election. Official development assistance dropped from around US$70 per capita in the early 1990s to US$15 per capita in the early 2000s, well below the average for sub-Saharan Africa (World Bank 2005b). Less than ten percent of the country's budget is financed through foreign assistance (World Bank 2009b). Much of Lesotho's economic growth in the late 1990s and early 2000s was spurred by the Bank-supported Lesotho Highlands Water Project, which employed a significant number of Basotho and provides substantial revenues through the sale of water to South Africa.

1.13 The World Bank's funding for health in Lesotho began in April of 1985, with the first of two population and health projects that ran through the late 1990s. The objectives of the Health and Population Project ($3.5 million, 1985 – 1992) were to strengthen the organization and management of the Ministry of Health; improve the efficiency, effectiveness, and coverage of health care and family planning services; and strengthen manpower development and training. The Second Population, Health, and Nutrition Project (US$22.1 million, 1989 –1998) was intended to introduce financial and institutional policy reforms and inject needed investment resources, with components related to population control, TB, sexually transmitted infections, the development of urban filter clinics, food security, and institutional development.

1.14 As recently as the early 2000s, few development assistance agencies supported Lesotho's health sector, with the African Development Bank (AfDB), Development Cooperation Ireland (DCI), and the Bank as the main donors. At that time, UN agencies (WHO, UNICEF, UNFPA) provided technical support, but their country offices were relatively small. DCI was the only bilateral donor with health sector experience in the country; the European Union, which had earlier provided substantial support through technical assistance, closed its office in 2005. Support for the health sector has increased dramatically in recent years, however, largely due to the rising share of HIV/AIDS in total health spending, from 5.2 percent in 2002 to 18.2 percent in 2005, and representing almost a

quadrupling in value from US$2.3 million to US$8.4 million annually. By 2005/2006, almost two-thirds of the country's HIV/AIDS spending came from international partners (NAC 2008b). This rapid increase in external funds, particularly for HIV/AIDS, presented a significant absorption challenge.

1.15 The most significant current sources of donor support for health are the Global Fund, DCI, the World Bank, AfDB, the United States Government, and the European Commission. The Global Fund is by far the largest external financer for HIV/AIDS, with a cumulative amount of US$66.2 million for HIV and TB programs committed between 2004 and 2008 (Annex E); the recently-approved Round 8 proposals, two grants of US$50.4 million (2009-2011) and US$6.8 million (2010-2012), add substantially to that amount. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) entered Lesotho in 2007 with a commitment of US$9.5 million, since increased to $29.6 million in 2008 and $26.7 million in 2009; Lesotho was added as a PEPFAR focus country in 2008. The U.S. Millennium Challenge Corporation (MCC) has pledged US$122.4 million to the health sector over five years (2008-2012), part of a larger $362.5 million grant that also covers water resources and private sector development. MCC's Health Sector Project focuses on renovation of health centers, establishment of antiretroviral treatment (ART) clinics in fourteen hospital outpatient departments, a new central laboratory and blood transfusion center, construction of student and staff residences for the National Health Training College, and overall health systems strengthening (MCC 2009).

1.16 Prior to 2000, the array of projects supported by various partners had been defined separately from other MOHSW activities, and minimal collaboration generally occurred across donor-supported projects. Each agency retained its own procedures for monitoring, reporting, disbursing, and accounting, conducted separate evaluations of "its" activities, and communicated directly with the respective implementing units within the ministry (rather than with the Health Planning and Statistics Unit (HPSU), which is charged with donor coordination and sector planning). Donor support to the Lesotho health sector since 2000 has flowed through a nominal sector-wide approach (SWAp), with coordinated policy advice by partners, an agreed sector expenditure framework, harmonized fiduciary systems, and common performance indicators (but not pooled financing). The Bank has played a critical role in facilitating the SWAp, in the area of institutional development and the development of systems capable of coordinating donor and government support to the sector. Given the rapid expansion in donor activity over the last four years, however, particularly that directed toward HIV/AIDS, the effectiveness and efficiency of coordination efforts has become a major issue. With fifteen development partner agencies now active in Lesotho, donor coordination occurs through monthly meetings of a Development Partners Consultative Forum, inaugurated in 2005, co-chaired by the United Nations Development Program (UNDP) and DCI. The co-chairs of the Forum meet with MOHSW every six weeks ("six-weekly meeting"), and all partners participate in MOHSW-led Joint Quarterly and Annual Reviews of the health sector. Yet interviews with key stakeholders reveal lingering questions about the comprehensiveness and effectiveness of these coordination mechanisms.

2. Health Sector Reform Project

Background and Context for Health Reform

2.1 In the 1990s, the health sector was widely perceived to have deteriorated in quality, while costs to the consumer had increased. Despite higher per-capita expenditures on health than sub-Saharan African averages, health status indicators lagged; money was not effectively buying health. An estimated 30 percent of the population did not have access to basic health services, and key health status indicators were either stagnant or worsening. Ministry budgets were regularly underspent (by 3-15 percent over the period 1991-1995), largely due to a lack of financial information to inform decision making, unrealistic estimations of implementation capacity, and an inflexible financing system that did not permit reallocation within the sector. Furthermore, sector expenditures were not aligned with stated objectives: up to 40 percent of the recurrent budget was being spent on Queen Elizabeth II Hospital, despite a stated commitment to primary care. Geographic inequities were evident, with per capita expenditures on primary and secondary care ranging from 23 Maloti in Mohale's Hoek to 90 in Maseru.

2.2 Shortly after the country's first democratic elections in 1993, the Ministry of Health held a workshop to define its strategy and policies for the subsequent decade. A national health policy was defined that year, with a commitment to progressive attainment of universal coverage of essential health care, social justice, and equity. A National Health Sector Plan 1995-2000 also emerged from the 1993 workshop, identifying six key areas for policy and institutional reform: financial reform, reform of human resources, decentralization of services, a district health package, safe and effective supply of pharmaceuticals, and better coordination of donor efforts.

2.3 Building further on the 1995-2000 plan, a February 1996 conference called together all of the major stakeholders in the sector, producing a more comprehensive implementation strategy. The Government's 1999 health policy (Government of Lesotho 1999) called for a sustainable increase in access to quality preventive, curative, and rehabilitative health care services throughout the country. It was supported by WHO, AfDB, the Bank, and the EU with training and significant financial and technical assistance. Bank-supported analytic work in 1999 led to the production and marketing of a user-friendly document explaining the rationale for health system reform and intended to mobilize public support (MOHSW and World Bank 1999). It was this experience in collaborative analytic work and policy formation, together with widespread recognition of the need for donor harmonization and political consultation, that led to the adoption of the sector-wide approach in 2000.

Design

Objectives and Components

2.4 The HSRP was designed as the first phase of a three-phase adaptable program loan (APL) to support a ten-year Health Sector Reform Program (2000-2009) whose objective, according to both the Development Credit Agreement and the Project Appraisal Document,

was to achieve a "sustainable increase in access to quality preventive, curative, and rehabilitative health care services in Lesotho." This project, designated as Phase I: Strengthening Institutional Capacity (2000-2003), was intended to lay the foundation for Phase II (Policy and Institutional Reform, 2003-2006, piloting or testing, critically assessing, and revising proposed reform strategies), and Phase III (Nationwide and Sector-Wide Implementation, 2006-2009, bringing to scale strategies for which there was established evidence of effectiveness). The Program and this first phase were to be co-financed by the Government and other core health sector development partners. The MOHSW and these partners were to define common systems, procedures, and standards to support a longer-term objective of disbursing donor and Bank support as time-slice financing against a single sector budget. It was thought that the timeframe required to realize sustainable institutional change, combined with the opportunity to tie allocations to achievements, would be strongly supported through an APL.

2.5 The objectives of the project, as stated in the Development Credit Agreement, included language both general to the overall Program objective and specific to Phase I: "to assist Lesotho in achieving a sustainable increase in access to quality preventive, curative, and rehabilitative health care services, including: (a) strengthening the Ministry of Health and Social Work's capacity to develop, carry out, and monitor the Program; and (b) expanding the capacity of the public sector to respond to HIV/AIDS." While improvements in service delivery targets and health outcomes were Program objectives, they were not anticipated as results of Phase I. The PAD indicated that, by the end of the first phase, the MOHSW should have been able to collect and analyze information, formulate and assess sectoral strategies for improving equity, quality, and access, meet international standards for financial management, monitor progress against a stated workplan towards measurable targets, evaluate strategies, and attract and retain qualified staff.

2.6 According to the DCA and the PAD, the project (Phase I) contained six components:

A. Financial Planning and Management (US$1.13 million), including the strengthening and improvement of MOHSW's financial management and information systems.

B. Planning and Monitoring (US$8.43 million), including strengthening the planning and monitoring capacity of MOHSW, and the establishment within MOHSW of an Estates Management.

C. Human Resources Development (US$3.42 million), including development of a Human Resource Management Information System in MOHSW, and formulation of a strategic plan for human resource development, with development and carrying out of a program to provide incentives for the retention of staff working in the health sector, including the provision of in-service training, staff housing, and other appropriate benefits to the said staff.

D. HIV/AIDS (US$2.00 million). Support for the Borrower's National AIDS Control Program, the National AIDS Commission, and the AIDS Task Force, for: (i) the formulation of the Borrower's National AIDS Strategic Plan; (ii) the carrying out of activities aimed at reducing the transmission of HIV and mitigating the impact of

HIV/AIDS being undertaken by (a) agencies of the Borrower; (b) nongovernmental organizations (NGOs); and (c) other private sector entities and community-based organizations (CBOs); (iii) the making of grants to NGOs, churches, industries, the private sector, and CBOs involved in the fight to reduce HIV transmission and mitigate the impact of HIV/AIDS; and (iv) the production of annual implementation plans for Part D of the project.

E. Partnerships (US$1.10 million), including coordination of donor support; the analysis and determination of the most efficacious means of working out arrangements for cooperation between the Borrower and CHAL in order to achieve the Project's objectives; support for CHAL, including the rehabilitation of CHAL's facilities; and facilitating collaboration on health matters between agencies of the Borrower and those of the Republic of South Africa.

F. Planning for Second Phase Activities (US$3.67 million), including carrying out preparatory and analytical activities for the second phase of the Program; formulation of proposals for piloting sustainable financing strategies for the health sector; and technical advisory services for (i) architectural design of health facilities; (ii) development of procurement plans and tender documents for proposed civil works, including staff housing, rehabilitation of CHAL hospitals, NHTC, and Mohlomi Mental Hospital; and (iii) structural and economic analysis to determine the future role of Queen Elizabeth II Hospital, and plans for construction of a replacement referral hospital.

2.7 Specific performance indicators for Phase I, as specified in the Development Credit Agreement, were:

- Budgetary allocation forecasts for FYs 2004, 2005, and 2006 made in accordance with health sector priorities indicated in the Borrower's medium-term expenditure framework.
- Financial data of acceptable quality produced no later than 60 days after the end of each fiscal year during the project implementation period.
- Quarterly reports produced with respect to monitoring and evaluation activities carried out under the project for each preceding quarter, not later than 45 days after the end of said quarter.
- At least 80 percent of professional positions within MOHSW not left vacant for more than three months during the execution of the Program.
- At least 50 percent of funds granted to Beneficiaries for the carrying out of activities related to HIV/AIDS disbursed by the end of each project year.

2.8 The PAD also specified triggers for progression from Phase I to Phase II of the program, as well as indicators to be employed to assess achievement of the objectives of the overall ten-year Sector Reform Program (Annex D).

2.9 The $20.4 million project was financed by a $6.5 million IDA credit, planned counterpart contribution of $3.52 million, and cofinancing from five donors: US$3.4 million from the African Development Bank; US$360,000 from the European Union; US$1.3 million from the Republic of Ireland; US$1.59 million from UNICEF; and US$3.73 million from WHO. Each partner was to contribute resources in its area of comparative advantage.

IMPLEMENTATION ARRANGEMENTS

2.10 Project management was integrated within the structures of the MOHSW, a departure from the past practice of implementing through Project Implementation Units, in order to avoid parallel systems, increase capacity, and integrate the management of the project into the ministry. The units responsible for planning, implementation, and monitoring functions were to be assisted by focused, external technical assistance at various management levels. A project-financed Financial Management and Information System (FMIS) Technical Assistance Team was to design management systems and their roll-out during the first 24 months of the project; then, following a transition period, a new Project Accounting Unit (PAU) was to be established at the ministry to be responsible for financial management and reporting arrangements under the reformed FMIS procedures. Procurement was to be managed by a new Procurement Unit that would work closely with the PAU. It was anticipated that bringing these functions directly within MOHSW structures would institutionalize on-the-job training and learning. All donors to the ten-year sector reform program worked through these implementation structures.

2.11 Monitoring and evaluation (M&E) was to be coordinated by a newly-established unit. MOHSW constructed a Logical Framework to demonstrate how sub-sectoral outcome objectives (for infrastructure, human resources, and financing, for example) would contribute toward the impact objectives of the Program, and how Project activities would contribute toward sub-sectoral outcome objectives. This Framework also contained indicators for monitoring progress and achievement. Donor missions were to be coordinated around Joint Annual Reviews each October to reduce the burden on Government to report to multiple agencies, and also to support efforts to maintain a comprehensive perspective on the sector. A baseline survey of the Phase I performance indicators was to have been supported under project preparation, with the results available prior to project effectiveness.

2.12 To facilitate and expedite the implementation of the HIV/AIDS component of the project, an implementing agency was to be contracted by the National AIDS Control Program to manage, monitor, and evaluate AIDS-related activities supported by the project. The vehicle for implementation of most of the HIV/AIDS interventions was to be NGOs and CBOs, with activities undertaken within the framework set out by the National AIDS Strategy and Annual Implementation Plans to be prepared by the contracted implementing agency.

Implementation

PLANNED VERSUS ACTUAL COST AND FINANCING

2.13 The project was approved on June 30, 2000, and became effective on January 31, 2001. Total actual costs were US$19.53 million, or 95 percent of the original estimate. Of the IDA credit of US$6.50 million equivalent, US$6.16 million, or 94.8 percent, was actually spent. Actual cofinancing was US$12.11 million, about 120 percent of initial estimates. The Government's actual counterpart contribution of US$0.82 million was only one-quarter of what was planned. The project spent about double what was planned on the Financial Planning and Management component and over triple what was planned on Planning for Phase II Activities, while underspending at 50 percent of planned amounts for Planning and Monitoring, 81percent of planned for Human Resources Development, and 20 percent of planned for Partnerships (Annex Table C.1).

2.14 The closing date for the project was extended once, by fifteen months, to June 30, 2005, to allow additional time for achievement of the triggers to move to Phase II.

IMPLEMENTATION EXPERIENCE

2.15 ***Human Resources:*** Staff shortages at all levels affected the pace and success of implementation. Rapid staff turnover (including at the highest levels of MOHSW) and transfers to other ministries after undergoing training exacerbated these problems. The project's mid-term review (November 2002) expressed concern regarding the lack of counterparts for consultants and follow-up on consultancies, resulting in a situation where the MOHSW remained reliant on expensive consultants because it did not always internalize the capacity intended to be built through the consultancies.[1]

2.16 ***Lesotho AIDS Program Coordinating Authority (LAPCA):*** The condition of disbursement of the HIV/AIDS component was met only in August of 2002, when Crown Agents South Africa was contracted to supply implementation support to LAPCA, the institutional coordinating body in the country for the HIV/AIDS response. A significant amount of time was lost developing the terms of reference for this contract and conducting the recruitment. Throughout its existence, LAPCA lacked full government support; it did not have a legal status and lacked critical staff. The head of LAPCA was dismissed without clear reason in 2003, with a new director not appointed for two years, toward the end of the project period. It was also clear that MOHSW and LAPCA had not agreed on their respective roles and responsibilities, leading to unnecessary duplication (of, for example, procurement of home-based care kits) and lack of harmonization of guidelines for implementation of prevention, care, support, and treatment activities. All of this turbulence produced unanticipated delays in HIV/AIDS grants approval and processing and rampant speculation about LAPCA's demise. In September of 2003, a UNDP-led donor proposal was presented to the Government recommending the formation of a National AIDS Commission, while the Bank continued to advocate for strengthening LAPCA so that it would be able to play the

[1] The mid-term review called the production, retention, deployment, capacity, motivation, and security of staff the single greatest challenge for the health and social development sector of the country.

Secretariat role whenever a commission or council was constituted. Eventually, the National AIDS Commission (NAC) replaced LAPCA in September of 2005.

2.17 ***CHAL:*** A Government/CHAL partnership study was commissioned in 2000, proposing a framework for formalizing the process of coordinating the Government-run health care system with CHAL institutions and facilities. In December of 2002, a Supplementary Emergency Financing Facility was signed, providing for salary subsidies and additional funding to bring all CHAL institutions to a threshold level equivalent to 20 percent of their annual operating costs during a two-year interim period, while arrangements were supposed to be made for a long-term Memorandum of Understanding (MOU). After repeated delays, the MOU was finally signed in February of 2007.

2.18 ***Decentralization:*** The MOHSW was committed to a process of progressive decentralization, where authority and accountability for primary health care would be passed to local authorities as soon as sufficient capacity was attained at that level. Milestones that would trigger the handover of facilities to local councils had not been developed by project closing, however, and it was not clear whether the ministry would grant authority to local councils to manage the delivery of the district health package. It should be noted that decentralization was an intensely politicized issue, and trade-offs were sometimes made based on non-technical considerations. Piloting of decentralization in three districts started late and encountered two additional constraints: late election of local councils, and failure to designate cost centers for the District Health Management Teams (DHMT), resulting in inadequate work space and equipment. By project closing, the DHMTs in the three pilot districts had been set up, and efforts were ongoing to expand the DHMT approach to the entire country. Linkages between MOHSW and local government were still weak, however, leading to confusion at the district level, where district health officers did not know whether they were answerable to the local council or to the Ministry of Health. The process was further complicated by the establishment of Community Councils through the Ministry of Local Government, in essence inaugurating a government-wide decentralization process that lagged that in the MOHSW by several years and in many ways was not congruent with it. By the end of the project period, a final decision was taken to decentralize health centers and public health functions but retain hospitals under central administration.

2.19 ***User fees:*** The possibility that user fees constituted a barrier to access by the poor was an ongoing concern, with widespread perception that the existing exemption policy was poorly implemented. In addition, during the project period, Malawi and Lesotho were the only two Anglophone sub-Saharan African countries that did not allow for the retention of user fees within the health sector. In response to previous requests to retain revenues, the Ministry of Finance had cited concerns about financial accountability. With improvements in financial management and accounting capacity during the life of the project, it became appropriate to request from the MOFDP permission to pilot retention of user fees in a small number of districts, and to test ways to improve implementation of user fee exemptions/waivers to avoid the adverse distributional impact of improved revenue collection and retention. Toward the end of the project period, the Government decided to abolish user fees altogether at the clinic level; concern remained about the lack of fee retention at the district hospital level, reducing staff incentive to collect.

2.20 ***Sector-wide Approach:*** This Health Sector Reform Program was the first attempt by the health sector to use one consolidated plan as the basis for mobilization of resources for all development partners. Joint missions have become standard, and Annual Joint Program Reviews have been held and attended by all partners since 2000. The move to a three-year sector expenditure plan in 2005 made this process more efficient in many ways, and the first Annual Joint Review of the sector expenditure plan (conducted in 2008) found it to be comprehensive, costed according to program activities, and focused on key priorities. Donor funds are not pooled, but in concept the sector operates according to a SWAp in most other senses of the term: a long-term, joint strategic approach; annual joint reviews; common financial, accounting, and procurement procedures and institutions; common M&E systems; and a medium-term expenditure framework (MTEF) that coordinates financing. The Bank times its missions to coincide with the Joint Annual Review and other key decision points; Bank missions serve to focus the attention of Government and other players on key issues requiring resolution.

2.21 The SWAp approach is clearly most visible during the Joint Annual Review. Many of the policies set and decisions made during this annual process, however, lack follow-up. MOHSW rarely calls upon development partners to work together outside the mandated Joint Annual Review process, and over the last two years, there has been a trend for bilateral donors to sign their own separate MOUs with MOHSW in addition to the joint Health Development Partners MOU that defines the SWAp. There is some indication that MOHSW would like to control its relationships with bilateral donors independently, rather than overseeing a process in which those donors collaborate with one another. In other words, the joint sector planning process appears much more coherent on paper than it does in reality. Several key development partners observed that there is still no genuine common strategy among donors, resulting in persistent geographic and programmatic overlap and gaps. The monthly health partners' forum is viewed by some as extremely useful, but by others as problematic, with rare development of action plans and even more uncommon action on those plans. Perceptions of the SWAp's success vary from development partner to development partner, as does the level of participation in joint forums. Interviews with stakeholders revealed a common perception that the donors who bring substantial resources of their own to the table see limited value in collaborating with others.

Outputs and Outcomes by Objective

STRENGTHEN THE MOHSW'S CAPACITY TO DEVELOP, CARRY OUT, AND MONITOR THE HEALTH SECTOR REFORM PROGRAM: MODEST

Outputs

2.22 Technical assistance was contracted to develop FMIS software, which was piloted at the new Project Accounting Unit. The software was successfully employed and improved the management of the capital budget, as evidenced by several consecutive years' worth of satisfactory audit reports. Accountants were trained and equipment was procured, including computers. The Financial Management Unit was established within the Health Planning and Statistics Unit (HPSU), and the Project Accounting and Procurement Units were created within the HPSU, replacing individual Project Management Units. A Financial Management

Committee, responsible for overseeing financial management across the Ministry, was established. MOHSW cost centers were rationalized. Financial and procurement procedures and guidelines were developed and applied, alongside the necessary equipment and training. One shortcoming here is that the HPSU, which was capacitated significantly and quickly, came to spearhead the reforms and to hold all of these new structures under its own roof. While it has been useful to have the HPSU as a focal point of reform, other offices, such as the MOHSW financial controller's office, did not receive similar attention, leading to a lack of balance in capacity.

2.23 A three-year sector expenditure plan was completed at the end of November 2004; there were delays because the cost centers were defined on the basis of Health Service Areas while the long-term strategy was to define the district as the basic health planning unit.[2] There was also no MTEF for the country that set hard budget constraints for the various sectors and defined outputs that each sector was supposed to deliver. The Bank, in the absence of a macroeconomic lending program in the country, had not performed a recent public expenditure review (the last multisectoral review had taken place in 1999, and the last health sector review in 1996), and therefore such analysis was not available to inform the MTEF. In 2005/2006 the MOFDP introduced an MTEF process beginning with a few ministries, including MOHSW.

2.24 A Pharmaceutical Master Plan was established, based on a report submitted by a private firm in August of 2003 that had been contracted to conduct a comprehensive review of pharmaceutical services. On the basis of this Plan, a National Medicines Policy was approved in September 2004, and a draft strategic plan for implementation developed; a Drug Regulatory Authority was established to monitor drug quality and ensure that drug selection was based on an Essential Drug List; tools to facilitate rational prescription, including the Essential Drugs List and Standard Treatment Guidelines, were developed; appropriate legislation, such as National Medicines and National Drug bills, was passed; drug awareness campaigns were conducted; and pharmacy personnel were trained and deployed.

2.25 An Essential Services Package, consisting of selected essential health interventions that were to address the largest disease burdens in the country, was piloted in three districts. It included public health interventions (health education and promotion, immunization, nutrition, integrated management of child health, and environmental health); control of communicable diseases including HIV/AIDS, other STIs, and TB; sexual and reproductive health, including family planning, safe motherhood, adolescent health, and prevention of mother-to-child transmission of HIV (PMTCT); and essential clinical services for common illnesses. Although it was defined, it was not costed as of project closing. The Essential Services Package was to provide a framework for prioritizing public expenditures, provide benchmarks against which MOHSW could measure disbursements on the basis of equity, and form the basis of the provider-purchaser arrangement between the Government and CHAL. The Package was later rolled out to all districts, although the initial pilot in three districts was never thoroughly evaluated.

[2] This problem was resolved in future sector expenditure plans, which are now used to prioritize expenditures, including capital investments.

2.26 The process of construction of a new referral hospital was initiated, through an innovative concept involving public-private partnership. At the end of the project period, the International Finance Corporation was working with MOHSW and MOFDP to develop the concept for implementation during Phase II.

2.27 Under the previous Bank-financed population, health, and nutrition project (1989-1998), the Government had endeavored to conduct a Demographic and Health Survey (DHS), but after expending significant resources to collect data it failed to produce any analysis. The completion of Lesotho's first DHS in 2004 is therefore viewed as a significant output of the project. It provides robust baseline indicators for assessing the long-term impact of the project and program.

Outcomes

2.28 During the life of the project, there were improvements in the capacity of MOHSW to plan, implement, monitor, and evaluate comprehensive health sector reform strategies in the areas of service delivery, health financing, human resources, drug supply, and infrastructure development. Implementation of the ten-year health sector policy inaugurated in 1999 continued on track. The financial management and information system in the MOHSW was improved, with standardized budgeting procedures, integrated planning and budgeting processes, decentralized cost centers, improved application of budget against plans, and audits of external funds conducted on time with unqualified reports. A five-year strategic plan for M&E was developed and institutionalized, with regularly conducted quarterly activity monitoring reports and annual joint sector reviews, consistent with the sector-wide approach. The Government signed an interim agreement with CHAL, and a draft MOU was prepared to formalize the contractual arrangement. A human resources development needs assessment and strategic plan was completed in 2005, with a Directorate of Human Resources created and staffed. A long-term infrastructure plan was developed. An Estate Management Unit was created and staffed. An essential health package was defined to address the most prevalent diseases and service delivery requirements in the sector, and the package was extended to referral systems. District Health Management Teams (DHMT) were established in three pilot districts; it does not appear that these pilots were evaluated before setting up DHMTs in all districts.

2.29 Overall, most of the triggers relative to this objective set for movement from Phase I to Phase II were met (Annex D), and a Health Sector Reform Phase II project was approved in October 2005.

2.30 Shortcomings included a failure to: (a) fill vacant positions with appropriately skilled personnel (despite the implementation of the human resources plan, supply shortages and turnover were overwhelming, and scarce human capital was often not productively deployed); (b) establish a Health Management Information System (HMIS) that would managed the required information and evidence to report health sector reform program indicators; and (c) build capacity of several MOHSW departments and in the districts to implement the reform program and strengthen service delivery. Although several infrastructure projects were implemented, overall infrastructure development took place in an ad hoc fashion; the EMU did not carry out effective implementation of the infrastructure plan

in a way that included preventive maintenance and the construction of facilities that would accommodate the implementation of the District Health Package and decentralization.

2.31 Total per capita health expenditure more than doubled between 2001 and 2005 (from US$16 to US$42), but the impact of that increase was eroded by appreciation of the South African Rand and inflation. Government health expenditure in constant Maloti decreased at an average annual rate of four percent between 2001 and 2005. As a share of GDP, total health expenditure decreased from 7.1 percent in 2001 to 5.5 percent in 2005, and public health expenditure as a share of overall government spending also declined over the same period, from 8.8 to 6.7 percent (World Bank 2009b; Lievens and Manu 2008b).

2.32 MOHSW budget execution has worsened in recent years, from over-expenditure in 2004/05 (104 percent) to 87 percent in 2006/2007 (Lievens and Manu 2008b), indicating that capacity was not built and sustained for even a short period after the project closed. Some of the factors contributing to poor execution include confusion over the jurisdiction of district health management teams, late availability of budget allocations to cost centers, budgeting for staff posts that remain unfilled, and lack of clarification of roles of agencies responsible for HIV/AIDS. The program with the largest increase in budget over this time period, Disease Control, experienced the poorest budget execution, indicating a need for significantly improved management effort and institutional development before further resources should be allocated (World Bank 2009b). In other words, the main challenge facing the sector has not been a shortage of financial resources, but the capacity to use those resources effectively.

2.35 While the development budget was well managed by the Project Accounting Unit, financial management of the recurrent budget remained a cause for concern. The absence of a Financial Controller, combined with frequent rotation to other ministries of accountants who were trained in the MOHSW, undermined the aim of moving toward budget support. Although Government allocations to the health sector increased in nominal terms between 2002/03 and 2006/07, the rate of spending declined after 2003/04. As of December 30, 2006, the average spending rate of the recurrent MOHSW budget was 53 percent, with the lowest spenders those units most critical to public health: Family Health at 26 percent, Disease Control at 20 percent, and HIV/AIDS at 20 percent. District spending rates ranged from 32 percent for Quthing to 65 percent for Maseru. Explanations for the low spending rates include delays in districts' and units' access to the recurrent budget, which was frequently not made available until the second quarter of the fiscal year, and a persistent shortage of accountants and financial management specialists due to a lack of qualified candidates. Improvements in planning and timely procurement were also suggested to facilitate budget execution.

2.33 A 2009 World Bank Public Expenditure Management Review found that challenges remained in the areas of budget execution, internal controls, and fiscal reporting (World Bank 2009b). Another criticism is that budget allocations are largely on an incremental basis, mainly on the basis of inputs (such as salaries and operating expenses). The outputs and outcomes of public spending are not explicitly stated; for example, service delivery targets in terms of quantity or quality are not set. There remains difficulty with activity-level costing; budget classification has remained largely unchanged, with programs and subprograms

basically referring to organizational structures rather than to functional orientation; and there is limited or no integration of recurrent and development budgets during budget planning (World Bank 2009b).

2.34 Overall, health system development led to little improvement in service delivery over the lifetime of the project, and health outcomes improved only modestly. Vaccine coverage did not increase significantly, with coverage of DTP1[3] increasing from 74 to 78 percent from 2001 to 2004, while DTP3 was basically unchanged, from 72 to 71 percent; coverage of the first dose of measles vaccine decreased from 63 to 59 percent during this time period, but the second dose of measles vaccine increased from 46 to 56 percent (WHO data). Antenatal care coverage (at least one visit) remained steady at around 91 percent (United Nations data). Infant and under-five mortality decreased modestly. The major reasons for this disconnect between health system development and trends in service delivery and health outcomes were the persistent problems in human resources and capacity. In addition to shortages in raw numbers, there were also problems with: (a) maldistribution, with the Central region much better covered than the Northern and Southern regions; (b) production and deployment, with operational inefficiencies in the National Health Training College resulting in some occupations experiencing excess enrollment while others saw high dropout rates; and (c) weak human resource systems and management, where problems remained in posting policies, equity in remuneration, loose promotion criteria, limited opportunities for career advancement (especially for much-needed nurses), and ad hoc in-service training. In other words, existing human resources were not effectively deployed and used. Historic wage differentials between Government and CHAL facilities were not remedied. The politics of the situation were a further aggravating factor, as elected officials pushed for the creation of new health facilities – which accrued political benefits to them – without regard to the challenge of staffing them.

2.35 The MOHSW commissioned a Human Resource Needs Assessment Study in 2002 and subsequently a Human Resource Development and Strategic Plan (2005-2025), and the ministry's personnel division was elevated to a directorate (and therefore allocated additional staff at central and district levels). A MOHSW Integrated Human Resource Management Information System was developed, but it was not compatible with analogous systems used by the Ministries of Finance and Public Service. The Government, however, was not treating the human resource situation as a crisis during this time period, and MOHSW was constrained by lack of priority accorded to the issue in other ministries.

EXPAND THE CAPACITY OF THE PUBLIC SECTOR TO RESPOND TO HIV AND AIDS: MODEST

Outputs

2.36 Policy and technical guidelines, protocols, and procedures were developed for TB, Integrated Management of Childhood Illness, HIV/AIDS treatment, and PMTCT. A National HIV/AIDS Strategic Plan (2000-2004) was developed and endorsed, to be coordinated through LAPCA/NAC at the national level and District AIDS Task Forces at the district level. The project supported non-governmental and faith-based organizations, along with one

[3] DTP1 and DTP 3 are the first and third dose of diphtheria, tetanus, and pertussis vaccine.

public sector institution (Lesotho Mountain Police), to implement interventions for HIV/AIDS prevention and care, including voluntary testing and counseling, condom distribution, home-based care, and support for orphans. Data are not available on specific interventions financed, the groups on which they focused, or their coverage, nor is there an indication of focus on any public sector institution other than the Lesotho Mountain Police. A behavioral surveillance survey was conducted in 2002, with preliminary results not yet available at the time of project closing. The Lesotho/South Africa working committee was revived, and collaboration on cross-border referrals, HIV/AIDS, and disease surveillance took place. Collaboration with traditional healers improved through regular dialogue and training on HIV/AIDS and referral to the regular health system.

Outcomes

2.37 The formal triggers relative to this objective set for movement from Phase I to Phase II were largely met (Annex D), but none of these three triggers (development of guidelines and protocols, evaluation of prevention interventions, and increased participation of the private sector and NGOs in HIV/AIDS prevention and control) is indicative of outcomes related to the development objective of increasing the capacity of the public sector to respond to HIV/AIDS. There is little evidence to indicate increased activity in the public sector, coverage of public sector activities, or efficacy of activities implemented in or by the public sector. For example, there are no data on numbers of public sector employees trained, the coverage of that training, and its impact.

Ratings

OUTCOME

2.38 The project had Substantially relevant development objectives, but Modestly relevant design, Modest achievement of both objectives, and Modest efficiency. Taken together, these ratings are indicative of significant shortcomings, resulting in a Moderately Unsatisfactory outcome of the project as a whole.

2.39 **Relevance of Objectives is rated Substantial.** The project aligned precisely with the objectives of the Government health sector strategic plan, and its objectives were responsive to sector issues and challenges in the country. Poverty in Lesotho is deemed not only chronic but self-perpetuating, as the poor have very low utilization of social services such as health care which, in turn, causes further impoverishment. According to a survey of 410 households carried out in 2002 by the University of Lesotho, 30 percent of respondents cited protracted sickness of a household member as a major cause of household poverty, with an additional 16 percent citing the death of a breadwinner (World Bank 2005b). The link between health and the potential for economic development was particularly strong during the project period, when migration to South Africa was still the main source of labor for Basotho males who could only work abroad if their health permitted. The project also responded to the current Country Assistance Strategy, approved in 2006, which has as objectives fighting the HIV/AIDS pandemic, improving human development outcomes and decentralization, and service delivery and M&E.

2.40 **Relevance of Design is rated Modest**. Project design responded explicitly to lessons learned about sustainability of achievements within previous sector operations. Previous efforts at development assistance in Lesotho's health sector had focused on improvements in priority health programs, but not on improving the ability of local institutions to evolve and respond independently to local health needs. This Program therefore prioritized, in Phase I, the strengthening of institutional capacity, to ensure that the government institution charged with assessing health needs and designing cost-effective and affordable responses had the capability to do so. In other words, the justification for this approach was the achievement of a *sustainable* increase in access to quality preventive, curative, and rehabilitative health services. The development of a single program plan and budget was to reduce fragmentation of financing to the sector, improve technical and allocative efficiency, and ensure that investments were sustainable.

2.41 Equally importantly, the development of common implementation procedures was to ensure that donors would have a vested interest in building the institutional capacity of the Government to make allocation and disbursement decisions, implement strategies, and evaluate impact, rather than establishing individual project management and implementation units that would rely on temporary capacity and systems. A Poverty Reduction and Management Group study in 2006 supported this approach, finding that the only realistic option for increasing fiscal space for the health sector was to enhance governance and improve efficiency of spending (World Bank 2009b).

2.42 The inclusion of an explicit HIV/AIDS component to the project came in response to a request from Bank management. Because the MOHSW's National AIDS Control Program was weak, LAPCA had not yet been established, and other government ministries were undertaking almost no HIV/AIDS activities, the project team at first argued that the addition of such a component without adequate preparation would inappropriately strain weak implementation capacity. The compromise decision was to add a relatively small amount for HIV/AIDS (US$2 million), require the government to contract implementation support, and specify that the funds be disbursed primarily through non-governmental actors. This coalesced well with the approach of the Bank's Multi-Country AIDS Program and its focus on channeling money to a range of actors to implement national strategy; the inclusion of this component brought important attention to an issue that was politically sensitive at the time.

2.43 However, it is a significant shortcoming that program components and activities did not map appropriately to the project's objectives. Given the high level of understanding of the sector's human resource challenges during project preparation, the project did not sufficiently incorporate concrete plans for increasing and sustaining performance in the sector; innovative solutions to the human resource retention problem were discussed, but there were no mechanisms for actual experimentation with or implementation of those solutions. Project design therefore did not respond to the development objective of *sustainable* development of capacity. In addition, most of thefunds for the HIV/AIDS component were directed toward NGOs and CBOs, even though the objective was to increase capacity for the public sector response to the epidemic, and project activities also focused on Integrated Management of Childhood Illness, which was not part of the development objectives.

2.44 Furthermore, the design of the HIV/AIDS component did not prioritize prevention to groups that were at highest risk of transmitting infection, nor did it attempt to assess and prioritize the highest-impact interventions; this was despite the fact that a Bank-authored study on HIV/AIDS in Lesotho, published in October of 2000, had identified multiple sexual partnerships and increasing incidence of STIs as the two key factors fueling the spread of the epidemic (World Bank 2000a).[4] The Government's September 2000 National AIDS Strategic Plan identified the same risk factors and priority interventions (Government of Lesotho 2000). Overall, the Bank could have demanded more emphasis on HIV prevention.

2.45 The choice of an adaptable program loan allowed the Bank's operations to be aligned with the Government's overall health sector reform program, ensured the Bank's continuous support in a phased approach throughout the reform, and helped to align support from other partners with the Government's reform program. Debate continues, however, about the decision to focus exclusively on policy and institutional reform during the first phase, explicitly deferring expectation of real improvement in service delivery and/or health outcomes until later phases of the Program. The Executive Summary of the Government's Program Implementation Report for Phase I is critical of this approach, as are many other key stakeholders. The priority interventions of Phase I focused on system building in an environment of declining service delivery, and this was seen as a significant limitation of the design: at the end of Phase I, there was no significant improvement in service delivery. The approach, with its resultant stagnation in quality of services, may have had an impact on public and political support for reform, a problem that was anticipated during some early project preparation missions but later neglected.

2.46 The MOHSW's 1999 publication, with Bank support, of "Strengthening Lesotho's Health Care System," may have contributed to this problem by specifically calling attention to the failure of the health system to address too-high infant mortality, increasing child malnutrition and maternal mortality, increasing prevalence of HIV, TB, and STIs, and rising incidence of alcoholism and trauma. Although this document explicitly made the case for long-term attention to capacity-building and institutional development in the sector, it may also have raised expectations regarding attention to immediate service delivery challenges. Furthermore, the focus on system building may have led to an under-appreciation of emerging immediate needs, such as the rapidly increasing burden of orphans and vulnerable children. In other words, it may have been the case that health objectives were somewhat lost as the ultimate aim of the work, and improved processes came to be seen as the goal rather than the means; at minimum, project design did not include provisions to prevent this from happening.

2.47 **Efficacy of both objectives is rated Modest.** The first objective, strengthening the MOHSW's capacity to development and implement the Health Sector Reform Program, was modestly achieved, with important systems and plans developed, but human resource shortages and turnover largely stalling the ability to implement the new plans and policies. Continued poor budget execution was a result. There is little evidence on outputs or

4. This report further stressed that there had been no study since 1989 to establish baseline levels of knowledge, risk awareness, and prevention measures against which progress could be measured, and that overall, the direction and strategy for information, education, and communication activities appeared inadequate.

outcomes related to the second objective, increasing the capacity of the public sector to respond to HIV/AIDS.

2.48 **Efficiency is rated Modest**. Operating from one sector plan and one logframe led to the development of one annual review plan and report for all partners, reducing transaction costs for MOHSW. However, there were costly mismatches in plans and approaches between Government agencies, including between the ministries of health and finance on the sector expenditure plan/MTEF, and between MOHSW and the Government as a whole on decentralization. Despite the common sector plan, the work of donors was not well coordinated; as more donors were entering the sector (particularly for HIV/AIDS) toward the end of the project period, inefficiencies resulting from inadequate capacity for coordination were increasing. Staff turnover led to long vacancies at key positions and inefficient requirementsfor training and retraining, and to the continued hiring of expensive consultants because of lack of internalization of capacity intended to be built through the consultancy process.

2.49 The HIV/AIDS component did not prioritize the targeting of groups most likely to spread the infection and therefore did not prioritize the most efficient, high-impact interventions. The delay in the implementation of the component, along with the continued controversy over LAPCA and its successor, likely reduced the efficient management ofHIV/AIDS resources.

RISK TO DEVELOPMENT OUTCOME

2.50 **Risk to Development Outcome is rated Substantial.** The project resulted in some institutional capacity strengthening in the MOHSW, especially in the Health Planning and Statistics Unit. Questions lingered about the extent to which the gains from the project were fully institutionalized and sustainable, however, given problems with staff turnover. Although human resource challenges were recognized from the beginning of project preparation, actual project interventions were focused too strongly simply on numbers – filling vacant slots, training more health workers – and not enough on the various kinds of staff incentives that would keep people in their positions and, importantly, raise productivity. Interviews with medical staff in the districts, for example, reveal that salaries are not the primary issue (salaries, in fact, while below levels in South Africa, are above that of many other countries in sub-Saharan Africa); instead, housing, security, contact and encouragement from headquarters staff in the districts, and above all the availability of equipment to perform their assigned tasks effectively are far more important. Although the institution-building focus of this first Program phase has benefited follow-on operations (see Chapter 5), it is not clear that the institutions created will be able to mitigate the perpetual human resource crisis.

BANK PERFORMANCE

2.51 Overall Bank Performance is rated **Satisfactory.**

2.52 **Quality at Entry is rated Satisfactory.** Project preparation activities included appropriate analytic work (Institutional Capacity Assessment and Health Sector Expenditure Review), identification of risks, consultation with donors and a wide range of other

stakeholders (including members of the political opposition), political economy analysis, and careful selection of the adaptable program loan instrument. The Bank was a key player in the formation and operation of a series of Government Working Groups whose outputs contributed to the development of the overall 1999 health sector reform program. Project design, for the most part, responded appropriately to lessons learned from the previous Population, Health and Nutrition Project (1989-1998): the need to ensure Government ownership and commitment to the project, and a focus on institutional strengthening to ensure sustainability of achievements. The adaptable program loan design, with a phased approach and pre-defined triggers for moving to the next phase, was appropriate for achieving the project's objectives.

2.53 More emphasis might have been placed, however, on tailoring activities to the Borrower's capacity. Although the project included an institutional assessment, there was no prioritization among the numerous capacity-building interventions, which should have been important given the complexity of the project and the large number of triggers (14) for movement to Phase II. Ironically, given capacity constraints, it may have been preferable to design fewer and smaller components into a capacity-building project. Although the triggers were largely met, some of those achievements were not well established. Even though the Bank was not directly responsible for each of the many areas of capacity building, as other development partners covered niches according to their areas of comparative advantage,[5] overall it was too much for MOHSW to master – and sustain -- in one dose. Greater selectivity would have been appropriate.

2.54 Because the overall Program design dedicated Phase I to institutional strengthening and capacity development, most of the project's specified outcome indicators actually involved outputs: budgets allocated, reports produced, systems established, policies and guidelines drafted. There was no attempt during project design to determine ways to measure the quality and sustainability of these outputs and whether they were likely to lead to achievement of overall Program outcomes (service delivery quality and health status). Furthermore, Program design did not project specific targets for the end-of-program indicators that did constitute measurable outcomes; for example, the PAD (p. 51) lists as an end-of-program indicator "increased TB treatment success rate," with no baseline or magnitude/rate of increase specified.

2.55 Project design documents accurately identified substantial human resource risks, acknowledging that the recruitment and retention of staff was essential to achieving and sustaining project objectives. These documents also correctly realized that Lesotho was unlikely to be able to compete effectively with South Africa in terms of staff salaries, and that innovative approaches would therefore be required. The project's design proposed approaches to reduce rates of civil service attrition included the provision of staff housing,

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[5] The Bank assumed primary responsibility for assessing financing strategy and infrastructure/physical planning; AfDB and DCI focused on human resource development; WHO and UNICEF focused on disease control, family health, nutrition, and service delivery; and WHO addressed pharmaceutical issues (World Bank 2000c).

greater attention to security issues in rural areas, tying performance to advancement, tying training opportunities to job functions, and improving procedures for appointments, promotions, and deployment. It is a significant shortcoming, however, that the project did not follow through on these non-salary-related approaches to human resources recruitment and retention.

2.56 There was also an appropriate effort to market reforms. Despite the evidence that the health sector was not responsive to the population's needs, there was not any vocal widespread dissatisfaction with the health care system, and therefore the potential for opposition to allocation of significant resources to strengthening of capacity (particularly when prioritized over immediate improvement in service delivery) was high. Civil society organizations were not advocating reform, nor was health reform an explicit issue in the political debate at the time (World Bank 2000c). The Bank therefore appropriately assisted with the publication of "Strengthening Lesotho's Health Care System" (1999) in order to market the reform effort.

2.57 Politicization of the civil service was a key issue during preparation, with decision-making, staffing, and collaboration among staff frequently affected by political and familial affiliations. This problem came to a head during the 1998 civil unrest in the country. The Bank team supported small-scale analyses of the cultural background to these schisms and subsequently contracted a consultant during the preparation process to facilitate team-building within the MOHSW. Given these concerns, project design could have included activities to continue the process of professionalization and forging a sense of a common purpose within the ministry.

2.58 There was also insufficient attention during preparation to the relationship between the Government and CHAL. Preparation missions cited as an "absolute for success" the negotiation of an effective partnership agreement, including a focus on compensating CHAL not merely on the basis of the number and qualifications of its health staff, but instead concluding – before project effectiveness – an outcome- or performance-based compensation arrangement. This arrangement was not finalized until early 2007.

2.59 **Quality of Supervision is rated Satisfactory**. The relationship between the Bank and the Government remained excellent throughout the project. Supervision and involvement of management, when necessary, was appropriate, as was expertise within supervision teams. The task team included a strong skills mix: effective team leadership combined with the skills of a health economist, operations advisor, financial management advisor, procurement specialist, health systems specialist, and consultants with expertise in human resource development, capacity assessment, and other critical areas. Supervision of M&E was appropriate, with attention to progress on attainment of the 14 triggers for movement to Phase II; the Bank team was proactive in recognizing that the triggers would not be met by the original deadline and therefore in extending the project as appropriate.

BORROWER PERFORMANCE

2.60 Overall Borrower Performance is rated **Moderately Unsatisfactory**.

2.61 **Government performance is rated Moderately Unsatisfactory**. Since 1996, the MOHSW had been firm in its intent to develop a single, comprehensive Sector Program towhich government and all partner agencies would contribute. The Government undertook its own process, with assistance from development partners, of developing that Sector Program and a parallel policy regarding HIV/AIDS.

2.62 The budget for MOHSW as a percentage of the total Government budget increased steadily from 2000/01 to 2004/05, an indication of Government commitment to the health sector (World Bank 2005b). Government budget details reflect increasing shares to MOHSW in terms of recurrent expenditures, domestically-funded capital expenditures, and loan- and grant-funded capital expenditures. Per capita MOHSW budget figures also increased, in aggregate terms and in terms of specific budget components. Government documents at the time, however, indicated that health budgets would be unlikely to rise further in the medium term. These statements could raise questions about the longer-term commitment to health budgets over the course of the entire health reform program, although it should be noted that responsible budget management would limit allocations to a sector that was under-spending.

2.63 Lack of continuity in the Minister and Principal Secretary positions in MOHSW greatly hindered the program and project in its early years. Units within the Ministry did not communicate and coordinate well with one another. Other ministries, including finance, public service, and local government, failed to provide strong and timely support, resulting in damaging delays in approvals for several important policy documents and continuations of consultancies, transfers of key skilled MOHSW personnel to other sectors, and delayed appointments for key positions (including the Chief Executive of LAPCA). Perhaps most compelling was the failure to staff LAPCA at the highest levels at a time when HIV prevalence was known to be high. These problems diminished in the latter years of the project, when turnover at the highest levels of MOHSW ceased and the Principal Secretary of the ministry regularly attended the entirety of the Joint Annual Review meetings.

2.64 **Implementing Agency performance is rated Satisfactory**. Initially, staff resistance to health reforms within MOHSW posed major challenges; advocacy of the reform program was insufficient within the various departments of the ministry and in the districts. Over the life of the project, however, the ministry has been transformed into a more professional organization with increased commitment to reform, and many MOHSW staff have claimed ownership of the reform process. Technical assistance was appropriately deployed for M&E, financial management, procurement/accounts/audits, pharmaceuticals, infrastructure development, and human resource development, resulting in additions in institutional capacity. All legal covenants were met, reports were issued in a timely fashion, and reviews were conducted as planned. The Project Accounting and Procurement Units are now used by a number of development partners.

MONITORING AND EVALUATION

2.65 Monitoring and Evaluation is rated **Modest.**

2.66 **M&E Design is rated Substantial**: M&E was to be carried out by a newly-established M&E Unit within the HPSU. The ministry, with the cooperation and approval of

all development partners, developed a logframe for the sector reform program, linking Project activities to the achievement of objectives and developing a set of indicators for monitoring progress. Short-term training and technical assistance were to enhance the capacity of HPSU to carry out M&E functions, and a draft M&E Plan was produced. Donor missions were to be coordinated around Joint Annual Reviews each October to reduce the burden on Government to report to multiple agencies, and also to support efforts to maintain a comprehensive perspective on the sector. A comprehensive Health Sector Report was to be produced annually to summarize financial and programmatic reports, as well as to report on core indicators, as the basis of the annual review. A baseline survey was to be supported during preparation, with the results available prior to effectiveness, and a similar survey commissioned at the end of Phase I, along with a Joint Evaluation to determine whether the Program was ready to proceed to Phase II. The baseline survey was to include data on public and household expenditures on health, with particular attention to vulnerable and under-served populations: the poor, those living in rural areas, households headed by single mothers, and other high-risk groups identified as relevant to the HIV/AIDS component. The implementing agency contracted by LAPCA was to be responsible for M&E of the HIV/AIDS component of the project.

2.67 **M&E Implementation is rated Modest**: At the outset of Phase I, a private firm was contracted to conduct the baseline survey. Baseline values were not established, however, because population- and facility-based surveys employed sample sizes that were too small, and because the Health Management Information System was not adequate to support the task. Significant technical assistance and training took place among personnel in the M&E Unit, including post-graduate training across a variety of disciplines (epidemiology, public health, health economics, biostatistics, demography, and population statistics) in South Africa. An appropriate manpower mix was therefore established at the central level. However, an automated and decentralized M&E system was not achieved by the end of the project period due to the slow pace of development of the HMIS and FMIS. As a result, a system was not in place by the end of Phase I to produce accurate and relevant data to monitor the reforms. The HMIS was not operational, data were not routinely collected from the districts, and therefore data analysis did not take place. Staff levels and skills were inadequate at the district level, and appropriate tools and equipment at that level were not present; there were no health information officers deployed at the district level by the end of the project period. Initial Annual Joint Reviews did not present empirical information on health status, service delivery, and care-seeking; at these initial reviews, even the presentation of key indicators missed sources of data that were known to be available. In sum, although the MOHSW was expected to be in a position routinely to produce accurate data to monitor reforms by the end of the project, this did not happen. Although initially planned for 2001, the completion of Lesotho's first Demographic and Health Survey in 2004 was an important achievement of the project.

2.68 **Utilization of the data is rated Modest**: Significant amounts of effort and resources were expended on M&E. The project supported a number of studies that generated important information on human resource planning and management, the pharmaceutical sub-sector, financial management, estate management, and the QEII Hospital. Although quarterly reviews of progress in the sector were conducted and quarterly M&E reports produced by

project closing, there was little evidence that these reviews were used for decision making by senior management.

3. HIV and AIDS Capacity Building and Technical Assistance Project

Background and Context on HIV/AIDS

3.1 In 2000, the Government of Lesotho adopted a National HIV/AIDS Strategic Plan and a National AIDS Policy Framework. These were based on a multi-sector approach to the fight against HIV and AIDS, and embraced engagement with civil society and communities. The Lesotho AIDS Program Coordinating Authority (LAPCA) was established in 2001 as a department of the Government Cabinet Office with a mandate to coordinate, monitor, and evaluate implementation of the national response. Its ability to fulfill that mandate was limited by many factors, including a lack of autonomy, inability to recruit a full complement of staff, and the dismissal of its Executive Director that left it leaderless for over a year. Although the HIV/AIDS unit of the MOHSW had also been engaged in efforts to address HIV and AIDS since the late 1980s, as a unit under the Division of Disease Control it did not have the status, commitment, and leadership required to assume the level of responsibility necessary to lead the sector's response.

3.2 The approval by Lesotho's Cabinet in early 2004 of a document titled "Scaling Up the Fight against the HIV/AIDS Epidemic in Lesotho" reflected increased high-level attention to the epidemic. Endorsement of this document was accompanied by a decision to create an independent National AIDS Commission (NAC) to oversee the national response, an autonomous statutory body that in effect reports to the Prime Minister (ACTAfrica 2010). The Commission was initially envisioned to comprise an appointed Commissioner and four other Commissioners elected by their constituents (youth, women, church groups, and people living with HIV/AIDS (PLWHA)), and with an improved LAPCA functioning as its Secretariat. It was intended to imbue the country's approach to HIV/AIDS with an appropriate sense of urgency, and it was therefore given improved autonomy, resources, and staff in comparison with LAPCA. The process of creating the NAC was prolonged for a variety of reasons, including initially a lack of adequate consultation among stakeholders.

3.3 Meanwhile, in 2002, with support from external partners (particularly the Clinton Foundation), the Lesotho Country Coordinating Mechanism (CCM) submitted a successful proposal to the Global Fund for a US$34 million grant ($29 million for HIV/AIDS and $5 million for TB) to scale up efforts against those infections over the subsequent five years (see Box 3-1 for an overview of the Global Fund). The Principal Recipient of the Global Fund resources was the MOFDP, and the two sub-recipients LAPCA and the MOHSW.

The specific goal of the Round 2 Global Fund grant to Lesotho was to "contribute to the reduction of HIV incidence, particularly among youth, and improve the care and support of PLWHA and those affected by the epidemic" (Global Fund 2010). The five-year grant's original start date was January 1, 2004, with the grant period divided into two phases: Phase

1 (two years) was scheduled to end on December 31, 2005, and Phase 2 (three years) on December 31, 2008. The Phase 1 budget totaled US$10.6 million, and the total budget including Phase 2 totaled US$29.3 million. Specific target groups and beneficiaries were youth and PLWHA. Strategies included youth education and prevention, behavioral change communication (BCC) and community outreach, condom distribution, prevention of mother-to-child transmission of HIV, care and support for the chronically ill and their families, antiretroviral treatment and monitoring, HIV counseling and testing, care and support for orphans and other vulnerable children (OVCs), stigma reduction in all settings and respect for confidentiality, policy development (including workplace policy), and information systems and operational research.

Box 3-1: The Global Fund to Fight AIDS, Tuberculosis, and Malaria

The Global Fund was established in January of 2002 as a mechanism to support national programs to combat AIDS, TB, and malaria. It is a financing agency, with grant application and implementation the responsibility of country-based Country Coordinating Mechanisms (CCMs) composed of government, NGO, donor, faith-based, and private sector stakeholders. Grants are signed for an initial period of two years (Phase 1), and are extended for longer periods (Phase 2, from year three through the end of the grant period) only after review of achieved results. The Global Fund operates as a financing instrument and does not provide the kind of supervision or implementation support typically provided by the Bank or a bilateral donor. Monitoring of programs is carried out by staff in Geneva.

To date the Global Fund has committed US$19.3 billion in 144 countries to support prevention, treatment, and care interventions for all three diseases. Applications for funding are, as a rule, accepted only from CCMs, and they are accepted not on a rolling basis but in designated Rounds. Applications are currently being accepted for Round 10, with proposals due in August 2010.

Lesotho's CCM is chaired by the Principal Secretary of the MOHSW, with a representative of the Lesotho Network of People Living with HIV/AIDS serving as Vice-Chair. CCM membership in Lesotho is statutorily specified as six seats from government, six from civil society, four from multilateral/bilateral donor agencies, two from academic institutions, and two from the private sector, with these constituencies each choosing their own representatives. The Principal Secretary of the MOFDP is a member, and a GFCU representative attends CCM meetings but is not a formal member. The Bank is not a member of the CCM. Lesotho's commitments and disbursements from the Global Fund are in Annex E.

3.4 Planned activities (outputs) included efforts to: (a) improve life skills, peer education training, and HIV/AIDS prevention services to adolescent and pre-adolescent young people, with specific focus on girls; (b) establish and support youth resource centers and adolescent reproductive health corners; (c) promote access to condoms for sexually active youth by installing condom vending machines in youth-friendly corners; (d) establish PMTCT programs in all 18 health service areas; (e) establish and operate voluntary counseling and testing (VCT) centers; (f) provide antiretroviral therapy (ART); (g) provide drugs and supplies (including drugs for opportunistic infections); (h) provide community home-based care support to PLWHA and their families; (i) develop and disseminate HIV/AIDS-related policy guidelines and protocols; (j) support OVCs with a basic package of care (including material and financial support), and include as many OVCs as possible in the school program; (k) train health service providers in the management of HIV/AIDS; (l) train community health assistants and volunteers in HIV/AIDS care and support; (m) strengthen the umbrella bodies of NGOs and other CBOs to coordinate implementation of HIV/AIDS

activities at the community level; (n) provide outreach programs focusing on the human rights of PLWHA; (o) ensure HIV/AIDS workplace policies and programs in line ministries; and (p) strengthen institutions in charge of coordination and management of the HIV/AIDS response.

3.5 The grant was signed in 2003, and implementation began as scheduled in January 2004. By December of 2005, however, after almost US$8 million had been disbursed, the Global Fund indicated that its Secretariat was considering issuing a "No Go" recommendation for Phase 2, effectively cancelling the grant. Disbursement of funds was relatively low despite the negative effect of appreciation of the local currency against the US dollar. Concerns included (Global Fund 2005):

- **Implementation issues:** The Principal Recipient (MOFDP) seemed unable to coordinate implementation efforts and to absorb the funds of the Global Fund and the technical partners to the grant. There was little activity in 2004, and only modest evidence of programmatic activity by late 2005. Youth education results were poor despite their importance to the program's goals.

- **Monitoring and evaluation issues:** The M&E plan was not being implemented. Results were not properly verified and were therefore unreliable. No Data Manager or M&E specialist was in place, and there were "laborious and lengthy" disbursement processes due to the absence of a continuous results verification system. These M&E failures were said to have occurred despite the availability of technical support.

- **Grant management capacity:** There were significant management capacity and coordination issues at the Principal Recipient and Sub-Recipient levels. The Sub-Recipients appeared to have direct access to the grant bank account.

- **Procurement and supply management:** There was no clearly defined procurement strategy, and capacity was weak. Problems with procurement and disbursement functions were seen as likely to impede the smooth implementation of activities and coordination among the implementers.

3.6 In sum, the Global Fund observed in late 2005 that although there was potential in the HIV/AIDS program funded by the Round 2 grant to Lesotho, a variety of key issues were not being addressed effectively and rapidly, with no clear plan in place to overcome these obstacles. It was determined that there was "currently insufficient evidence to justify continued funding."

3.7 Support for the receipt, management, disbursement, and accounting for funds, implementation of effective interventions, and monitoring of implementation and results was provided neither by the Global Fund nor by the few development partners operating at the time in Lesotho (despite their having assisted in the development of the Global Fund proposal). Although Lesotho's first Global Fund proposal could have encompassed capacity-building and technical assistance, neither the authors of the proposal nor the Global Fund appraised the capacity of existing institutions to implement the extensive program. Financing

from the Global Fund focuses almost exclusively on HIV/AIDS activities. The challenge facing Lesotho was therefore how effectively to implement a large amount of external financing, given limited experience to date and national institutions that were still in the process of being defined. It was clear that additional financial resources for implementation were not required from the Bank, that implementation capacity for HIV/AIDS was a cross-cutting factor in the public sector, and that additional efforts were required to mobilize latent capacity in civil society.

3.8 The last World Bank Country Assistance Strategy for Lesotho had been discussed by the Bank's Executive Directors in 1998 and therefore did not anticipate an HIV/AIDS capacity-building project. Given the size of the Global Fund award, initial plans for a second-generation World Bank project in the Multi-Country AIDS Program (MAP) were rejected. The challenge had shifted from advocacy and resource mobilization to implementation and delivery on the ground. The Bank's recognition of the devastating impact of HIV/AIDS in Lesotho, coupled with the obvious capacity constraints in the country, had been firmly stated in project documents dating back to 2000. The concept for a capacity-building project specifically to address implementation constraints surrounding the Global Fund grant was first floated by the task team in the summer of 2003, resulting in a firm decision in November 2003 to rapidly prepare the HCTA project in order to avert the risk that the Global Fund could suspend its support.

3.9 The HCTA was designed to provide technical and implementation support, complementary to that being provided by other donors who were supporting Lesotho's national response to HIV/AIDS (UNDP, WHO, UNICEF, Development Cooperation Ireland, the African Development Bank, and the U.K. Department for International Development (DfID)). Project designers determined that additional financial resources for implementation were not what was required; rather, targeted implementation support was needed to facilitate use of Global Fund resources as well as to leverage additional external financing. The project defined implementation capacity broadly, to include not only adequate systems and procedures, but also sufficiently competent and committed human and physical resources to implement proposed activities (World Bank 2004).

3.10 At the time, the Bank had more experience than any other agency in implementation of national multi-sector HIV/AIDS programs in Africa through the MAP. Through previous project activity, the Bank was also familiar with the challenges of addressing HIV/AIDS in Lesotho. The Bank had been working with LAPCA and was aware of the additional capacities needed to perform its functions. The Global Fund proposal had been built on the design of the HIV/AIDS component of the Health Sector Reform Project and had been similar to the design of many MAP projects in the region: mostly grant financing to communities and line ministries for direct implementation of the multi-sector response. During preparation of the HCTA, there was extensive collaboration across the various external partners providing support for HIV/AIDS in Lesotho. The pre-appraisal mission was a joint mission undertaken together with UNDP, WHO, UNICEF, Development Cooperation Ireland, DfID, and the Global Fund, and there were additional consultations with the US Embassy and the African Development Bank.

Design

OBJECTIVES AND COMPONENTS

3.11 The objective of the $5 million equivalent HIV and AIDS Capacity Building and Technical Assistance Project, as stated in the Development Grant Agreement, was to "increase the Recipient's capacity to use effectively the resources provided through the Global Fund grant to support the implementation of HIV and AIDS programs within the Recipient's territory." The PAD states the development objective slightly differently: "to increase the capacity of government and non-governmental institutions responsible for the national response to HIV and AIDS to utilize and assess the impact of funds received for HIV/AIDS." Although these objectives are worded differently, their meaning is essentially the same; both wordings highlight the use of funds, and the language of the PAD on assessing the impact of funds received underpins the Grant Agreement's emphasis on effectively using the resources provided. This review will assess the achievement of the objective as stated in the Grant Agreement, as it addresses the more specific task of increasing the capacity to use Global Fund resources, and the key performance indicators in the PAD focus exclusively on performance with respect to use of Global Fund resources..

3.12 The project contained four components:

A. Strengthening the Ministry of Finance and Development Planning's capacity for overall management of external grant funding for HIV and AIDS programs ($0.37 million planned), including long-term technical assistance to coordinate between the principal recipient and sub-recipients of Global Fund support and ensure timely submissions of annual work programs and approval of those work programs by the CCM, facilitate disbursement of funds to the sub-recipient's accounts, ensure adequacy of financial controls and audits, and ensure timely reporting on agreed monitoring and evaluation indicators to the Global Fund.

B. Strengthening the Ministry of Health and Social Work's capacity for implementation of HIV and AIDS programs ($2.14 million planned), including acquisition of technical advisory services, enhancing the capacity of the MOHSW to: (a) design and implement effective strategies aimed at changing behavior related to HIV and AIDS; (b) oversee the performance and security of drug inventory management systems; and (c) establish efficient logistics systems for adequate provision of laboratory services; and enhancing NDSO's capacity to procure and distribute adequately and efficiently all required drugs and other relevant goods needed to sustain performance in the health sector, including expansion of warehousing facilities.

C. Strengthening LAPCA's capacity for coordination, monitoring, and evaluation of national HIV and AIDS programs ($1.38 million planned).[6] A firm was to be engaged to generate and manage proposals submitted for funding through LAPCA,

[6] At the time of appraisal, it was anticipated that LAPCA would be transformed into or replaced by a National AIDS Commission and Secretariat that would become the subject of this component.

strengthen district-level entities, monitor implementation by civil society and private and public sector grant recipients, and ensure that appropriate fiduciary safeguards and procedures were in place.

D. Strengthening involvement of civil society and private sector entities in combating the spread of HIV and AIDS ($1.11 million planned), including formulation and implementation of programs designed to spur the involvement of civil society organizations and private sector entities in the fight against the spread of HIV and AIDS in an adequate and sustainable manner, and establishment of a coordination mechanism. Dedicated NGO and private sector focal persons were to be located in LAPCA, and a civil society consortium with substantial grass-roots involvement was to be contracted to work with medium and small NGOs and CBOs in development of proposals and in implementation.

3.13 Performance indicators and their targets, as defined in the DGA and the PAD, were:[7]

- 80 percent of the Global Fund grant disbursed by the end of the project;
- 30 percent of the Global Fund grant disbursed through civil society organization;
- 50 percent of HIV/AIDS sub-projects financed through the Global Fund grant implemented in a satisfactory manner; and
- annual reports on all key HIV/AIDS program indicators produced and disseminated.

IMPLEMENTATION ARRANGEMENTS

3.14 The project capitalized on existing institutional structures. The implementing agency for the project was the Global Fund Coordination Unit (GFCU) within the MOFDP, which was also the Principal Recipient of the Global Fund grant. It held responsibility for overseeing project implementation and monitoring, and for coordinating project support to the MOHSW and the NAC. However, as with the implementation of the Global Fund grant itself, the MOHSW's Project Accounting Unit (which was managing funds of multiple external financiers, including the Bank's support for the Health Sector Reform Program) managed disbursements of funds against expenditures, and the MOHSW's Procurement Unit handled the procurement of contractual services and goods. This institutional arrangement was complex, involving several agencies, and required careful coordination.

3.15 Specific recipients of technical assistance under the project were to be the MOFDP's Global Fund CoordinationUnit; LAPCA and its local arms, the District AIDS Task Forces; the MOHSW's HIV/AIDS Directorate, M&E Unit, the Project Accounting and Procurement Units, as well as the National Drug Supply Organization and National Public Health Laboratory; other government ministries and agencies; and NGOs, CBOs, and private sector entities throughout the country. Technical assistance was to be contracted to firms and individuals, except in the case of civil society, where proposals were to be sought from a

[7] While the indicators in the DGA and the PAD are identical, the targets are not. In the PAD, all targets are set for year 4 of the project and there are no targets for project closing. In addition, the year 4 target for the first indicator is 75 percent disbursement.

consortium of large, experienced NGOs and umbrella organizations. Particular stress was to be placed on expanded and more effective engagement of civil society organizations, including NGOs, industry, small businesses, churches, and CBOs. Project design explicitly included a commitment to developing the ability of these many actors to make a contribution by defining their comparative advantage; ensuring that they employed tested interventions; and building their capacity to design, implement, monitor, and evaluate effective projects, and to manage and account for funds received.

Implementation

Planned Versus Actual Cost and Financing

3.16 The project spent more than planned on activities supporting the MOHSW (133 percent of planned) and the National AIDS Commission (120 percent of planned), and significantly less than anticipated on the Ministry of Finance (65 percent of planned) and on civil society and private sector capacity development (only $150,000, or 14 percent of planned) (see Annex Table C.4 for planned and actual spending by component). A reallocation of funds was done in November of 2007 from the unallocated category to civil works. This reallocation, and the overall reallocation of funds between components, was justified to take into account increases in construction costs for the National Drug Supply Organization warehouse and unanticipated high costs for several consultancy contracts. Currency fluctuations, particularly a strengthening of Special Drawing Rights against the Maloti, produced gains that helped to cover deficits. Flexibility in reprogramming helped to move resources to where they were most needed, although it remains unclear why civil society activities were funded at levels much lower than had been anticipated.

Implementation Experience

3.17 The HCTA was approved on July 6, 2004 and became effective on January 31, 2005, about a year after the implementation of the Global Fund Round 2 grant was launched. Project effectiveness was delayed by three months, largely because of the delay in recruitment of the Chief Executive of LAPCA/NAC. Disbursement was slow in the early stages of implementation, with only US$245,000 having been disbursed as of January 2006. Institutional arrangements began to function relatively smoothly about 18 months into implementation.

3.18 By February of 2006, after receiving additional information from Lesotho's CCM, the Global Fund changed its recommendation for Phase 2 funding to a "Conditional Go," with recommendations for a number of time-bound actions. Among those were several remedies to be supported by the World Bank, most specifically the hiring (for a period of 3-4 years) of a Grant Management Agent dedicated to the following tasks: coordination and liaison with project stakeholders; establishment of a Grant Management Unit within the National AIDS Commission; procurement of goods and services; disbursement of funds; contracts management, monitoring, and evaluation; capacity-building of staff of the Grant Management Unit; capacity-building for line ministries, district AIDS task forces, and affected communities; and development and execution of an exit strategy and plan (Global Fund 2006a).

3.19 Disbursements picked up significantly as technical assistance contracts were awarded in subsequent months, but still only 73 percent of funds had been disbursed as of May 2008. Disbursement delays were attributed to delayed payments on three major contracts: grant management, behavior change communication, and support for civil society organizations. The pace of implementation accelerated during the last months of implementation, and 98 percent of planned funds were eventually disbursed. The project closed as scheduled on December 31, 2008, which coincided with the end of the Global Fund Round 2 grant.

3.20 A number of institutional changes occurred during the life of the project, including the disbanding of LAPCA and establishment of the National AIDS Commission in 2005, as well as the establishment of the National AIDS Secretariat of the NAC; the upgrading of the HIV/AIDS Unit under the MOHSW Disease Control Division to a full-fledged Directorate designed to guide the technical aspects of the national response; establishment of positions for HIV/AIDS, TB, Data Management, and Information Officers at the district level; and dramatically increased participation of development partners and implementing partners in the HIV/AIDS response. Delays in the setting up of the HIV/AIDS Directorate in the MOHSW, the NAC Secretariat, and the GFCU caused significant slowdowns in initial project implementation.

3.21 There was high turnover of staff after capacity building, with personnel trained under the project moving to international NGOs, other organizations within the public sector, or NGOs. For example, all of the staff recruited under the Behavior Change Communication Unit in MOHSW moved to the NAC because of better conditions of service (with those MOHSW positions still unfilled). The rate of international migration of staff trained under the project, however, was only five percent. This dynamic illustrates the need for the Government to harmonize the conditions of service to curtail destabilizing movement of staff between government institutions.

Outputs and Outcomes by Objective

INCREASE THE INSTITUTIONAL CAPACITY TO USE GLOBAL FUND RESOURCES: SUBSTANTIAL

Outputs

3.22 The project conducted technical assistance as planned, including extensive training of staff and development of policies and guidelines, for the ministries of finance and health, the NAC Secretariat, and civil society organizations. Equipment, including computers, vehicles, and office equipment, was procured. Long-term technical assistance was well integrated in most hosting agencies and helped to strengthen capacity of those agencies in coordination, program implementation, and fiduciary issues.

3.23 **Ministry of Finance and Development Planning/Global Fund Coordination Unit:** An M&E coordination plan was developed, with manuals, systems, procedures, tools, and data base. Flowcharts for data were developed, with institutional roles and responsibilities specified. An implementation plan and budget were developed.

3.24 **Ministry of Health and Social Work:** The HIV/AIDS Directorate was established, equipped, and staffed. The Project Accounting Unit was staffed, and an accounting procedure manual and other project reports were produced. The Procurement Unit was strengthened through staffing and improved record-keeping and procurement documentation. The Global Fund Coordinating Unit and the procurement and financial management units in MOHSW became well coordinated in their work, even though they fall under different ministries. Approval procedures and lines of communication were clear and effective. The National Drug Supply Organization was strengthened through the creation and staffing of a procurement department and the production of manuals. Functional warehousing capacity was enhanced by 1000 square meters. Inventory management and security at all hospitals were strengthened, and drug supply overall was transformed from a push system to a pull system. The Drug Supply Manual and Lesotho Standard Operating Procedures were developed. (This strengthening and related drug supply procedures are regularly cited as one of the most important outputs of the project.) However, only 56 percent of posts in the HIV/AIDS Directorate were filled, with high staff turnover a continued challenge. In particular, there was difficulty filling positions in the Behavior Change Communication Unit of the MOHSW; all three staff members of that unit took positions with other Government agencies. This situation negatively impacted the country's ability to formulate and implement an effective BCC campaign, key to prevention.

3.25 **National AIDS Commission:** The NAC Chief Executive was appointed in 2005, and the Grant Management Unit was staffed and made fully operational, helping to accelerate the disbursement of Global Fund resources toNGOs. A procurement manual was developed. District AIDS Coordinators and district AIDS task forces were trained. Public sector line ministries were provided with assistance to develop fundable proposals for mainstreaming HIV/AIDS activities, and to support implementation. Appropriate fiduciary safeguards and procedures were put in place without constraining implementation. A Behavioral Change Communication strategy was developed. Ninety-two percent of posts in the NAC were filled, a higher percentage than for the HIV/AIDS Directorate of the MOHSW because of higher remuneration.

3.26 **Civil Society Organizations:** The project established and strengthened umbrella organizations to enhance coordination among NGOsand increase participation of civil society in the fight against HIV/AIDS. There were unspecified activities intended to coordinate civil society functions and increase NGOcapacity to develop proposals. A consultant was hired to perform an institutional capacity assessment before proceeding with capacity-building activities, although this work did not begin until late in the project period (July 2007) (Armstrong 2007). The civil society consultant engaged NGOs effectively, enhanced trust between Government and the NGO community, and galvanized the civil society movement within the country. As a result, NGOs are a central part of the national response (as evidenced, in part, by the Lesotho Council of NGOs being named a Principal Recipient for Round 8 of the Global Fund). However, capacity-building activities focused primarily on training and procurement of equipment for umbrella organizations rather than for specific NGOs.

Outcomes

3.27 Lesotho's Round 2 Global Fund grant was 99 percent disbursed by the end of the project, almost half of it (47 percent) through civil society organizations. Almost all (93 percent) of the 15 grant-funded subprojects were implemented with a satisfactory Global Fund rating. [8] Annual reports on all key HIV/AIDS program indicators were produced and disseminated each year of the project, informing both future programming and policy/strategy development (see Annex Table C.5 for HCTA achievements against targets). Key informants repeatedly offer the same bottom-line analysis: in the absence of the Bank's intervention, the Global Fund's Round 2 grant to Lesotho would have been cancelled. The capacity to mobilize additional resources for the national program also increased, as exemplified by additional grants from the Global Fund (Rounds 5, 6, 7, and 8) and PEPFAR.

INCREASE THE INSTITUTIONAL CAPACITY TO USE GLOBAL FUND RESOURCES EFFECTIVELY: MODEST

3.28 The objective of the project was not only to increase Lesotho's institutional capacity to use Global Fund resources, but to use those resources more *effectively* in achieving the goal of the Global Fund grant, namely to "contribute to the reduction of HIV incidence, particularly among youth, and improve the care and support of PLWHA and those affected by the epidemic." (Global Fund 2010)

3.29 The Global Fund considers that the targets for the Round 2 grant have largely been met. By December 2008 the Round 2 grant received a Global Fund performance rating of "A2," based on "exceeding expectations" for the performance indicators (A1 rating) but "adequate" performance (B1 rating) on management issues.[9] All but two of the "top 10" output targets on deliverables were met or exceeded (Table 3-1, lower panel).[10] Clearly there was significant progress, using Global Fund resources, in delivering treatment to HIV-infected people.

3.30 However, the Global Fund ratings are based largely on meeting targets for delivering outputs – and not their effectiveness in improving intermediate or final HIV/AIDS outcomes. With respect to assessing the impact of the HCTA on the *effective* use of Global Fund resources, this evaluation must assess, first, the evidence that HCTA invested in the capacity of government and civil society to use the resources more effectively (the outputs), and

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[8] The Global Fund rates performance of its grantees along the following scale: A1 (exceeds expectations), A2 (meets expectations), B1 (adequate), B2 (inadequate but potential demonstrated), and C (unacceptable). The ratings are based on two main criteria: performance of indicators against targets and management issues. Ratings of A1 or A2 are considered to be satisfactory.

[9] "...the performance on indicators rating for this Grant continues to be 'A'. However, the inconsistency of data reported, errors in financial reports and bank reconciliations coupled with lack of action on the TGF's previous recommendation to provide evidence that HTC are operational, continue to downgrade the performance rating to 'B1'." (Global Fund 2010, p. 33)

[10] There were 14 "top 10" indicators, of which one is not presented here because both the target and the actual were not set until the last year of the project (and the target was set at 10% of the actual). It is not clear whether the baseline of "0" for the percent of children receiving ARV prophylaxis is correct and whether this indicator was to represent only the contribution of the Global Fund or all programs.

second, evidence that any increase in capacity resulted in the more effective use of Global Fund resources to achieve the Round 2 grant goal of reducing the spread of HIV among youth and improving care and support among PLWHA (the outcomes).

Outputs

3.31 **Efficacy of government**. The overwhelming share of HCTA project resources (97 percent) was spent on building government capacity. The investments in the Ministry of Finance and Development Planning and in LAPCA/National AIDS Commission were primarily with respect to improving capacity for program management and procurement. The investments in capacity of the Ministry of Health and Social Work, on the other hand, had the greatest scope for improving effectiveness of the funds disbursed, as they were aimed at raising capacity to design effective behavior change strategies, improve the performance and security of drug management and distribution systems, and improve the efficiency of laboratory logistics.

3.32 The evidence of improved capacity for effective use of funds at MOHSW presents a mixed picture. On the one hand, the strengthening of the National Drug Supply Organization and related drug supply procedures is regularly cited as one of the most important outputs of the project and has the potential to improve drug availability and thus the efficacy of treatment programs. This was regularly cited by respondents as one of the most important contributions of the project. On the other hand, the investments in the technical capacity of the HIV/AIDS Directorate in behavior change communication – a potentially critical input into the efficacy of prevention programs – were thwarted by staffing problems referred to earlier. Only about half of the posts in the Directorate, which is the main government technical resource for HIV/AIDS programs in Lesotho, were filled, and all three positions in the behavior change communication unit were vacated after being filled.

3.33 **Efficacy of civil society.** Civil society organizations implemented nearly half of the $29 million Global Fund grant, yet HCTA spent only 3 percent of its resources ($150,000, only 14 percent of what was planned) to build the capacity of civil society to effectively use these funds. Those investments were made late in the project and primarily in larger NGO umbrella organizations as opposed to direct investments at the district level and below. The capacity-building activities were primarily aimed at mobilizing and coordinating NGOs, as opposed to improving their technical capacity. The Project did not, for example, provide sufficient support to enable communities to assist the chronically ill and OVCs effectively.

3.34 An independent review of civil society involvement in Global Fund-financed activities found a number of constraints impeding effective participation: lack of knowledge and understanding of Global Fund processes; inadequate capacity-building activities, in particular training that is consistently too short in duration; lack of financial resources, including for such basic tasks as printing out large documents from the CCM; poor communication and information-sharing among civil society organizations; continuity gaps resulting in frequent job-changing from one NGO to another; and an absence of alliances or partnerships among NGOs (Akoku 2009).[11] The fact that an independent report issued in

[11] This was a review undertaken and written independently by a staff member for one of the umbrella NGOs.

June 2009 recommended significant investment in capacity-building for NGOs, including strengthening of their management and technical capacity, indicates that the project fell short of its goals in this area. The Bank's follow-on project is addressing this need.

Outcomes

3.35 The HCTA project did not include any indicators to measure the extent to which the Global Fund grant was used effectively, nor did the Global Fund grant include such measures. The latter did track three "impact" indicators: infection rates among children born to HIV-infected mothers; attitudes about people living with AIDS; and condom use among young people (Table 3-1, upper panel). The infection rate among newborns reached the target of 15 percent, a reduction from the 25 percent "baseline" from 2002 (Global Fund documents do not note the source for the baseline value, however). Based on preliminary results from the 2009 DHS, it appears that condom use among people 15-24 with a non-cohabiting partner may have risen from about 53 to 67 percent (short of the 80 percent target, but still progress), while the target of 40 percent of the population with accepting attitudes toward people with HIV/AIDS was not met (24 percent only). While there has been some modest progress, it is difficult to attribute this to Global Fund outputs *per se* or to attribute the effectiveness to the impact of the very modest HCTA capacity-building investments in technical capacity for effective interventions. Further, problematic for assessing both the achievements of HCTA and of the Global Fund grant, the IEG mission was unable to obtain information on how the roughly half of all grant resources implemented by civil society were used or their effectiveness.

3.36 Thus, even though there was a large increase in the number of young people, both in and out of school, taught life skills education, and a large number of condoms was distributed through multiple channels, there have been limited observable behavioral results attributable to these activities. For example, according to the Five-Year Evaluation of the Global Fund case study in Lesotho (Macro International, Inc., 2008), there was no evidence of behavior change that could have explained a decline in incidence for the period 2005-2007. Comparing the results of the 2004 Demographic and Health Survey (DHS) with the preliminary results of the 2009 DHS, the percent of men 15-24 who had two or more sexual partners in the past 12 months fell from 36 to 21 percent, but the mean lifetime number of partners rose from 4.4 to 5.1. Among women 15-24, the percent with two or more sexual partners in the past 12 months declined from 9 to 4 percent, but the mean number of lifetime sexual partners doubled, from 1 to 2.

Table 3-1: Lesotho's Performance on Round 2 Global Fund Grant, Formal Indicators

Indicator	Baseline value (2004)	Target (2008)	Result (2008)
"Impact indicators"			
Percent of infants born to HIV-infected mothers who are infected	25[a]	15	15
Percent of people expressing accepting attitudes toward PLWHA, of all people surveyed aged 15-49	__.	40	24
Percent of people aged 15-24 reporting the use of a condom the last time they had sex with a non-regular sexual partner	53[b]	80	49 [c]
"Top 10 Indicators" (Outputs)[e]			
Total # of young people in school taught life skills education	---	127,636	209,275
Total # of young people out of school taught life skills education	2,164[d]	390,000	487,155
Number of condoms distributed to youth corners and the general population	100,000[f]	21,500,000	28,433,320
Percent of infants (born to HIV-infected mothers) who receive ARV prophylaxis as per WHO protocol	__	90	61
HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT	---	10,000	15,015
Number of pregnant women visiting an ante-natal PMTCT site counseled/tested for HIV	---	41,000	81,922
Number of health care service providers trained on diagnosing and management of HIV and AIDS	50 [d]	500	3,448
Number of people receiving ARV treatment	---	30,000	42,668
Number of sites with functional VCT centers	3 [d]	106	204
Number of people counseled and tested for HIV	---	400,000	552,382
Number of registered OVC receiving basic package of care and support	---	85,000	76,707
Number of PLWHA receiving advocacy skills training on their human rights	---	2,000	10,062

Source: Global Fund 2010, except as noted. The source of the baseline and actual results for the impact indicators and the baseline for output indicators is not reported in the Global Fund document.

a. Reported for 2005, source unknown. b. Source is the 2004 DHS (Macro International 2005), Tables 11.8.1 and 11.8.2, the percent of women and men who used a condom at last intercourse with someone who is not a spouse and not co-habiting. The Global Fund Scorecard presents a baseline figure of 9% for 2002, but no source is cited. c. Preliminary results from the 2009 DHS suggest that this figure has risen to roughly 67% (about 66% for women and 68% for men aged 15-24) in 2009. d. Reported for 2002, source unknown. e. There were in fact 13 "top ten" indicators in the Global Fund Scorecard. One is not reported here – the number of OVC provided financial support to attend high school and vocational training. This is because no target was set until 2008, and it was set at 10% of the actual for the same year. There were no baselines or actuals before that date. f. Reported for 2003, source unknown.

3.37 Government has not used Global Fund resources to finance prevention activities tailored to groups most likely to transmit HIV infection (although the country's Round 8 proposal to the Global Fund includes appropriately targeted prevention activities)(CCM 2008). Incentives to curb the prevalence of multiple partnerships and intergenerational sex have not materialized. Provision of prevention material through the school system has been delayed, in part because of perceived reluctance to discuss sex explicitly and to recommend

the use of condoms, meaning that the primary sources of information for youth are NGO-run after-school and summer programs; this is despite studies indicating broad support for the introduction of sex education in the national school curriculum among young people, parents, and teachers (Mturi and Hennick 2005). The "Be Faithful" part of the ABC strategy has been integrated into several policies and strategies, but policies and communication programs are not specific on multiple concurrent partnerships, which is particularly important given the difficulty of translating the term "be faithful" into Sesotho (NAC 2009a, 2009b). Current policies do not provide evidence-informed guidance on priority populations for intervention, and programs are not targeting the populations where most new infections happen. Almost no activities are targeted explicitly toward adults, married couples, and people in long-term steady relationships (NAC 2009a). "Migrating" couples have not received focus.[12] In other words, there is no evidence that Global Fund resources were spent effectively on prevention interventions that would importantly "turn off the tap" of new infections.

Table 3-2: Distribution of HIV/AIDS Prevention Spending 2007/08, from All Sources

Prevention activity	Percent
Voluntary Counseling and Testing	38
Prevention of Mother-to-Child Transmission	29
Condom Social Marketing	10
Youth	7
Behavior Change Communication	5
Community Mobilization	3
Post-exposure Prophylaxis	3
Universal Precautions	2
Blood Safety	2
Prevention, Diagnosis, and Treatment of STIs	1

Source: National AIDS Spending Assessment, 2005/06 – 2007/08

3.38 The 2006/07 National AIDS Spending Assessment (NASA) suggests that only 10 percent of total HIV/AIDS funding was spent on HIV prevention (15 percent in 2005/06),[13] and the share of spending for efficient prevention interventions remains quite low (Table 3-2). The Global Fund's own reporting on Lesotho's Round 2 grant and the Five-Year Evaluation stressed voluntary counseling and testing and PMTCT. The 2007/08 NASA showed some improvement, with 12.9 of all HIV/AIDS spending going toward prevention,

12. Modes of transmission apart from heterosexual sex are apparently relatively rare (NAC, 2008a). Several studies have indicated the presence of sex work in some locations in Lesotho, but it is not as prevalent as in many other countries (Leclerc and Garenne 2008). In the 2004 DHS, around 1.7% of men reported having paid for sex in the last twelve months, and of these, 58% said they had used a condom during their most recent encounter. There is also, of course, anecdotal evidence of men having sex with men, but there has been no systematic effort to estimate the size of that population or its HIV prevalence. Injection drug use has not been reported in the country.

[13] In contrast, 33 percent was spent on care and treatment, 24 percent on program management, 13 percent on OVC support, and 11 percent on social protection, putting prevention in fifth place on the priority list (NAC 2009a).

but this represented an under-spending of the 20.9 percent that had been planned. In 2008, only 10.6 percent of Global Fund spending was budgeted for prevention, and 10.4 percent was actually spent on prevention activities (NAC 2009b).

3.39 There is no unified operational HIV prevention strategy, with no coordinated, intensive, multi-service approach to reducing HIV transmission and scaling up a comprehensive range of prevention interventions. In the absence of such a strategy, the Government instead pursued a highly politicized "Know Your Status" (KYS) campaign, which allocated significant resources toward mass testing and diverted attention away from more cost-effective focus on groups most likely to transmit infection (Box 3-2). Given the significant investments in VCT, there has been no impact evaluation to reveal the extent to which dis-inhibition behavior has occurred (the tendency of those tested negative for HIV to return to risky sexual behaviors).

Box 3-2: "Know Your Status"

In March 2004, the Government of Lesotho launched the Know Your Status (KYS) campaign. Designed not only as an HIV prevention measure, but also as a way of enabling the infected to receive care and treatment, the campaign's goal was that "all people over 12 years old living in Lesotho would know their HIV status by the end of 2007." During the launch, the country's Prime Minister publicly took an HIV test, making a strong statement against the stigma attached to HIV testing (and indicating the high political significance of the national effort). The campaign received technical support fromWHO and financial backing from the Global Fund, the United Nations Development Program (UNDP), and the Global Business Coalition on HIV/AIDS. In the absence of a coherent national HIV prevention strategy, the KYS campaign became the focal point of the country's prevention efforts.

The KYS scheme planned for 7,200 community health workers to be trained in HIV testing and counseling. These workers would then offer rapid HIV tests to every household in the country, with everyone tested and counseled then referred to post-test services according to their HIV status (AVERT 2009). Communities were given wide leeway to determine how testing and counseling would be rolled out.

By October of 2006, however, only half of the planned community volunteers had been recruited, and conditions of poverty and rural isolation hindered efforts to reach the entire population. A Human Rights Watch report found some positive aspects of the campaign: there was no evidence of involuntary testing, only a few unproven allegations of breach of confidentiality, some effort to ensure that testing was linked to HIV treatment and care services, and great commitment among counselors to bringing counseling and testing to communities (AIDS Rights Alliance for Southern Africa and Human Rights Watch 2008). The report also, however, found a tremendous gap between the planning of the KYS campaign on paper and the capacity to implement what had been planned. Medical staff were in short supply (IRIN 2009), testing counselors were poorly trained and supervised, there were significant failures to safeguard human rights, and links between testing and treatment centers were inconsistent.

There are major discrepancies in the reported eventual reach of the campaign: the government cites an increase in testing coverage from 2.7 percent in 2004 to 17.2 percent in 2007, but Human Rights Watch claims that only 2 percent of the target 1.3 million people – fewer than 25,000 – were tested through the KYS scheme by August 2007. A WHO press release stated that 240,000 people in Lesotho knew their HIV status at the end of the year, but it is not clear how many of those were tested as part of the KYS campaign. A 2007 survey by the Apparel Lesotho Alliance to Fight AIDS found that, despite the considerable investment in KYS, there was no preventive effect on workers' engagement in sexual risk behaviors as a result of HIV testing, calling into question the behavior change impact of post-test counseling (NAC 2009a). Lesotho's National HIV/AIDS Strategic Plan 2006-2011 includes a target of 80 percent of the population age 12 and older knowing their HIV status by 2011.

3.40 More could have been done to identify high-impact interventions, including male circumcision and a more cohesive prevention program focusing on partner reduction and HIV/AIDS education for youth, and a more intensive integration of HIV services with traditional public health interventions such as family planning and maternal and child health. The Basotho are a highly religious people, and opportunities were missed to work with pastoral voices of all denominations to send appropriate prevention and behavior change messages to youth and adults alike. Because of lack of effective communication strategies to engage youth, there are reports that young people are persisting with known risky sexual behaviors on the assumption that they can remain alive and healthy indefinitely on ARVs should they become infected. Also, there have been missed opportunities to engage key men's groups from civil society, such as the Association of Former South African Miners and the Association of Herd Boys; men-to-men peer forums on prevention, if properly identified and capacitated, could prove to be efficient vehicles for transmission of prevention messages. Overall, the Government remains timid about discussion of risk groups and behaviors that facilitate HIV transmission, preferring to leave these tasks to consultants rather than engaging necessary subject matter head-on.

Ratings

OUTCOME

3.41 The project had Highly relevant objectives and Modestly relevant design, Substantial achievement of one of its development objectives and Modest achievement of the other development objective, and Substantial efficiency in meeting those objectives. Taken together, these ratings are indicative of moderate shortcomings, resulting in a **Moderately Satisfactory** outcome of the project as a whole.

3.42 **Relevance of Objectives is rated High**. Fighting the HIV/AIDS pandemic is one of four pillars of the current Country Assistance Strategy, making the focus on HIV/AIDS highly relevant. Indeed, a follow-on HIV/AIDS project was explicitly included in the FY 06-09 Country Assistance Strategy as part of the Bank's support to the fight against HIV/AIDS in the country. The project directly supported the Government's priorities as set out in the 2001 Poverty Reduction Strategy Paper, Vision 2020, the National HIV and AIDS Strategic Plan (2006-2011), and the Millennium Development Goals.

3.43 The objective of the national HIV/AIDS program in Lesotho was to control the spread of HIV/AIDS and mitigate its impact on vulnerable groups, individuals, families, communities, and the nation as a whole. Global Fund support to Lesotho served this objective, with activities designed to scale up interventions for prevention, care, treatment, and impact mitigation, including the expansion of training and education, provision of basic care to those infected and affected by the epidemic, home-based care, community mobilization, and promoting civil society and public-private partnerships in the fight against HIV/AIDS. The HCTA project was designed to provide targeted to support to enable the recipient and implementing agencies effectively to receive, manage, and assess the impact of these funds.

3.44 According to the 2007/08 NASA, more than 76 percent of resources for HIV/AIDS, from both the Government and development partners, was budgeted for direct programs (prevention, treatment, care and support, and impact mitigation). Increasing resources were being absorbed relatively slowly due to limited capacity. The National Strategic Plan (2006-2011) explicitly called for greater attention to system strengthening and capacity building.

3.45 The recently-published Five-Year Evaluation of the Global Fund notes that Global Fund grants often require country capabilities that do not exist (Macro International 2009). An overarching finding from the evaluation is that CCMs are largely ill-equipped – in terms of resources, capacity, and political will – to either take on or coordinate the myriad functions required for adequate grant oversight and management. The Bank team was remarkably prescient in reaching this conclusion years earlier, and in designing a project specifically to address this issue.

3.46 **Relevance of Design is rated Modest**. The HCTA project design was uniquely different from all other World Bank HIV/AIDS projects. It exclusively focused on using the Bank's comparative advantage to complement the Global Fund grant. The design was intended to remove capacity bottlenecks and speed up the pace and effectiveness of implementation of the Global Fund grant. It harnessed the Bank's comparative advantage in system and fiduciary strengthening in an effort to complement, rather than compete with, Global Fund and other partners' financing. This innovative design reflected a new partnership model never before attempted by the Bank in the health sector. The project team was strategic and innovative in adapting project design to the country situation.

3.47 Project design was flexible, given the rapidly evolving nature of the HIV/AIDS epidemic in Lesotho. New capacity-building requirements and new resources emerged during implementation, and the project was able to respond appropriately, for example, by canceling a consultancy that was no longer needed because it was financed by other partners, or by extending the term of a consultant whose contract financed by another partner was expiring. Flexibility was occasionally constrained, however, by the fact that some project activities, particularly consultancies, were not adequately covered by the planned budget.

3.48 Key performance indicators were output-oriented and designed to focus on the implementation status of the Global Fund grant, which proved to be practical and easy to monitor. However, this focus emphasized the fact of disbursements and reporting rather than the quality or impact of interventions, or the use of data or analysis from reports for policy or program design and implementation. Most importantly, project design did not include, in its results framework or its indicators, focus on a key part of the development objective: increasing Lesotho's capacity for *effective* use of Global Fund resources. Particularly in light of the stress in a recent evaluation of the Global Fund on this very issue (Macro International, Inc. 2009), this omission is an important shortcoming.

3.49 There was also insufficient focus on capacity building below the national level. Local councils, district-level civil society organizations, and private sector organizations were neglected in project design. As a result, there were problems with parallel implementation arrangements at the district level, with the NAC, Ministry of Local Government and

Chieftainship, and MOHSW all recruiting M&E officers and other staff without appropriate consultation and harmonization.

3.50 **Efficacy of the first objective is rated Substantial and of the second objective is rated Modest.** Capacity-building support provided through the project substantially increased Lesotho's capacity to disburse Global Fund resources. However, the project only modestly improved the *effective* use of those resources.

3.51 **Efficiency is rated Substantial**. Implementing arrangements were efficiently aligned with those of the Global Fund grant. The project used and built capacity of existing structures and capacities in the GFCU, NAC, and MOHSW. For example, GFCU, which was the implementing agency for the project, was also the Global Fund grant Principal Recipient. The PAU and Procurement Unit of the MOHSW, responsible for managing the funds of multiple external financiers under the HSRP, also managed the HCTA. The PAU and Procurement Unit also provided financial management disbursement and procurement services for the Global Fund grant (although it should be noted that, toward the end of the project period, the PAU's tasks under the Global Fund grant were transferred to an analogous department directly within the GFCU, largely because of PAU-caused bottlenecks).

3.52 However, there were some shortcomings. Inefficient implementation delays plagued the early phases of the project, due to the controversy over restructuring and eventually eliminating LAPCA, the delay of recruitment of the NAC Chief Executive (which was a condition of project effectiveness), poor understanding of procurement procedures by user departments, and inadequate capacity to develop TORs for technical assistance due to differences of opinion on the roles and functions to be performed under the technical assistance contracts. Role-definition among implementing agencies was not clear; for example, while GFCU was responsible for overall coordination and financial management and expenditure were the purview of MOHSW, much time was lost in trying to decide where overall leadership would reside. Eventually, an Operations Manager was appointed in MOHSW, and a Steering Committee with representation from all relevant agencies was established, but valuable time was lost in realizing these efficiencies.

3.53 As the country's M&E capacity was strengthened, several parallel systems were created without proper plans for coordination and integration. Each system has created its own arm at the district level. For example, the M&E system under NAC recruited ten data officers for the ten districts; likewise, MOHSW recruited ten HIV/AIDS officers and ten information officers to facilitate health sector M&E in the ten districts. There has been inadequate synergy between these decentralized units, and in some cases competition between them and deliberate hoarding of data.

Risk to Development Outcome

3.54 **Risk to Development Outcome is Substantial**. The project's contribution to the country's ability to absorb Global Fund and other donor resources has proven its effectiveness in attracting additional resources. While donor funds are no guarantee of sustainability, the increase in financing creates favorable conditions for maintaining and

improving upon capacities that were created, particularly in the presence of a partner such as the Bank that has focused attention on capacity-building imperatives.

3.55 International technical assistance, however, is a short-term solution to a long-term problem. It is not clear that the Government adequately planned for absorption of technical assistance provided by the project to facilitate permanent improvements in local capacity. Institutionalizing the systems created or supported by the project remains a concern (World Bank 2009c). While the positions for head of the NAC and the director/staff of the HIV Directorate of the MOHSW have been internalized and are fully financed by the regular budget of the Government, the MOHSW procurement manager and finance manager continue to be maintained through external funding. This is mainly due to restrictions arising from civil service regulations and less competitive salary scales for civil servants. Progress has been made recently by moving the finance manager position from an international technical assistant to a local technical assistant, and both the procurement manager and finance manager are locally hired. Furthermore, the MOHSW has recently formulated a medium-term plan on building local capacity, and the follow-on Bank project is explicitly designed to work with the Government to ensure that HCTA-provided gains are sustained.

BANK PERFORMANCE

3.56 Bank performance is rated **Satisfactory.**

3.57 **Quality at Entry is rated Satisfactory**. The Bank worked together with other development partners, including a joint pre-appraisal mission, to identify capacity constraints in relevant agencies. The project team conducted a sound analysis of the financial support to the technical capacities already existing in government and civil society, as well as the technical assistance needed from development partners. Partners participated effectively based on their comparative advantages at the time. Development Cooperation Ireland and DfID supported institutional capacity assessments of LAPCA, while WHO did the same for the MOHSW HIV/AIDS Unit. These assessments informed the TORs for the technical assistance provided under the project. The Bank's role here was catalytic, supporting innovations in institutional capacity development to increase adequacy of procedures and systems as well as individual capabilities.

3.58 Some risks were effectively identified, most notably the potentially harmful impact of lack of consensus over the roles of LAPCA, NAC, and the NAC Secretariat. The Bank's mitigation measure, making the appointment of a Chief Executive for the NAC a precondition for effectiveness, forced a resolution of this issue (at least for the short term).

3.59 However, there were some shortcomings at entry, including failure to focus on the well-known problem of human resource retention, targeting of capacity-building at national-level institutions at the expense of the district level and below, and failure to take advantage of opportunities to explore synergies between HIV/AIDS and TB. Lesotho's Round 2 Global Fund grant application specified the relationship between HIV and TB: the success of the HIV/AIDS grant would enhance the performance of the TB grant, while the failure of the TB grant would undermine the potential for success of the HIV/AIDS grant (Global Fund 2006a). The proposal specifically noted that, at the time, TB was the most common co-

infection of HIV/AIDS and that the trend was increasing, with sentinel surveillance data from Maseru revealing an increase from 11.3 percent of TB patients being HIV-positive in 1991 to 49.6 percent in 2000, and an overall increase in TB cases from 249/100,000 in 1995 to 501/100,000 in 2000 (CCM 2002). However, the preparation and design of the project did not include an analysis of the TB program, and TB was not explicitly a focus of project activities. Despite this omission, however, the project team provided support and monitored implementation progress of the TB program during supervision missions. This support may have been more efficiently and effectively provided had it been initially designed into the project. The project did not take into consideration possible synergies between HIV/AIDS and TB to inform integrated implementation arrangements.

3.60 Only three risks to achievement of development objectives were identified during project preparation, and all were assessed as modest or low: that internal politics would undermine decisions on how the Global Fund grant would be managed; that the areas targeted for capacity support would not be sufficient to support Global Fund grant implementation; and that Global Fund resources would become insufficient to meet demand. Risks to components identified as substantial related to ongoing debates over the role of LAPCA and the NAC, and to possible delays in the procurement of consultant services that would address Global Fund implementation challenges; the identified mitigation measures were appropriate, if not always effective. Risks related to human resource shortage and retention were not specified, however, despite overwhelming accumulated experience with this problem during other projects, and these issues were a challenge throughout project implementation.

3.61 **Quality of Supervision is rated Satisfactory**. During preparation, the Bank correctly observed that even though this was a small Technical Assistance Loan, supervision would have to be substantial, as the project was in essence serving as supervision of implementation of the Global Fund grant itself. Supervision missions collaborated effectively with Government and the CCM to identify and manage proactively implementation problems. The Mid-Term Review in September/October 2006 correctly identified institutional coordination problems and recommended effective measures to address them. Supervision documents reveal that the task team repeatedly expressed concern over the quality of HIV prevention activities and the pace of their implementation.

BORROWER PERFORMANCE

3.62 Borrower Performance is rated **Moderately Satisfactory**.

3.63 **Government performance is rated Moderately Satisfactory**. Government commitment remained high throughout, as evidenced by counterparts' special efforts to attend scheduled meetings with Bank mission personnel even during periods of political instability, including strikes called by the opposition party in 2007.

3.64 The Government developed appropriate policy documents and strategies to guide the national response: the National HIV and AIDS Policy, National Orphan and Vulnerable Children Policy, HIV Testing and Counseling Policy, and Blood Transfusion Policy. In addition, the Labour Code Act was amended to prohibit discrimination against PLWHAs,

and a Legal Capacity of Married Person's Act was passed to empower women. However, the Government was slow to respond to high staff turnover and both internal and external migration of skilled manpower, and also to Bank mission exhortations about the need to focus attention on HIV/AIDS prevention.

3.65 **Implementing Agency performance is rated Moderately Satisfactory**. The GFCU ensured that annual work programs were submitted on time and approved by the CCM, that disbursements of funds to sub-recipients were facilitated, that financial controls and audits were adequate, and that reporting on agreed indicators was timely. GFCU coordination of both the Global Fund grant and the HCTA was smooth, and staff performance was excellent.

3.66 The MOHSW was the successful beneficiary of capacity-building within the PAU, PU, M&E Unit, HIV/AIDS Unit, and fiduciary systems. This enabled MOHSW to provide quality treatment and care to a substantial number of those infected with HIV/AIDS and to fulfill its role as sub-recipient of the Global Fund grant.

3.67 The NAC was capacitated through the establishment of its Grant Management Unit, which became fully staffed and operational. Although it has evolved into one of the primary stakeholders in the national response, questions remain about its effectiveness. The development of the National Behavior Change Communication Strategy, capacity development in community M&E at district and sub-district levels, and mainstreaming HIV/AIDS in public sector ministries has not developed as planned. Political controversy continues to swirl around the NAC, and it remains to be seen whether it will persist in its current institutional form.

3.68 The GFCU and Procurement Unit became increasingly efficient at working together throughout the life of the project, even though they were located under different ministries. Approval procedures and lines of communication between them were clear and effective. There were, however, reports of tension between GFCU and NAC over leadership and control of civil society capacity-building (Armstrong 2007), and the PAU's performance on the Global Fund grant was perceived to be causing delays to such an extent that its functions were eventually transferred to another office directly under the GFCU.

3.69 There was poor understanding of Bank procurement procedures by the user departments. There were delays in procurement of technical assistance due to lack of capacity in user departments to generate TORs acceptable to all stakeholders and the absence of clear institutional mechanisms to link and coordinate the various implementing agencies. This affected all tenders under the project, resulting in a situation where the Government did not benefit from technical assistance for the first year of the project. Once the procurement process was successfully completed, however, the value and contributions of technical assistance were consistently realized. The procurement of goods also began slowly, particularly for health products such as drugs for opportunistic infections and STIs. Furthermore, forecasting, quantification, and coordination between MOHSW, NDSO, and GFCU were not consistent.

3.70 Umbrella civil society organizations such as Lesotho Council of NGOs (LCN) built capacity to the point that LCN was named a Principal Recipient of the Global Fund Round 8

grant. Almost half of the Round 2 grant was disbursed to NGOs, with 14 of 15 funded subprojects rated satisfactory by the Global Fund.

MONITORING AND EVALUATION

3.71 Monitoring and Evaluation is rated **Modest.**

3.72 **M&E Design is rated Modest**. Project preparation documents state that M&E requirements for assessing the outcome and results of the HCTA itself would be limited. Presumably this meant that the success of implementation of the Global Fund grant would serve as a sufficiently reliable marker for the impact of the Bank-financed technical assistance. Measures of success for the technical assistance were set at how well systems were developed and strengthened to generate early and regular information on the national HIV/AIDS program's outputs and impact, epidemic trends, and the Government's ability to assess the impact of the national program. There was no provision directly to assess the performance of the technical assistance that made up the bulk of project-financed interventions. Supervision missions encouraged the government to introduce a formal performance evaluation process on the technical assistance and to share that evaluation with funding agencies, but such evaluation activity was not incorporated into project design.

3.73 **M&E Implementation is rated Modest**. An M&E Unit in the NAC was established, with ten data officers recruited (one for each district) to strengthen local M&E capacity. Two international technical advisors financed by the Global Fund and USAID were put in place to assist this M&E Unit. An electronic database system was developed to improve overall data management. The M&E team under the MOHSW HIV/AIDS Directorate took parallel capacity-building steps, now having several units with qualified staff: Epidemiology and Research, M&E, and Information Communication and Technology. The MOHSW also appointed ten HIV/AIDS data officer posts, one in each of the districts. There is an agreement that the NAC will collect non-clinical data and rely on MOHSW for clinical data, but division of labor and data sharing remains problematic.

3.74 Overall, the M&E system remains fragmented. M&E planning and design has taken place at a very sophisticated level, but those plans are grossly mismatched with the capacity of the staff and systems implementing them. HIV/AIDS data, financial management data, TB data, and human resource data still run as vertical systems (Macro International 2008). Preparation documents for the follow-on HIV and AIDS Technical Assistance Project stress that M&E strengthening requires immediate attention (World Bank 2009c). Redundant systems at the district level remain highly inefficient, particularly in a context of overwhelming human resource shortages. Similarly, the support to M&E from development partners has been uncoordinated, and various vertical programs have their own systems with their own specific data needs that are not well integrated with the overall M&E system. As a result, MOHSW departments collect large amounts of data required by various programs, overburdening the M&E system while leaving it with critical gaps and significantly impeding the quality of data and the extent to which data are used.

3.75 **Utilization of the data is rated Modest**. The Principal Recipients and Sub-Recipients have collected data on key indicators and used those data to prepare quarterly and

annual reports, including Joint Annual Review reports. These M&E reports were used to formulate key policy and strategy documents such as the National HIV/AIDS Policy, the National HIV/AIDS Strategic Plan (2006-2011), and the National HIV/AIDS Coordination Framework. Improved capacity was also used to conduct research studies and surveys such as HIV/AIDS workplace and drug stock studies, antenatal epidemiological sentinel surveillance, surveys on gender and multiple concurrent partnerships, and a modes-of-HIV-transmission study. However, data use remains limited due to system fragmentation, the planning cycle not being synchronized with the reporting cycle, and limited advocacy using strategic information (NAC 2008a).

4. Conclusions and Lessons

Health Reform

4.1 Country ownership and commitment to the reform process are key to successful implementation. The HSRP was preceded by extensive consultation among stakeholders on the vision for reform. Implementation of the project increased ownership of the reform process, but staff turnover was high. Ownership and accountability for the reform program was not sufficiently rooted within all MOHSW departments and units and the health sector in general; the HPSU was the only department well-versed with the reform program. Communication within the MOHSW remains weak. Similarly, lack of coherence on decentralization pace and scope between MOHSW, MOFDP, the Ministry of Public Service (MOPS), and the Ministry of Local Government and Chieftainship led to inefficient deployment of scarce resources. The MOHSW should be encouraged to be more proactive and consistent in promoting the content and image of the reform program both within and outside the ministry. Throughout HSRP, the HPSU spearheaded the reforms, a task it managed partly due to stability in leadership and staffing. But ownership of the reforms must be more widespread across the sector to ensure accountability for results and to build up a pool of champions for the process.

4.2 Political economy analysis must be ongoing. Even issues that are seemingly resolved can re-emerge unexpectedly. For example, there are current political controversies swirling around the NAC, with continuing rumors that it is about to be dissolved. Other agencies question its usefulness and critique it as simply an additional layer of bureaucracy; certainly other Government departments, particularly MOFDP/GFCU, would like to absorb its budget along with its functions, and the MOHSW would like exclusive purview over HIV/AIDS transferred back to its HIV/AIDS Directorate. Given that the NAC's initial creation was viewed by many as simply a quick political fix, intended to placate public outcry over the increasing number of AIDS-related illnesses and deaths, it is not surprising that it remains controversial, in many cases merely a tool in ongoing power struggles. These ongoing internal political skirmishes have been tactfully mediated by the Global Fund and especially by the Bank, but neither external agency managed to stifle the feud. In retrospect, some informants suggest, perhaps less tact and a more forceful approach would have been appropriate. It should be noted, however, that competing agencies – in part due to Bank persuasion – have continued to function relatively well together at the technical level.

4.3 There is a strong need to balance improvements in health sector processes with a focus on improving health services delivery – and it may not always be necessary to assume that there are tradeoffs between the two. Stakeholders across the sector stressed that institutional capacity is key to adequate functioning of the health system, but attention to service delivery, quality of care, and health outcomes cannot be deferred, particularly when health indicators are declining.

4.4 Health sector reform does not and cannot take place in a vacuum. In the case of the HSRP, the lack of a macroeconomic support program to push for difficult policy issues outside the purview of the MOHSW probably constrained or delayed actions, particularly in the areas of decentralization of services and upgrading the salaries and benefits of health workers (civil service salaries being a system-wide issue). A dedicated local government support program could have helped the project sort out knotty institutional issues among the ministries of finance, local government, and technical lines agencies on these issues. Lack of progress or clarity on "upstream" issues – most importantly, setting the rules of the game for an eventual fiscal devolution to local authorities – meant that "downstream" activities within the health sector itself had to be deferred, or redesigned to fit within the purview of only the health sector.

4.5 The use and strengthening of existing systems is preferable to the creation of new and separate fiduciary and other systems. The successful strengthening of capacity in the project accounting and procurement units underscores the value of using and building on existing systems.

4.6 Sustainable human resources retention requires long-term planning, ownership, and innovation. Like many countries in the region, shortage of skilled manpower is one of the main challenges facing the Government of Lesotho. Although Bank-financed projects have helped to build capacity in government and non-government institutions, staff that are critical to delivery of services, particularly nurses and doctors, migrate freely to neighboring South Africa. Other staff that have been empowered under the Bank project have left those positions, moving internally or to other institutions, and staff at the district level have moved to the capital. The Government, Bank, and other development partners remain faced with the challenge of formulating innovative and affordable manpower development and retention policies and strategies. It cannot be overstressed that innovation is required in this area. Levels of remuneration, while important, are not the primary issue. Staff in rural areas cite a variety of more compelling factors that make it difficult for them to attract qualified personnel: neglect by senior management and headquarters offices, who virtually never spend time outside Maseru conferring with service providers at the health facilities themselves; housing and security; and most importantly, lack of resources, especially equipment and vehicles/fuel, that would make it possible for staff to perform their main task – saving lives – effectively. It is also not clear that an exclusive focus on supply-side issues is appropriate in the human resources area. If all staff worked to full capacity, the situation would be improved greatly, but existing approaches have not focused on the productivity and duplication sides of the equation.

4.7 Caution must be exercised to ensure that countries do not become over-dependent on technical assistance, and that technical assistance is reasonably priced and appropriately

monitored. It is important to ensure that implementation capacity remains after provision of technical assistance has ended. This can take place through support for capacity-building of existing local staff (through external training or on-the-job training) as well as specific skills transfers. Building local capacity and skills should be included in technical assistance contracts, and the Bank should work with Government to develop medium- and long-term plans to internalize key positions. In making a decision about whether to import expertise or build local capacity, the local context and ability of the country to employ or transfer skills from technical assistance to local staff should be taken into consideration.

4.8 It is also important, however, to balance training meetings, seminars, and workshops with the implementation of operational plans. In most work plans for the MOHSW, training constitutes more than 40 percent of the activities planned for the year (MOHSW 2008a). Many staff prefer training sessions to the undertaking of their regular responsibilities, because of the additional stipends and meals that are frequently made available. Consideration should be given to on-the-job training methodologies as an adjunct or alternative to traditional seminars and workshops.

4.9 Some procurement delays have been caused by lack of clarity between user departments on the functions to be performed by various technical assistance consultants. There should be a coordination mechanism within implementing agencies to lay out, from the beginning, clear responsibilities for each department/unit. Streamlining institutional arrangements and roles of various components at the design stage is a necessity for avoiding implementation delays. Individual technical assistance provision should be evaluated for effectiveness in terms of capacity built by the client entity.

4.10 Civil society in Lesotho remains relatively neglected, and its potential to contribute to the solution of a wide array of problems in the country is underacknowledged. This is a particularly significant gap considering the magnitude of donor funds flowing to Lesotho to support the response to HIV and AIDS, and the growing proportion of those funds that now supports local, non-governmental organizations and other civil society entities. The Bank project took important initial steps to assess and close this gap, and naming the LCN as a PR for the Round 8 Global Fund grant is a landmark achievement. More effort is required, however, to strengthen logistics for communities to define and carry out their work effectively.

4.11 Monitoring and evaluation must be afforded appropriate attention both during project design and throughout implementation. Incentives for M&E must be structured into project activities. Care must be exercised during M&E planning exercises to take into consideration the capacity of the staff and institutions that will implement those plans.

Health Systems and Communicable Diseases

4.12 There is near-universal agreement that HIV has crowded out attention to other important health challenges in Lesotho. The HCTA's focus on Global Fund resources may have exacerbated this problem, with its exclusive focus not only on HIV, but on Global Fund-financed HIV interventions; Government attention, largely because of the significant dollars involved, remains with the Global Fund grant, and opportunities to integrate both

Global Fund activities and HIV-related activities with the health sector in general have been missed. Bank projects could have encouraged integration of HIV with other health services, including those for TB, reproductive health, and OVCs. Insufficient attention has been paid to the low capacity of social welfare agencies.

4.13 There have been important steps forward in this area, however. Current trends are encouraging, with more linkages between HIV and reproductive health services. For example, because of the resources devoted to PMTCT, antenatal clinics now offer HIV testing, linking HIV services to antenatal services. Very recently, MOHSW launched a new program intended to integrate child health services with HIV services, but it is premature to assess results in this area. And it is undeniable that HIV funding has had positive externalities for the rest of the health sector, most notably strengthened laboratory systems and drug supply chains.

Relationship between the Bank and the Global Fund

4.14 The Bank's entrance was prescient, strategic, even pioneering, coming in at the right time and with the right forms of assistance. In other words, the Bank – in an environment where there were very few donors active on HIV/AIDS in Lesotho – was the first institution to act on the increasingly urgent need to assist countries in developing capacity to spend all the new funds coming from the donor community. Informants recommend the Lesotho model as strongly relevant for other countries, with a relatively small Bank investment facilitating the absorption of much larger sums from other donors.

4.15 The form of the Bank's intervention on HIV/AIDS was not without controversy, however. Bank management was initially planning a more traditional MAP project for Lesotho, but some Bank staff argued that the country would be hard-pressed to spend all the money it was about to receive from the Global Fund, let alone additional funding from the Bank. Significant non-governmental participation and implementation was envisioned for any HIV/AIDS interventions funded by the Bank from the very beginning, for example, in part because of a judgment that the government would not have the capacity to absorb the new funds. It was these arguments that led to the capacity-building project rather than the MAP approach.

4.16 Global Fund staff (the Fund Portfolio Managers), though based in Geneva, have been active partners with the government during grant implementation. In particular, Global Fund staff have intervened at critical points to discourage key personnel from leaving the Global Fund Coordinating Unit (GFCU) for other positions inside or outside Lesotho, primarily by persuading the Ministry of Finance (the Principal Recipient) to provide incentives to stay (the Global Fund grant pays GFCU staff salaries). The GFCU and the Ministry of Finance (where it is institutionally located) enjoy a productive working relationship, with MOFDP routinely placing GFCU matters at the top of its agenda. The Bank does not sit on the CCM, and although its impact has been crucial and the HCTA's results demonstrable, the relationship between the Bank and the GFCU has not always been smooth. Staff on the ground in Lesotho observed that until recently, it was occasionally difficult to obtain timely decisions on important matters from the Bank, and that the Bank was not as flexible as it could have been in adapting to changing implementation circumstances. It does not appear that Bank

interventions have been deliberately coordinated with Global Fund staff in Geneva, although there is strong appreciation from Global Fund management for the Bank's contributions to capacity-building, particularly in the areas of procurement and institutional development at MOHSW. The Bank and Global Fund missed opportunities to work together to overcome the political tensions between the MOHSW, MOFDP, and the NAC, and therefore fully to develop the NAC into a highly-regarded agency that can effectively take the lead in the country's response to HIV/AIDS.

Value Added of the Bank

4.17 The Bank is clearly regarded by both the Government and most development partners as a critical player in the health and HIV areas, mainly due to its effective catalytic and complementary role. The Bank was an essential player in fostering a sector-wide perspective, building the ownership necessary to sustain progress, and creating a demand for the information required to plan, monitor, and react effectively to sectoral needs. The Bank was also key in moving the health sector to a higher position on the MOFDP's priority list. The Bank's approach has encouraged other partners to consider how each can best coordinate support that will tap into its specific comparative advantage.

4.18 As more resources are becoming available to finance HIV programs, it is the Bank's comparative advantage to focus on system strengthening. The Bank's hands-on implementation support is still needed, given the Global Fund's status as a grant-providing agency that offers limited implementation support. Continued Bank support for strengthening of implementation systems can help remove capacity bottlenecks and speed up the pace of implementation of other partners' HIV programs. This approach is also an effective way to invest limited Bank resources, as compared to a much costlier expenditure on mainstream HIV interventions. Building capacity and filling gaps uses the Bank's comparative advantage, particularly in system and fiduciary strengthening, in a way that complements, rather than competes with, other partners' financing. In short, the Bank's approach to health and HIV/AIDS in Lesotho has accomplished a lot with relatively little money. In the current environment, with a number of global initiatives providing substantial resources toward improving health, nutrition, and population outcomes, the Bank's approach in Lesotho should serve as a valuable lesson to be extended to other priority development areas.

5. Epilogue

5.1 There have been follow-ons to both of the projects assessed here. The US$33.5 million Health Sector Reform Project Phase 2, which was approved in October 2005 and closed in September 2009, was intended to achieve a sustainable increase in quality preventive, curative, and rehabilitative health services by increasing access to and quality of delivery of essential health services. A US$5 million HIV and AIDS Technical Assistance Project, approved in August 2009 and scheduled to close in January 2015, is intended to build capacity of government and civil society at both the national and local levels to address the identified key gaps in implementing the National HIV/AIDS Strategic Plan in an effort to contain and reverse the epidemic. In addition, a US$6.25 million New Hospital Private

Public Partnership (PPP) Project, approved in November 2007 and ongoing, is to increase the access, range, and quality of medical services in Lesotho through the replacement of the existing main public hospital (Queen Elizabeth II). This sequence of health operations, reflecting the consistency and continuity of the Bank's engagement in Lesotho's health sector, flow from long-term strategic thinking dating back to the first Health Sector Reform Project.

5.2 The Global Fund has approved additional grants to Lesotho in Rounds 5 and 6 (2007), 7 (2008), and 8 (2010) (Annex E), with a Round 9 grant covering mainly HIV/AIDS and orphans and vulnerable children also signed in 2010. The total approved grant amount as of June 2010 is US$143.4 million, with US$123.3 of that for HIV/AIDS and US$20.1 million for tuberculosis. A total of US$77.9 million has been disbursed.

5.3 The Bank is currently preparing a results-based financing project, coinciding with the preparation of a new National Development Plan that will introduce the concept to the health sector and generate evidence and experience. This project is intended to introduce a new way of thinking about health care financing and service delivery. It is small in monetary terms (US$5 million), but it is to serve as a catalyst to support not only results-based financing programs and systems but also leverage large investments from other health sector partners (such as MCC) towards a results focus.

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Annex A. List of People Consulted

World Bank, Washington, DC

- Lilia Burunciuc, Country Program Coordinator, Lesotho (AFCZA)
- Pamela Cox, Vice President, Latin America and Caribbean Region (Country Director, Lesotho, 1995-2000) (LCRVP)
- Marelize Gorgens-Albino, Global AIDS Monitoring and Evaluation Team (GAMET) (HDNGA)
- Larisa Leshchenko, Senior Country Officer, Lesotho (AFCZA)
- Gayle Martin, Senior Economist (AFTHE)
- Julie McLaughlin, Sector Manager, Health, Nutrition, and Population, South Asia Region (Task Team Leader at appraisal, Health Sector Reform Project and HIV/AIDS Capacity Building and Technical Assistance Project) (SASHN)
- Peter Okwero, Senior Health Specialist (AFTHE)
- Rosemary Sunkutu, Senior Population, Health, and Nutrition Specialist, Zambia Country Office (author of the ICR for HCTA) (AFTHE)
- Kanako Yamashita-Allen, Senior Health Specialist (AFTHE)
- Feng Zhao, eHealth Coordinator, Africa Region (formerly Senior Health Specialist and Task Team Leader, HCTA and Health Sector Reform Phase II Project) (AFTHE)

The Global Fund to Fight AIDS, Tuberculosis, and Malaria, Geneva

- Tatjana Peterson, Fund Portfolio Manager, Lesotho (by telephone)

Maseru, Lesotho

World Bank

- Husam Abudagga, Senior Country Officer

Government

- M. N. Khethisa, Principal Secretary, Ministry of Finance and Development Planning
- Motlalepula Shadrak Khobotlo, Director of Policy Strategy and Communication, National AIDS Commission
- Mrs. M. Makhakhe, Director, Department of Health Planning and Statistics, Ministry of Health and Social Welfare
- Mokhothu Makhalanyane, Deputy National Coordinator, Global Fund Coordinating Unit, Ministry of Finance & Development Planning
- Mrs. Karabo Mokobocho-Mohlakoana, Principal Secretary, Ministry of Health and Social Welfare
- Mr. J. T. Nteso, Director, Public Debt Division, Ministry of Finance and Development Planning
- Honorable Timothy Thahane, Minister of Finance & Development Planning

Donors

- Dr. Wisam Al-Timimi, Chief, Child Survival, Care, & Development, United Nations Children's Fund, Lesotho
- Dr. Esther Mary Aseng, Country HIV Officer, World Health Organization
- Dr. Givans Ateka, HIV/AIDS Advisor, Irish Aid, Lesotho
- Mpolai Cadribo, Assistant Representative, United Nations Population Fund, Lesotho
- Dr. Gael Claquin, Health System Strengthening Advisor, Millennium Challenge Corporation, Lesotho
- Katie Crowley, Coordinator, U.S. President's Emergency Plan for AIDS Relief (PEPFAR), Lesotho
- David Halejone, Infrastructure Specialist, Millennium Challenge Corporation, Lesotho
- Dr. Phiny Hanson, Country Director, South Africa Health Capacity Development (SAHCD), Lesotho
- Amaury Hoste, Attaché, European Union
- Dr. Semakaleng Phafoli, Health Advisor, Irish Aid, Lesotho
- Mapaseka Selikane, Economic Advisor, Irish Aid, Lesotho
- Dr. Henry N. Tabifor, Institutional Development and Partnership Advisor, UNAIDS

Civil Society

- Derick Akoku, Volunteer Assistant, Lesotho Network of AIDS Service Organizations
- 'Mapokane 'Mamokhele Kosene, National Coordinator, Lesotho Network of AIDS Service Organisations
- Agnes Lephoto, HIV/AIDS Coordinator, Christian Health Association of Lesotho
- M. Ntholi, Executive Secretary, Christian Health Association of Lesotho
- Boshepha Ranthithi, National Coordinator, Lesotho Network of People with AIDS
- Alphoncina Thakane Tsosane, Director, Tsosane HIV/AIDS Support Group
- 'Mabulara Tšuene, Programmes Director, Lesotho Council of Non-Governmental Organizations

Mamohau Hospital, Leribe, Lesotho

- Dr. Albert Kitwanda, Physician
- Mr. Paul Manka, Administrator
- Mr. Rafube, Head, Human Resources Department
- Mrs. Tlebere, Assistant Administrator

Paray Hospital, Thaba-Tseka, Lesotho

- Mrs. Aletta, Senior Nursing Officer
- Sister Annunciata, Principal Tutor, School of Nursing
- Sister Imelda, Assistant to the Administrator
- Mrs. Lepau-Ranthithi, Public Health Nurse
- Dr. Patrick, Physician

Annex B. Basic Data Sheet

HEALTH SECTOR REFORM PROJECT (CR. 3376)

Key Project Data (amounts in US$ million)

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project costs	20.40	19.09	93.6
Loan amount	6.5	6.16	94.8
Cofinancing*	11.90	12.11	101.8
Cancellation		0.76	

*Government contribution not included in the total

Cumulative Estimated and Actual Disbursements

	FY01	*FY02*	*FY03*	*FY04*	*FY05*	*FY06*	*F07*
Appraisal estimate (US$ M)	1.5	4.0	6.5	6.5	6.5	6.5	6.5
Actual (US$ M)	0.34	1.76	2.88	4.14	5.98	6.12	6.17
Actual as % of appraisal	23	44	44	64	92	94	95
Date of final disbursement: na							

Project Dates

	Original	*Actual*
Concept Note	04/19/1999	04/19/1999
Negotiations	04/18/2000	04/25/2000
Board approval	06/08/2000	06/13/2000
Signing	NA	07/21/2000
Effectiveness	01/31/2001	01/31/2001
Closing date	03/31/2004	06/30/2005

Staff Inputs (staff weeks)

	FY99	*FY00*	*FY01*	*FY02*	*FY03*	*FY04*	*FY05*
Preappraisal (April-Oct)	NA						
Appraisal-Negotiations							
Negotiations							
Supervision		47.32	20.61	20.04	16.83	16.99	23.31
Other							
Total	NA	47.32	20.61	20.04	16.83	16.99	23.31

Mission Data

	Date (month/year)	*No. of persons*	*Specializations represented*	*Implementation Progress*	*Development Objective*
Identification/ Preparation	03/12/1998		NA		
Appraisal/ Negotiation	11/29/1999	13	Team Leader (1): Health Planner AfDB (1); Health Service Ireland AID (1); Health Economist (1); Economist (1); Sr. Financial Mgmt Specialist (1); Operations Analyst (1); Internal Auditor Ireland AID (1); Rational Pharma Mgmt/USAID/WB (1); Physical Planner (1); Architect (1); Health Sector Specialist/WHO/AFRO (1); CDS &R, WHO (1)		
	04/23/2000	5	Team Leader (1); Health Economist (1); Sr. Counsel (1); Financial Officer (1); Procurement Specialist (1)		
Supervision	11/06/2000	3	Team Leader (1); Health Economist (1); Sr. Financial Mgmt Specialist (1)	S	S
	04/25/2001	2	Team Leader (1); Health Economist (1);	S	S
	10/30/2001		Team Leader (1); Health Specialist (1); Health Planner, AfDB (1); Health Adviser, EU (1); Health, Ireland AID (1)	S	S
	02/28/2002	3	Team Leader/Health (1); Architect (1); Consultant Nutritionist	S	S
	11/07/2002	3	Team Leader (1); Health Specialist (1); Financial Mgmt Specialist (1)	S	S
	06/02/2003	4	Team Leader (1); Health Specialist (1); Operations Officer (1); Procurement Specialist (1); Health Economist (1)	S	S
	09/07/2003	4	Team Leader (1); Health Specialist (1); Operations Officer (1); Health Financing (1)	S	S
	11/07/2003	6	Team Leader (1); Health Specialist (1); Operations Officer (1); Health Finance Specialist (1); Country Office Liaison (1); Civil Works (1)	U	S

	Date (month/year)	*No. of persons*	*Specializations represented*	*Implementation Progress*	*Development Objective*
	05/13/2004	3	Team Leader (1); Health Specialist (1); Operations Officer (1)	S	S
Completion	10/22/2004	6	Lead Health Specialist (1); Public Health Specialist – Team Leader (1); Sr. Health Specialist – Primary Author (1); Operations Officer (1); Task Team Assistants (2)	S	S

Other Project Data

Borrower/Executing Agency:			
Follow-on Operations			
Operation	***Credit no.***	***Amount (US$ million)***	***Board date***
Health Sector Reform Phase II Project	4118	6.5	10/13/2005

HIV AND AIDS CAPACITY BUILDING AND TECHNICAL ASSISTANCE PROJECT (H113)

Key Project Data (amounts in US$ million)

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Total project costs	5.05	NA	
Loan amount	5.00	4.88	97.6
Cofinancing			
Cancellation			

Note: There are no data on actual total project cost in the ICR.

Cumulative Estimated and Actual Disbursements

	FY05	*FY06*	*FY07*	*FY08*	*FY09*
Appraisal estimate (US$M)	0.5	1.25	2.25	3.75	5.00
Actual (US$M)	0.25	0.62	1.99	3.58	4.62
Actual as % of appraisal	50	50	88	95	92
Date of final disbursement:		05/28/2009			

Project Dates

	Original	*Actual*
Concept Note	NA	05/14/2004
Negotiations	05/10/2004	05/11/2004
Board approval	07/06/2004	07/06/2004
Signing	NA	08/05/2004
Effectiveness	01/31/2005	01/31/2005
Closing date	12/31/2008	12/31/2008

Staff Inputs (staff weeks)

	FY04	*FY05*	*FY06*	*FY07*	*FY08*	*FY09*	*Total*
Preappraisal (Jan-March)	6.42						6.42
Appraisal-Negotiations	12.30	4.59					16.89
Supervision		4.54	17.85	23.90	24.68	23.74	94.71
Other							
Total	18.72	9.13	17.85	23.90	24.68	23.74	118.02*

*There is a discrepancy between these figures and those in the ICR.

Mission Data

Names	*Title*	*Unit*
Julie McLaughlin	Senior Health Specialist – TTL	AFTH1
Sheila Dutta	Senior Health Specialist	AFTH1
Andrew C. Follmer	Senior Country Officer	LCC7A
Edmund Motseki	Operations Officer	AFCO1
Jonathan Nyamukapa	Financial Management Specialist	AFTH1
Helen Tadesse	Team Assistant	AFTH1
Pascal Tengwa	Senior Procurement Specialist	LEGAF
Muhammad Ali Pate	Country Sector Coordinator	EASHD
T. Mpoy Kamulayi	Lead Counsel	LEGAF
Feng Zhao	Senior Health Specialist – TTL	AFTH1
Julie McLaughlin	Sector Manager	SASHD
Henri A. Aka	Procurement Specialist	AFTPC
Andrew Osei Asibey	Senior M&E Specialist	AFTRL
Lori A. Geurts	Senior Program Assistant	AFTH1
Wedex Ilunga	Procurement Specialist	AFTPC
Jonathan Nyamukapa	Senior Financial Mgmnt Specialist	AFTFM
Peter Okwero	Senior Health Specialist	AFTH1
Muhammad Ali Pate	Country Sector Coordinator	EASHD
Helen Tadesse	Team Assistant	AFTH1
Oscar Picazo	Senior Economist (Health)	AFTH1
Joel C. Spicer	Senior Health Specialist	AFTH1
Musonda Rosemary Sunkutu	Senior PHN Specialist	AFTH1
Joao Tinga	Financial Management Analyst	AFTFM
Christopher D. Walker	Lead Specialist	AFTH1
Kanako Yamashita-Allen	E T Consultant	AFTH1

Other Project Data

Borrower/Executing Agency:			
Follow-on Operations			
Operation	***Credit no.***	***Amount (US$ million)***	***Board date***
HIV and AIDS Technical Assistance Project	H502-LS	5.0	08/27/2009

Annex C. Outputs and Outcomes

Health Sector Reform Project

Table C.1. Planned versus Actual Bank Financing by Component

Component	Appraisal Estimate (US$ million)	Actual (US$ million)	Percent of appraisal
Financial Planning and Management	0.73	1.51	207
Planning and Monitoring	2.59	1.30	50
Human Resources Development	0.94	0.76	81
Partnerships	0.05	0.01	20
Planning for Phase II Activities	0.19	0.70	368
HIV/AIDS	2.00	1.88	94
Total Project Costs	6.50	6.16	95

Table C.2. Outputs (Phase I project indicators, which were output-based)

	Baseline	Target	End of project (June 30, 2005)
Project (Phase I of Program)			
Allocation of MOHSW budget for three-year period defined based on stated priorities (MTEF)	N/A		Achieved: Planning cycle redefined to facilitate integration of planning and budgeting processes. MTEF-based, three-year integrated rolling expenditure plan in place, implementation began in 2005/2006.
Financial Management and Information System (FMIS) in place	N/A		Achieved: FMIS developed and installed, including establishment of a Financial Management Committee (FMC) to guide and oversee overall budget execution in MOHSW, and all components of MTEF system installed on Financial Management Unit (FMU) computer systems.
Revised interim and final financial statements produced monthly for six months	N/A		Unknown achievement: Monthly status expenditure report for both recurrent and capital funds produced. Audit report for period ending 3/31/04 was submitted on 10/1/04.
Defined and functional procedures/systems for disbursement, procurement, accounting, and reporting	N/A		Achieved: Project Accounting Unit (PAU) and procurement unit functional, handling disbursements and procurement for Bank and other donors (Ireland, AfDB).
Quarterly M&E reports produced for the past six months			Achieved: M&E Unit established, and M&E guidelines and strategic plan developed. Quarterly M&E reports produced since 2003. DHS conducted in 2004. Quarterly and Annual Joint Review meetings held since 2000.
Documented partnership agreement between all CHAL partners and Government			Achieved during second, not first, phase of APL: Draft MOU in place. Supplementary Emergency Financing Facility providing CHAL with funds equivalent to 20% of operating costs was signed in 12/02, extended to 03/06. Final agreement reached in 2/07.

	Baseline	Target	End of project (June 30, 2005)
Vacancies of six weeks duration or longer filled within three months	60% filled, 40% vacancies (2000/2001); 85% filled, 15% vacancies (2001/2002)	80% filled (20% vacancies)	Not achieved: 44% filled (56% vacancies), 2004/2005
Budget committed		70%	Not achieved: Average MOHSW spending rate for recurrent budget was 53%, and for capital budget 69%. Recurrent budget spending rates for key programs in 2006: family health, 26%; disease control, 20%; HIV/AIDS, 20%.
Long-term plan for health infrastructure development produced			Achieved: Plan developed and disseminated.
Estates Management Unit (EMU) established			Partially achieved: EMU was established, but lacks operational tools and managerial capacity. Unit was strengthened in 2003 by merger with Rural Health Service Project and support from AfDB's Health Six project.
Documented guidelines, policies, protocols, and procedures for TB, Integrated Management of Childhood Illness (IMCI), and HIV/AIDS created			Achieved: Policy guidelines developed and in use for TB, IMCI, PMTCT, ARV, and HIV post-exposure treatment. Five-year strategic plan for TB (DOTS) expansion developed.
Completed impact evaluation of Phase I			Not achieved: Annual Joint Review held every year since 2000, and most Phase II triggers met, but there was no specific impact evaluation of Phase I.
Completed evaluation of AIDS prevention interventions			Not achieved: DHS conducted in 2004. Sentinel surveillance among women attending antenatal clinics conducted in 2003. Behavioral Surveillance Survey conducted in 2002. However, there was no completed evaluation of AIDS prevention interventions.
Increased participation of private sector and NGOs in HIV/AIDS prevention and control			Achieved: After delays, a firm (Crown Agents) was hired to engage civil society. Planned $2 million was disbursed to CSOs in last two years of project.

Source: World Bank 2000c (for the indicators and baseline); World Bank 2005a (for end-of-project data, except where otherwise specified).

Table C.3. Outcomes (Program Targets)

Program (original indicators from PAD)	Baseline (2000; no baselines given in PAD)	Targets given for 2008	End of project (2005)
Children under 5 fully immunized	N/A	80%	68% under one year of age fully immunized: 68% (2004 DHS)
TB treatment success rate	N/A	N/A	N/A
Ante-natal clinic attendance	N/A	95%	91% (2004 DHS)
Percent of deliveries assisted by trained provider	N/A	80%	69% (2004 DHS)
Contraception prevalence rate (CPR)	N/A	N/A	35.2% (modern methods; 2004 DHS)
Prevalence of STIs	2.9% (syphilis; 2003 ANC sentinel survey)	N/A	2.2% (syphilis; 2005 ANC sentinel survey)
Percent of population within 2 hours walking distance of a health facility meeting national standards for service delivery	79.5% for any type of facility (2000 Baseline Survey) 34% within one hour walk to any kind of facility (2002 HHBS)	80%	N/A
Percent of recurrent costs recovered through fees and risk pooling schemes	N/A	N/A	N/A
Percent of Government and CHAL facilities staffed with standard number and type of qualified staff for level of facility	Government hospitals: 0% CHAL hospitals: 0%	Minimum staff complement as specified in HR strategic plan	N/A
	Government health centers: 34% CHAL health centers: 2%	Nursing clinican + registered nurse + nurse assistant	
Variance in per capita weighted allocations to districts	N/A	N/A	Ratio of highest district per capital allocation (Maseru, including QEII) to lowest (Thaba-Tseka): 4.78 (Lievens and Manu 2008b)
Demonstrated ability of private sector or NGO partnerships to prevent HIV transmission and mitigate AIDS	N/A	N/A	N/A
Proportion of patients attending QEII that are referred by health service provider from other facilities	N/A	50%	N/A

Program (original indicators from PAD)	Baseline (2000; no baselines given in PAD)	Targets given for 2008	End of project (2005)
Percentage of budget allocated for hospital equipment and maintenance	N/A	15% of budget for physical assets maintenance and 10% for equipment replacement	N/A
Percentage of budget allocated to district health and social welfare management teams	16%	50% increase	N/A
Percentage of health budget that is expended by programs	Recurrent: 103% Capital: N/A	Recurrent: 100% for all programs Capital: > 70%	Recurrent: 104.2% (Lievens and Manu 2008b)
Percentage of district/health service areas where quarterly M&E reports are received by the due date	10%	100%	N/A
HIV prevalence among men and women ages 15-24	F 15-19: 7.8% F 20-24: 24.5% M 15-19: 2.3% M 20-24: 12.3%	25% reduction	(2007) F 15-24: 14.9% M 15-24: 6% (World Development Indicators)
HIV prevalence among women ages 15-49	Pregnant: 23.9% (2003 sentinel survey) Pregnant + non-pregnant: 26.5% (2004 DHS)	25% reduction	23%, total population ages 15-49 (World Development Indicators)
Percent of eligible men, women, and children receiving ART	18% (HIV/AIDS Directorate reports)	80%	40% (2007, Government data)
Percentage of facilities reporting one-month "stock-out" for any of the drugs on the Essential Drugs List	N/A	Less than 20%	N/A
Ratio of orphans to non-orphans who are attending school	F: 1.0 M: 0.9 All: 1.0	F: 1.0 M: 1.0 All: 1.0	N/A
Percentage of health facilities with functioning incinerators	8% (National Health Care Waste Management Plan, 2004)	80%	N/A

Source: World Bank 2000c, 2005a, unless otherwise specified.

HIV and AIDS Capacity Building and Technical Assistance Project

C.4. Planned versus Actual Bank Financing by Component

Component	Appraisal Estimate (US$ million)	Actual (US$ million)	Percent of appraisal
Support to Ministry of Finance and Development Planning	0.37	0.24	65
Support to Ministry of Health and Social Welfare	2.14	2.84	133
Support to Secretariat of the National AIDS Program	1.38	1.65	120
Support to Civil Society and Private Sector Capacity Development	1.11	0.15	14
Total Project Costs	5.00	4.88	98

Table C.5. Outputs (key project indicators, which were output-based)

	Baseline (2004)	Target (2008)	End of project (December 31, 2008)
Project			
Percentage of GFATM resources disbursed	15	80	99% of Round 2 grant disbursed
Percentage and amount of financing disbursed through civil society (CBOs, NGOs, FBOs, and private sector)	N/A	30	47%
Percentage of subprojects financed under the GFATM grant that are judged to be implemented satisfactorily	N/A	50	93% (14 of 15 subprojects)
Annual reports on all key HIV/AIDS programs produced and disseminated		none	5 (completed annually by NAC together with MOHSW)
Components			
Timely submission of quarterly reports to the CCM and GFATM	N/A		Joint Annual Review reports and M&E quarterly reports for year 2008-2009, on key HIV/AIDS indicators, produced and posted on GFATM website.
Percentage of established posts filled in the MOHSW HIV/AIDS Directorate	0	100	56%
Percentage of facilities that are familiar with national guidelines on VCT, ARVs, care & treatment, and orphans	0	100	N/A
Number of VCT sites with required test kits and counselors, and that are following national protocols	0	26	N/A
Institutionalization of International Competitive Bidding (ICB) for large procurement of medical goods by the public health sector	0	50	N/A
Percentage of established posts filled in LAPCA/NAC	0	75	92%
Quality of BCC strategies within the MOHSW, LAPCA/NAC, and NGOs, as assessed.	N/A	N/A	N/A

Source: World Bank 2004 for the indicators and component targets; the Development Grant Agreement for the targets on the four project indicators at the end of the project; Global Fund 2010 for baseline and actual disbursements; World Bank 2009 for the share of spending on CSOs and the Global Fund performance ratings. The PAD identified similar targets, but for the fourth year of the five-year project.

Annex D. Triggers for Health Sector Reform Program, movement from Phase I to Phase II

Trigger	Baseline (2000/01)	Achievement
Allocation of MOHSW budget for three-year period based on stated priorities (sectoral MTEF)	Non-existent	Achieved: First three-year comprehensive expenditure program based on sectoral priorities (MTEF for MOHSW) was produced in January 2005.
FMIS in place	Non-existent	Achieved: An FMIS was produced. Decentralized cost centers were established and produced monthly expenditure reports; budgeting procedures were standardized; a user manual was developed.
Timely production of revised interim and final financial statement produced monthly for six months	Available only for capital budget	Unknown achievement: Monthly Status of Funds Report (expenditure) produced for both recurrent and capital funds.
Defined procedures/systems for disbursement, procurement, accounting, and reporting.	Development ongoing	Achieved: PU and PAU were established, and both developed and implemented procedures manuals. Guidelines for accounting and disbursement of funds used by districts.
Quarterly M&E Report produced for the past six months	Produced only for donor funds	Achieved: M&E Unit established and M&E policy guidelines and strategic plan developed; quarterly activity monitoring report and annual program review conducted regularly; Quarterly and Annual Joint Review meetings institutionalized.
Documented partnership agreement between all CHAL partners and the Government of Lesotho	Non-existent	Achieved during second, not first, phase of APL: A Supplementary Emergency Financing Facility that provides CHAL with funds equivalent to 20% of operating costs for two years was signed in December 2002. An MOU was drafted and was to be submitted to the Cabinet. A coordinator was recruited in MOHSW to oversee implementation of the MOU. The final agreement with CHAL was signed after the project closed, in February 2007.
80% of vacancies of six weeks duration or longer filled within three months	40%	Not achieved: 15% vacancies (85% filled) in 2001/02, but 56% vacancies (44% filled) in 2004/05. New structure for the HR department approved by the Ministry of Public Service, and the director for HR was in place.
70% of IDA financing disbursed or committed	N/A	Achieved: 96% disbursed or committed as of July 18, 2005.
A long-term plan for health infrastructure development produced	Non-existent	Partially achieved: Estate Management Unit was established in 2001, but lacks operational tools and managerial capacity.
Completed impact evaluation of Phase I	N/A	Not achieved: Annual Joint Review held every year since 2000, and most Phase II triggers met, but there was no specific impact evaluation of Phase I.
Documented guidelines, policies, procotols, and procedures for TB, IMCI, and HIV/AIDS	TB: outdated policy; IMCI and HIV/AIDS: non-existent	Achieved: Policy and guidelines developed and in use for IMCI and PMTCT. ARV and HIV post-exposure treatment guidelines developed and disseminated. Five-year strategic plan for TB (DOTS) expansion developed and TB treatment policy reviewed and updated.
Evaluation of AIDS prevention interventions	N/A	Not achieved: A second anonymous, unlinked sentinel surveillance among women attending antenatal clinics was conducted in 2003. An HIV/AIDS impact assessment at household levels was completed by WHO in 2004. A DHS was completed, including a population-based HIV prevalence survey, in 2004. An NGO component evaluation was completed in April of 2005. There was no completed evaluation of AIDS prevention interventions.
Increased participation of the private sector and NGOs in HIV/AIDS prevention and control	N/A	Achieved: Eight NGOs and private sector entities awarded grants for HIV/AIDS prevention, care, and impact mitigation interventions.
Source: World Bank 2005b		

The PAD also specified the set of indicators to be employed to assess achievement of the objectives of the overall ten-year Sector Reform Program:[14]

- Increase percentage of children under 5 fully immunized (later changed to fully immunized by 12 months of age, under Phase II of the Program)
- Increased TB treatment success rate (eliminated under Phase II of the Program)
- Increase in ante-natal clinic attendance
- Increase in percent of deliveries assisted by trained provider
- Increase in contraception prevalence rate (eliminated under Phase II of the Program)
- Reduced prevalence of STIs (eliminated under Phase II of the Program)
- Increased percent of the population within two hours walking distance of a health facility meeting national standards for service delivery
- Increased percent of recurrent costs recovered through fees and risk pooling schemes (eliminated under Phase II of the Program)
- Increased percent of Government and CHAL health facilities staffed with standard number and types of qualified staff for level of facility
- Reduced variance in per capita weighted allocations to districts (eliminated under Phase II of the Program).

14. The following indicators were also added to Phase II: increased proportion of patients attending QEII Hospital that have been referred by health service provider from other health facilities; increased percentage of budget allocation for hospital equipment and maintenance; increased percentage of budget allocated to district health management teams; increased percentage of health sector budget that is expended by programs; increased percentage of district/health service Health Information Management System (HIMS) reports received by due date; reduced prevalence of HIV among women 15-24 years of age; reduced percentage of health facilities reporting "one month stock-out" in any of the drugs on the essential drug list for the facility in the last 12 months; and increase percentage of facilities with functional incinerators.

Annex E. Global Fund Commitments and Disbursements to Lesotho

Table E.1. Global Fund Grant Commitments: Lesotho

Comp ID	Round	GA Sig Date	WB FY	Compo-nent	Source	Principal Recipient	Approved Grant Amount (US$)	Disbursements to March 2010 (US$)	Grant End Date
246	2	10/10/2003	2004	HIV/AIDS	CCM	The Ministry of Finance and Development Planning of the Government of the Kingdom of Lesotho	29,312,000	28,884,104	6/30/2009
248	2	10/10/2003	2004	TB	CCM	The Ministry of Finance and Development Planning of the Government of the Kingdom of Lesotho	5,000,000	4,947,928	6/30/2009
1131	5	9/16/2006	2007	HIV/AIDS	CCM	The Ministry of Finance and Development Planning of the Government of the Kingdom of Lesotho	15,781,572	15,781,572	10/31/2011
1359	6	6/4/2007	2007	TB	CCM	The Ministry of Finance and Development Planning of the Government of the Kingdom of Lesotho	5,543,805	3,071,843	6/30/2012
1532	7	6/16/2008	2008	HIV/AIDS	CCM	The Ministry of Finance and Development Planning of the Government of the Kingdom of Lesotho	10,626,665	5,155,757	6/30/2010
1709	8	11/4/2009	2010	HIV/AIDS	CCM	Lesotho Council of Non-Governmental Organizations	6,821,386	386,271	
1709	8	11/5/2009	2010	HIV/AIDS	CCM	The Ministry of Finance and Development Planning of the Government of the Kingdom of Lesotho	50,393,403	0	10/31/2011
Total							123,478,831	58,227,475	

Table E.2. Global Fund Grant Disbursements: Lesotho

Comp ID	2004	2005	2006	2007	2008	2009	2010	Total
246	1,271,000	4,918,325	4,057,050	3,255,260	9,504,738	5,877,730		28,884,104
248	179,300	767,029	707,681	370,080	705,395	643,438	1,575,005	4,947,928
1131				2,295,859	3,363,211	3,207,245	6,915,256	15,781,572
1359					1,573,586	1,400,000	98,257	3,071,843
1532						2,841,914	2,313,843	5,155,757
1709							386,271	386,271
Total	1,450,300	5,685,354	4,764,731	5,921,199	15,146,931	13,970,328	11,288,633	58,227,475

Annex F. Timeline

Year	Lesotho political and economic developments	Lesotho health sector	World Bank and other donors	Exogenous relevant international events
1985			April: Bank approves first Health and Population Project (1985-1992).	
1986	January: Prime Minister Leabua Jonathan, of the Basotho National Party (BNP) that had ruled the country since independence in 1966, overthrown by a military coup. Military rule continues through 1992.	Lesotho's first AIDS case reported.		
1987		July: National AIDS Prevention and Control Program initiated.		
1989			July: Bank approves Second Population, Health, and Nutrition Project (1989-1998).	
1990	May: Lesotho Council of NGOs (LCN) established.			
1992		Sentinel surveys to monitor the spread of HIV/AIDS initiated. Intended to be conducted every two years, the surveys were inconsistently implemented due to lack of funding and technical problems.	December: Bank's first Health and Population Project closes.	
1993	Country's first democratic elections are held. Basotho Congress Party (BCP) takes majority.	National health policy defined, committing the government to progressive attainment of universal access to essential health care, social justice, and equity.		
1995		Government adopts National Health Sector Plan 1995-2000, a systematic attempt to identify priorities and improve planning of health care delivery.		

Year	Lesotho political and economic developments	Lesotho health sector	World Bank and other donors	Exogenous relevant international events
1996		February: Major stakeholders participate in conference focusing on Lesotho's health sector, resulting in a proposal to develop a comprehensive implementation strategy for the national sector plan.	Lesotho first requests World Bank assistance to develop a long-term health sector reform program. The government was committed to a sector-wide approach.	UNAIDS launched.
1997	The ruling Basotho Congress Party (BCP) splits into two parties. The Lesotho Congress of Democrats (LCD) is formed by Mokhehle, former leader of the BCP.			
	Local Government Act confers on local communities responsibility for their own affairs and development.			
1998	Lesotho Highland Water Project's Katze Dam completed, with World Bank support.		March: Bank participates in a Health Reforms Update Workshop in Lesotho, intended to help prepare new health credit to provide sectoral support to reforming the health system.	
	May: Parliamentary elections are held, with Pakalitha Mosiili of the Lesotho Congress for Democracy (LCD) elected Prime Minister, and the LCD winning all but one contested seat. Widespread civil unrest ensues, as opposition raise doubts about the legitimacy of the elections.		March: Bank's second Population, Health, and Nutrition Project closes.	
	August/September: Violent riots take place outside royal palace in Maseru. South African Development Community (SADC) intervenes with military force, provoking further unrest.			
	December: Multiparty Interim Political Authority (IPA) established to investigate the elections, and to organize next round of elections (which do not take place until 2002).			

Year	Lesotho political and economic developments	Lesotho health sector	World Bank and other donors	Exogenous relevant international events
1999	May: SADC defense forces withdraw from Lesotho after almost 10 months.	Health Sector Reform Strategy document developed, with realization that previous gains in the sector were eroding.	World Bank and MOHSW publish *Strengthening Lesotho's Health Care System*, a document designed to educate public and other constituencies about the need for reform.	
		National AIDS and Prevention Control Program (NAPCP) established under MOHSW.		
2000	January: Plan for Free Primary Education (FPE) takes effect, proposing a gradual increase in access to primary education, to be fully implemented by 2006.	Government declares HIV a national emergency and adopts National HIV/AIDS Strategic Plan (2000-2004) and National AIDS Policy Framework.	June: Bank approves Health Sector Reform Project (2000-2005, US$ 20.4 million).	Millennium Development Goals established, including goal to halt and reverse the spread of HIV/AIDS by 2015.
		November: MOHSW conducts first Joint Health Sector Review, held annually ever since.	October: Bank publishes "Lesotho: The Development Impact of HIV/AIDS: Selected Issues and Options."	
2001		March: Lesotho AIDS Program Coordinating Authority (LAPCA) established, with mandate to coordinate, monitor, and evaluate implementation of the national response.	January: Health Sector Reform Project becomes effective.	June: Lesotho is party to United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV and AIDS, which set a consolidated framework of global response.
				Lesotho accedes to Abuja Declaration and Framework for Action in the Fight Against HIV and AIDS, Tuberculosis, and other Infectious Diseases.

Year	Lesotho political and economic developments	Lesotho health sector	World Bank and other donors	Exogenous relevant international events
2002	May: Masupha Sole, the Chief Executive of the Highlands Development Authority, found guilty of accepting bribes in exchange for contracts with the Highland Water Project.	August: Crown Agents South Africa contracted to provide support to LAPCA.	April: Country Coordinating Mechanism (CCM) formed for application to Global Fund to Fight AIDS, Tuberculosis, and Malaria. Lesotho later submits first proposal, for US$34 million.	
	May: Parliamentary elections are held. The LCD wins 77 of the 130 seats, and the Basotho National Party (BNP) wins 21. Elections are peaceful and widely perceived to be fair.	December: Government and CHAL agree on Supplementary Emergency Financing Facility, providing salary subsidies and other financing to CHAL institutions for a two-year period.		
		First antiretroviral therapy (ART) site in Lesotho established in Maseru.		
2003	Lesotho Revenue Authority (LRA) established. Value added tax introduced, increasing revenues and improving the country's fiscal balance.	Decision is made to replace LAPCA (widely perceived as ineffective) with a new National AIDS Commission (NAC).	October: First Global Fund grant to Lesotho signed (Round 2), to strengthen prevention and control of HIV/AIDS. Start date was January 1, 2004.	July: Lesotho hosts extraordinary meeting of SADC on HIV/AIDS, resulting in Maseru Declaration and Commitment to HIV and AIDS in the SADC Region.
	Labour Code (Codes of Good Practice) Notice states that no one should be dismissed from employment on the basis of HIV status.	July: Government approves strategy for "Scaling Up the Fight Against the HIV/AIDS Epidemic in Lesotho."		United States launches President's Emergency Plan for AIDS Relief (PEPFAR).
	Sexual Offences Act passed, with provisions making it mandatory for an accused person to undergo an HIV test within one week of being charged, and inflicting the death penalty for persons having "knowledge or reasonable suspicion" that they were infected with HIV at the time of commission of a sexual offense.	Family Health Division of MOHSW initiates Prevention of Mother-to-Child Transmission of HIV/AIDS (PMTCT) services.		

Year	Lesotho political and economic developments	Lesotho health sector	World Bank and other donors	Exogenous relevant international events
2003		NAPCP elevated to the level of a directorate under the MOHSW, becoming the STI, HIV, and AIDS Directorate.		
		King Letsie III declares HIV/AIDS a "national disaster."		
2004	February: Prime Minister Mosisili declares a state of emergency in response to severe drought, asking for food aid. The drought persists for several years.	March: "Know Your Status" (KYS) campaign formally launched, with goal of HIV testing of every Basotho over age 12. Prime Minister Mosisili tested in public.	July: Bank approves US$5 million HIV and AIDS Capacity Building and Technical Assistance Project (HCTA), a unique project designed to build capacity to absorb Global Fund grant funds (2004-2008).	
	March: Lesotho Highland Water Project's Mohale Dam completed, marking the overall completion of Phase I.	September: National Medicines Policy approved by the Cabinet, supporting monitoring of drug quality and selection based on an Essential Drugs List.		
	Draft Children's Protection and Welfare Bill introduced, for the first time promising comprehensive protection to the rights of children in Lesotho, including OVC; bill not passed as of mid-2009.	October: A costed National HIV/AIDS Monitoring and Evaluation Plan is approved.		
		Global Fund Coordination Unit (GFCU) established under the Ministry of Finance and Development Planning (MOFDP).		
		Government, together with WHO, adopts a scale-up plan to decentralize ART service delivery.		
		First Demographic and Health Survey (DHS) conducted.		
		MOHSW develops Human Resources Development & Strategic Plan, 2005-2025.		

Year	Lesotho political and economic developments	Lesotho health sector	World Bank and other donors	Exogenous relevant international events
2005	April: The first local elections are held since the country gained independence in 1966. The LCD takes the majority of seats. These elections form the basis of 10 district councils incorporating traditional authorities (Chiefs), alongside the previous district administration (representing the central Government). 58% of elected local councilors are women.	May: Lesotho Network of People Living with HIV and AIDS (LENEPWHA) formed.	June: Bank's Health Sector Reform Project closes. In October, Health Sector Reform Project, Phase II, is approved.	
	Lesotho reaches status of lower-middle income country (LMIC) (LMIC GDP cut-off is US$825 per capita).	September: After delays, National AIDS Commission (NAC) formally launched. A National AIDS Secretariat (NAS) is part of the NAC.	December: Global Fund Secretariat sends letter to Government of Lesotho threatening cancellation of Round 2 grant unless several issues, including management capacity, monitoring and evaluation capacity, delayed implementation, and low disbursements, are resolved.	
		November: MOHSW recruits a long-term advisor to support newly-formed HIV/AIDS Directorate.	Baylor School of Medicine/Bristol-Myers Squibb Children's Clinical Center of Excellence (CCCOE) opens in Maseru, treating HIV-positive children in coordination with MOHSW.	
		First Medium-Term Expenditure Framework (MTEF) (2005/06 – 2007/08) initiated within MOHSW, and subsequently applied Government wide.		
2006	October: The All Basotho Convention (ABC) is formed and headed by Tom Thabane, previously of the LCD party.	February: Ministry of Finance and Development Planning recruits a long-term advisor, enabling Ministry effectively to take charge of Global Fund Coordinating Unit (GFCU).	Spring: New Bank Task Team Leader introduced for HCTA and HSRP Phase II.	Lesotho commits to accelerated program to achieve universal access to HIV prevention, treatment, care, and support in Africa by 2010 (Brazzaville Declaration).
	Legal Capacity of Married Persons Act passed, providing equal legal status to married women.	August: Grants Management firm engaged by the NAC.	March: Bank publishes Country Assistance Strategy for Lesotho.	

Year	Lesotho political and economic developments	Lesotho health sector	World Bank and other donors	Exogenous relevant international events
2006	Labour Code (Amendment) Act, No. 5, prohibits discrimination at the workplace based on HIV status, prohibiting pre-employment HIV testing and HIV testing during employment.	September: Government approves a private-public partnership (PPP)-based plan to build a new national referral hospital, intended to replace the aging QE-II hospital in Maseru.	September: Round 5 Global Fund grant to Lesotho approved (US$15.8 million), for scale-up of prevention, care, and treatment.	
		December: New National HIV and AIDS Policy, National HIV and AIDS Strategic Plan (2006-2011) (NSP), and corresponding HIV and AIDS Monitoring and Evaluation Framework (2006-2011) approved.		
		District AIDS Task Forces (DATF), perceived as ineffective, formally replaced by District AIDS Committees (DAC), with plans for similar community-level committees (Community AIDS Committees – CACs).		
		National Blood Transfusion Policy approved, and Lesotho Blood Transfusion Services allocated its own budget.		
		National HIV Testing and Counseling Policy approved.		
		National Adolescent Health Policy approved.		
		Package of Accreditation Standards (2006-2007) approved by MOHSW.		
2007	February: Parliamentary elections are held, with the LCD winning the majority of seats. The ABC, winning only 17 seats, immediately contests the results. Soon afterward, HIV/AIDS select committees were established in both houses of Parliament.	February: Memorandum of Understanding between Government and CHAL signed.	June: Round 6 Global Fund grant approved (US$5.5 million), for scaling up interventions on TB and TB/HIV in communities.	

Year	Lesotho political and economic developments	Lesotho health sector	World Bank and other donors	Exogenous relevant international events
2007	March: Strikes occur over the allocation of seats in the February election.	November: All 128 Community Councils prepare HIV/AIDS action plans to implement essential package of services on HIV/AIDS at the community level.	August: European Union grant approved, focusing on orphans and vulnerable children (OVCs) (US$15.9 million, 2007-2011).	
	July: Lesotho declares a state of emergency, requesting food aid from several international organizations. The drought is called the worst in thirty years.	Fifteen senior Christian church leaders of various denominations sign statement of commitment on HIV/AIDS, in the presence of the King and the Prime Minister.	November: Bank approves US$6.25 million New Hospital Public Private Partnership (PPP) Project.	
	Lesotho's per capita income reaches US$1,030, just short of the US$1,095 cut-off for IBRD eligibility.	Government abolishes user fees at the primary care level for both government and CHAL facilities. Hospital fees are standardized (previously, CHAL hospitals generally charged higher rates).		
	Education Sector Policy on HIV and AIDS developed.	Government revises ART guidelines, to be in concordance with WHO guidelines (people with CD4 counts below 350 eligible for treatment; previous recommendation was to treat those with CD4 count below 200).		
		First round of accreditation of public and CHAL facilities takes place; no providers passed the accreditation.		
2008	Local Government Service act passed.	April: Government announced that it will provide voluntary/community health workers with stipend of LSL300 (about US$33) per month, under a "pay for performance" approach.	June: Round 7 Global Fund grant approved (US$10.6 million), with focus on OVCs and PMTCT.	

Year	Lesotho political and economic developments	Lesotho health sector	World Bank and other donors	Exogenous relevant international events
2008		July: Community Council Support Persons (CCSPs), stationed throughout the country's 128 Community Councils, established to help deliver HIV/AIDS services.	July: Two Round 8 Global Fund grant proposals submitted and approved (US$50.4 million and US$6.8 million), focusing on community-level response. Proposal also requests consolidation of grants from Rounds 5, 6, and 7.	
		Ministry of Local Government and Chieftainship (MOLGC) adopts "Guidelines for Scaling Up the Fight Against HIV and AIDS" through local authorities, later known as the Gateway Initiative.	December: HCTA project closes.	
2009	April: Assassination attempt against Prime Minister Mosisili.		June: GTZ funding for CCSPs phased out, with Bank-financed project assuming support.	November: World Health Organization (WHO) updates ART guidelines, including higher CD4 cell level for initiating ART.
			June: Round 9 Global Fund grant proposal submitted (US$10.4 million), focusing on OVCs.	
			August: Bank approves US$5 million HIV and AIDS Technical Assistance Project, with planned closing date of January 2015.	
			September: Health Sector Reform Project, Phase II, closes.	