COUNTRY PROFILE: LESOTHO

Overview of Lesotho's health system

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SOCIAL INNOVATION IN HEALTH INITIATIVE

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LIST OF ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
CHAL	Christian Health Association of Lesotho
HIV	Human immunodeficiency virus
LUNDAP	United Nations Development Framework and Plan
MoHSW	Ministry of Health and Social Welfare
NDSP	National Development Strategic Plan
OOP	Out-of-pocket
PHC	Primary Health Care
TB	Tuberculosis
US$	United States dollar
WHO	World Health Organization

EXECUTIVE SUMMARY

Lesotho is a mountainous landlocked country surrounded entirely by the Republic of South Africa. The vast majority of the population of just under two million people are Basotho; nearly three-quarters of whom live in rural areas. Approximately four-fifths of the people practise Christianity. The government is a parliamentary constitutional monarchy and is currently run by a coalition government with Bethuel Pakalitha Mosisili as prime minister and King Letsie III as head of state. Lesotho's economy faces a number of challenges including political instability, inequality, poverty, poor diversification of industry and dependence on donor funding and investment, which has hindered the attainment of Millennium Development Goals 4, 5, and 6. Migration of skilled workers to neighbouring countries and limited training capacity for health personnel have contributed to significant shortages in human resources in the health care sector. Other challenges include a high prevalence of HIV/AIDS, high maternal and infant mortality, poor sanitation infrastructure and high out-of-pocket expenditure for households that use private health care services. The emerging innovation ecosystem is largely technology-based.

1. COUNTRY AT A GLANCE

Component	Details/indicator/year	Data
Population	Total population (2014)	2 109 197[a]
	Percentage of urban vs. rural (2014)	Urban: 27, rural: 73[a]
Geography	Lesotho is a landlocked enclave within South Africa, and is comprised mostly of mountainous terrain. The climate is highly variable in terms of precipitation and temperature.[b]	
Ethnic composition	Mostly Sotho.[b]	
Government	Lesotho is a constitutional monarchy of 10 administrative districts. The king serves as head of state in a largely ceremonial role, while the prime minister serves as head of government. The two houses of parliament are the National Assembly, which is elected, and the Senate, which is appointed by the executive branch. The legal system is based on Roman-Dutch law. The High Court is the superior court of record.[b]	
Economic and infrastructure data	GDP per capita (purchasing power parity) (2014)	US$ 2 638.3 (current international dollars)[a]
	Economic growth as percentage of GDP (2014)	3.6[a]
	Gini-index (2013)	52.5[c]
	HDI (2014)	0.497 (ranked 161)[d]
	Percentage of people below national poverty line (2010)	57.1[a]
	Percentage of unemployment (2014)	26.2[a]
	Percentage of adult literacy (2009)	76[a]
	Education gender parity index (2012)	1.07[a]
	Percentage of population with access to sanitation (2015)	Access to improved drinking water: 82 (urban: 95, rural: 77)[a] Access to improved sanitation facilities: 30 (urban: 37, rural: 28)[a]
	Percentage of population with access to electricity (2012)	20.6[a]
Health system	Health expenditure as percentage of GDP (2014)	10.6[a]
	Annual public expenditure on health as percentage of total health expenditure (2014)	76.1[a]
	Health expenditure per person (2014)	US$ 105 (current US$)[a]
	Number of physicians per 1 000 population (2005)	0.05[e]
	Number of nurses and midwives per 1 000 population (2005)	0.62[e]
	Percentage of births with skilled attendants (2009)	62[f]
	Average life expectancy in years (2014)	50[a]

Disease burden	HIV prevalence as percentage among adults aged 15–49 (2014)	23.4[g]
	Deaths due to AIDS (2014)	9300[g]
	Deaths due to non-communicable diseases (2012)	7700[h]
	Deaths due to homicide (2012)	770[h]
	Maternal mortality rate per 100 000 births (2015)	487[a]
	Infant mortality rate per 1 000 births (2015)	69[a]
	Under-five mortality rate per 1 000 births (2015)	90[a]
Top five causes of mortality as percentage of deaths (2012)[i]	1. HIV/AIDS 2. Lower respiratory infections 3. Stroke 4. Diarrhoeal diseases 5. Preterm birth complications	41.4 6.0 5.2 3.3 3.2
Top five causes of DALYs (2012)[i]	1. HIV/TB/malaria 2. Maternal/neonatal/nutritional 3. Other infectious diseases 4. Cardiovascular diseases and diabetes 5. Unintentional injuries	ND ND ND ND ND

GDP: gross domestic product; gini-index: measures the extent to which the distribution of income (or consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution; HDI: human development index; DALYs: disability-adjusted life years.
Sources: [a] World Bank (2015b); [b] Guy (2015); [c] UNDP (2013); [d] UNDP (2015); [e] WHO Regional Office for Africa (2015); [f] UNICEF (2014); [g] Joint United Nations Programme on HIV and AIDS (2014); [h] WHO (2015b); [i] WHO (2015c).

2. COUNTRY CONTEXT

2.1 COUNTRY HISTORY AND POLITICAL SYSTEM

Lesotho gained independence from the United Kingdom on 4 October 1966 and was subsequently ruled as a monarchy, with King Moshoeshoe II as the head of state. The Basotho National Party won two consecutive national elections and ruled Lesotho for the first two decades of independence. The opposition Basotholand Congress Party won national elections in 1970, leading to allegations of election irregularities by the ruling Basotho National Party (led by Prime Minister Chief Leabua Jonathan) with subsequent suspension of the constitution and dissolution of parliament. The South African apartheid government accused Lesotho of housing African National Congress (ANC) cadres and threatened military attack, which exacerbated political instability. In 1986, a military government chaired by Major-General Justin Lekhanva assumed power after a coup d'état (BBC, 2015).

King Moshoeshoe II was deposed in 1990 and succeeded by his son King Letsie III. Prime Minister Lekhanya's tenure ended abruptly in 1991 after a mutiny by junior army officers and Colonel Elias Tutsoane Ramaema was appointed Chairman. A constitutional government was restored in 1993 after seven years of military rule. King Moshoeshoe returned to Lesotho and was reinstated in 1995, but died in a car crash in the same year resulting in restoration of King Letsie III (BBC, 2015).

In 1998, Pakalitha Mosisili won national elections, followed by violent protests and a military mutiny prompting intervention by South African and Botswanan military forces. Constitutional reforms restored political stability and peaceful parliamentary elections were held in 2002. However, National

Assembly elections in 2007 were hotly contested and the manner in which parliamentary seats were allocated led to widespread civil protest (BBC, 2015).

Motsoahae Thomas Thabane formed a coalition government after winning national elections in 2012. He left Lesotho in 2014 after an alleged coup d'état (BBC, 2014) and returned in 2015, subsequently losing an election to the previous incumbent Mosisili. However, he did not lose by outright majority and a new coalition government was formed that was comprised of the Democratic Congress, Lesotho Congress for Democracy, Patriotic Front for Democracy, Maramatlou Freedom Party, Basutoland Congress Party, Lesotho People's Congress and the National Independent Party (SABC, 2015).

2.2 POPULATION

The Sotho form the overwhelming majority (Guy, 2015) of Lesotho's population of about two million (World Bank, 2015b). The population is mostly rural, with nearly three-quarters living outside urban areas. Most of the population speaks Sesotho, though both Sesotho and English are official languages. Other languages spoken include Zulu, Phuthi (a dialect of Swati) and Xhosa. About four-fifths of the population practises Christianity, while small percentages practise Islam, Hinduism, Buddhism, and traditional religions. Life expectancy is 50 years (World Bank, 2015b); largely a result of HIV/AIDS and other diseases (WHO Regional Office for Africa, 2014). The median age is about 20 years (United Nations, 2015). In 2010, the United Nations estimated that about 20% of Lesotho's population migrated to South Africa and other nearby countries in the region, with the majority of migrants being female, resulting in a significant loss of local human resources (Bicknell et al., 2002).

2.3 ECONOMY

Table 1. Economic measures of Lesotho

Indicator/year	Data
GDP per capita (purchasing power parity) (2014)	US$ 2 638.3 (current international dollars)[a]
Economic growth as percentage of GDP (2014)	3.6[a]
Debt as percentage of GDP (2015)	60.0[b]
Gini-index (2013)	52.5[c]
HDI (2014)	0.497 (ranked 161)[d]
Percentage of people below national poverty line (2010)	57.1[a]
Percentage of unemployment (2014)	26.2[a]

GDP: gross domestic product; NA: not applicable; gini-index: measures the extent to which the distribution of income (or consumption expenditure) among individuals or households within an economy deviates from a perfectly equal distribution; HDI: human development index.
Sources: [a] World Bank (2015b); [b] IMF (2015); [c] UNDP (2013); [d] UNDP (2015).

Lesotho's economy has a projected growth rate of 2.6%, with growth mainly limited to urban areas while rural communities remain impoverished. The mining and construction industries as well as government services are the main drivers of growth. Limited direct foreign investment and diversification of the private sector are challenging, particularly in light of the decline of traditionally dominant industries such as manufacturing and textiles. Lesotho has one of the highest public spending rates at 63%, which the World Bank has deemed unsustainable (World Bank, 2015a). Poverty is widespread (Nseera, Salami & Bhatia, 2015) and unemployment high, posing additional challenges.

According to the World Bank, Lesotho will require "new growth engines, a more streamlined role for the state and a dynamic private sector to seize opportunities in the Southern African market" (World Bank, 2015a).

2.4 ENVIRONMENT

Lesotho is landlocked and surrounded entirely by South Africa, with two-thirds of the land comprised of mountainous terrain. Precipitation is highly variable and mainly occurs between October and April, with an annual amount of 710 mm per year that decreases from east to west. There is also a wide range in temperature, from as high as 32 °C in the summer in the lowlands to -7 °C in the winter; this range is even greater in the highlands. Hail and frost often occur in the summer and winter, respectively (Guy, 2015). Lesotho is also especially vulnerable to periodic droughts. In 2007, for example, drought resulted in approximately 553 000 people being unable to meet their annual food requirements (Government of Lesotho, 2013).

3. HEALTH SYSTEM

3.1 OVERVIEW

Lesotho faces a double burden of disease that includes both communicable and non-communicable diseases: one of the highest rates of HIV prevalence in the world and high infant and maternal mortality, despite recent improvements. Many challenges exist in Lesotho's health system, which have contributed in the country's inability to reach Millennium Development Goals 4, 5, and 6. Some of these include insufficient qualified human resources (Nseera, Salami & Bhatia, 2015) and stock-outs of drugs in health facilities due to delays in processing payments. This has resulted in underutilization of government facilities (Downs et al., 2013). Laboratory services are also under-resourced. In addition to the shortage of personnel in the various tiers of health care, interrupted supplies and equipment shortages often result in backlogs. Poor infrastructure in certain parts of the country limits access to health care, as patients are often unable to reach facilities (Government of Lesotho, 2013).

3.2 ORGANIZATION

A Decentralisation Plan, begun in 2011, has devolved health service delivery from the Ministry of Health and Social Welfare (MoHSW) to 10 districts, managed by District Health Management Teams and overseen by the Ministry of Local Government and Chieftainship Affairs (Government of Lesotho, 2013; WHO, 2014). However, the MoHSW remains responsible for national health policies, standards and guidelines; mobilisation of health resources; monitoring and evaluation of health sector interventions; and the provision of a legal framework for health services delivery (Government of Lesotho, 2013).

Health services are delivered in a three-tiered system, described as follows (Government of Lesotho, 2013).

1. **Primary health services**: this level includes health centres, health posts and community-level initiatives, with each network of clinics providing basic services and treating common conditions for 6 000–10 000 people. User fees were removed in 2008. More than 6 000 village health workers act as volunteers with some incentive from the government and staff health posts, providing promotive, preventive and rehabilitative care including health education and immunisations. The connection between village health workers and health centres has remained

informal and the lack of funds and human resources limits the efficacy of the village health worker programme.

2. **District level of care**: district hospitals receive referrals from the primary level and offer primary health care services instead of specialised services, partly due to the lack of free health services for urban residents at the primary level.
3. **Tertiary level of care**: a national referral hospital, Queen Mamohato Memorial Hospital and the Mohlomi Mental Hospital and Bost'abello Leprosy Hospital comprise the tertiary level, providing specialised services. Other specialised facilities exist, including Senkatana for HIV/AIDS management, Botšabelo for multidrug resistant tuberculosis (TB) and Baylor's Paediatric Centre of Excellence. Patients are referred to quaternary care in South Africa, if necessary.

The main private provider is the Christian Health Association of Lesotho (CHAL), which has a memorandum of understanding with the government and provides care to 30% of the population, with facilities partly funded by the government (Government of Lesotho, 2013). Other private providers include the Lesotho Planned Parenthood Association, the Red Cross, the Clinton Health Access Initiative and Partners In Health (Government of Lesotho, 2011). Traditional healers also remain popular, including herbalists (ngaka chitja), diviners (ngaka ea litaola), those still in training (ngakana-ka-hetla) and other diviners/healers (mathuela) (Masupha, Thamae & Phaqane, 2013).

3.3 CAPACITY

Table 2. Number of facilities and health workers per population, Lesotho

Indicator	Data
Total number of health facilities (2013)[a]	**372**
Health centres	188
Nurse clinics	66
Pharmacies	46
Filter clinics	3
District hospitals	18
National referral hospitals	1
Specialty hospitals	2
Private surgery clinics	48
Physicians per 1 000 population (2005)	0.05[b]
Nurses and midwives per 1 000 population (2005)	0.62[b]

Sources: [a] Government of Lesotho (2013); [b] AHWO (2015).

The government owns 42% of health centres and 58% of hospitals, whilst 38% of health centres and hospitals are owned by the CHAL, with the remaining facilities run by other private providers (Government of Lesotho, 2013). Significant human resource shortages persist, with the most recent ratio of nurses/midwives and doctors at 0.62 and 0.05 per 1 000 population, respectively (AHWO, 2015). The shortage of pharmacists, medical doctors and dentists is exacerbated by the lack of capacity to train these personnel as well as frequent emigration of professionals seeking opportunities abroad. No medical school exists in Lesotho resulting in all physicians being trained externally. The National Health Training College offers training programmes in nursing, environmental health, medical laboratory technology and pharmacy as well as certificates in nursing assistance and auxiliary social work. Four CHAL health training institutions also train nurses (Government of Lesotho, 2013).

3.4 POLICY ENVIRONMENT

The World Health Organization (WHO) (2014) states the following:

> Lesotho has developed a 5-year National Development Strategic Plan (NDSP) for the period 2013-2017. The plan is a successor to the Poverty Reduction Strategy Paper and the Interim National Development Framework. It is an implementation strategy for the National Vision 2020. The United Nations in Lesotho has completed the United Nations Development Framework and Plan (LUNDAP), which is fully alignment with the NDSP 2013-2017. The first annual review of the LUNDAP was jointly conducted with Government in February 2014. The National Health Policy and Strategic Plan are both harmonized and aligned with the NDSP and the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa. The National Health Sector Policy 2011 has been finalized and disseminated. The National Health Strategic Plan 2013- 2017 has been finalized and is awaiting printing.
>
> The Primary Health Care (PHC) Revitalization was officially launched by Prime Minister in November 2013. The process has been guided by the PHC Revitalization Plan of 2013. The Ministry of Health has embarked on the process of decentralizing health services to the Ministry of Local Government and Chieftainship Affairs following the launch of the decentralization process in December 2011.

WHO (2014) lists the following five strategic priorities for Lesotho:

1. Strengthen the control of HIV/AIDS and TB.
2. Strengthen family and community health, including sexual and reproductive health.
3. Enhance capacity for the prevention and control of major communicable and non-communicable diseases.
4. Strengthen health-systems capacities and performance.
5. Foster health sector partnerships advocacy and equity.

3.5 HEALTH FINANCING

Table 3. Health financing data for Lesotho, 2014

Indicator	Data
Total health expenditure (current US$)	US$ 221 704 000
Public expenditure on health as percentage of total expenditure	76.1
Public expenditure on health as percentage of general government expenditure	13.1
OOP expenditure on health as percentage of total private expenditure	69.0
Private insurance expenditure on health as percentage of total private expenditure	-
Expenditure of non-profit institutions serving households as percentage of total private expenditure	31.0
External funding (current US$)	US$ 115 824 000
Health expenditure as percentage of GDP	10.6

OOP: out-of-pocket; GDP: growth domestic product.
Source: WHO (2015a).

Donor funding in the health sector is predominantly directed at decreasing the prevalence of HIV infection. This has contributed to the fight against HIV, but the possibility that donors will cease funding makes these programmes unsustainable if they remain donor dependent (Downs et al., 2013). CHAL, which oversees 90% of private-for-profit facilities, is partially government funded and privately run (Government of Lesotho, 2013).

The principal challenge within the private health-care sector is that out-of-pocket payments contribute 69% of total private expenditure, which may have dire long-term consequences for households that use large portions of their income on health care (Downs et al., 2013). The MoHSW of Lesotho requested WHO to undertake a financial feasibility study of social health insurance as one way of financing health care in Lesotho. The study revealed that, in principle, through tax financing and social health insurance contributions, all citizens of Lesotho could be covered by a defined benefits package which would provide financial risk protection and enhance equity in access to health and health financing (Mathauer et al., 2011).

3.6 COUNTRY DISEASE PROFILE

Table 4. Disease profile for Lesotho

Indicator/year	Data
Age-standardized DALYs per 100 000 for communicable diseases (2012)	64 355[a]
Age-standardized DALYs per 100 000 for non-communicable diseases (2012)	26 920[a]
Age-standardized DALYs per 100 000 for injuries (2012)	8 147[a]
Under-five mortality rate per 1 000 live births (2015)	90[b]
Infant mortality rate per 1 000 live births (2015)	69[b]
Maternal mortality rate per 100 000 live births (2015)	487[b]
Prevalence of TB per 100 000 (2014)	671[a]
Incidence of TB per 100 000 (2014)	852[a]
Deaths due to TB among HIV-negative people per 100 000 (2014)	64[a]
Prevalence of HIV as percentage among adults aged 15–49 (2014)	23.4[c]
Deaths due to AIDS (2014)	9 300[c]
Deaths due to non-communicable diseases (2012)	7 700[a]
Deaths due to homicide (2012)	770[a]
Percentage of top five causes of mortality (2012)[d]	
1. HIV/AIDS	41.4
2. Lower respiratory infections	6.0
3. Stroke	5.2
4. Diarrhoeal diseases	3.3
5. Preterm birth complications	3.2
Top five causes of DALYs (2012)[d]	
1. HIV/TB/malaria	ND
2. Maternal/neonatal/nutritional	ND
3. Other infectious diseases	ND
4. Cardiovascular diseases and diabetes	ND
5. Unintentional injuries	ND

DALYs: disability-affected life years; ND: not determined; TB: tuberculosis.
[a] WHO (2015b); [b] World Bank (2015b); [c] Joint United Nations Programme on HIV and AIDS (2014); [d] WHO (2015c).

According to the WHO, Lesotho faces a double burden of disease in the form of both non-communicable and communicable diseases (WHO Regional Office for Africa, 2009). In 2014, Lesotho had the third highest HIV prevalence in the world (Joint United Nations Programme on HIV and AIDS, 2014), with HIV being the biggest contributor to the national disease burden and mortality (WHO, 2015b). Significant causes of mortality include other infectious diseases, strokes, diarrhoeal diseases and diabetes (WHO, 2015b). This reflects the structural challenges within the health system, including staff shortages and poor infrastructure. For example, the high rate of death from diarrhoeal diseases may be attributed to poor sanitation as only 30% of the population has access to improved sanitation (World Bank, 2015b). Still, the country has made some progress with other indicators: infant and maternal mortalities have declined, for instance, from 86 deaths per 1 000 live births and 720 deaths per 100 000 live births in 1990 (WHO, 2015b) to 49 and 490 in 2015, respectively (World Bank, 2015b).

4. INNOVATION ECO-SYSTEM

Lesotho's National Policy on Science and Technology 2006–2011 emphasizes the use of technology, science, and innovation as a means of eradicating poverty through job creation and stimulating economic growth. Upcoming incubators and opportunities for funding have largely focused on technology-based innovations (Downs et al., 2013; United Nations, 2010). In terms of health innovation, the government of Lesotho has shown some willingness to innovate through health-care projects to improve the delivery of care but this has primarily been directed at HIV/AIDS programmes such as testing programmes and health education (Downs et al., 2013).

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