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**2018**

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# Inequity and Exclusion in the Delivery of Health Services in Maseru, Lesotho

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**Submitted in partial fulfilment of the degree of Masters of Management**

**(In the field of Public Policy)**

**……**

**School of Governance**

**University of the Witwatersrand**

**March 2018**

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**ABSTRACT**

For Centuries, health sectors have embarked on a journey to provide equitable and inclusive health services for all but it has been a major challenge. This is the case in Lesotho, the Ministry of Health has made it its priority to ensure the provision of equitable health services for all but, there are disparities observed. Consequently, this study explored the factors behind the problem of inequity and exclusion in the delivery of health services in Maseru, the governance trends and strategies in the Ministry of Health and their implications for equity and inclusiveness particularly with respect to access to health services.

The research study was conducted using qualitative approach and data collected through interviews to probe among the participants the factors behind the inequity and exclusion that exist. Secondary data in the form of the Ministerial Strategic Development Plans and Budget allocations were also analysed in the research to mainly identify the trends and strategies in the Ministry. The main purpose of the research was to establish the factors behind the inequity and exclusion problems, identify possible solutions and make recommendations.

The findings suggest a number of factors behind the problem of inequity and exclusion in the delivery of health services in Maseru. Included is lack of financial resources leading to multiple other factors such as poor infrastructure, limited human resources and failure by the Ministry to fully decentralize. Further, identified is the relationship between the factors thus we can conclude that one factor is as a result of another and visa-versa. Possible solutions to be the problem are provided and so are recommendations made.

**TABLE OF CONTENTS**

## Table of Contents


PLAGIARISM DECLARATION ..... i
ABSTRACT ..... ii
TABLE OF CONTENTS ..... iii
LIST OF FIGURES AND TABLES ..... vi
GLOSSARY OF TERMS ..... vii
ACKNOWLEDGEMENT ..... viii
1 INTRODUCTION AND BACKGROUND ..... 9
**1.1 Introduction** ..... 9
1.1.1 Socioeconomic Overview of Lesotho ..... 11
**1.2 Background of the Study** ..... 12
1.2.1Health Sector Financing and Expenditure ..... 18
1.2.2 Population and Geographic Context ..... 19
1.3 Problem Statement ..... 19
1.4 Purpose and Significance of the Research ..... 20
1.5 Research Questions ..... 21
The research study will investigate the following questions: ..... 21
2 LITERATURE REVIEW ..... 22
**2.1 Introduction** ..... 22
**2.2 The Country Lesotho** ..... 22
**2.3 Lesotho's Health Sector** ..... 23
**2.4 Health Care Related Studies in Lesotho** ..... 24
**2.5 Is There a Distinction Between Equity And Exclusion?** ..... 25
**2.7 Equity Studies** ..... 28
**2.8 Summary** ..... 32
**2.8 The Academic Field of Study Driving the Research** ..... 33
**2.9 Theoretical Framework** ..... 34
**2.9.1 Rational Choice Theory** ..... 34
**2.9.2 Elite Theory** ..... 36
**2.9.3 Institutional Theory** ..... 38
**2.10 Conceptual Framework** ..... 40
**2.10.1 Pluralist Theory** ..... 40

3 RESEARCH METHODOLOGY ..... 44
**3.1 Introduction** ..... 44
**3.2 Research Approaches** ..... 44
**3.2.1 Quantitative Research** ..... 45
**3.1.2 Qualitative Research** ..... 47
**3.3 Research Design** ..... 49
**3.2.1 Sampling** ..... 50
3.4 Data Collection ..... 50
**3.5 Data Analysis and Presentation** ..... 52
**3.6 Reliability and Validity** ..... 52
**3.7 Significance of the Study** ..... 53
**3.8 Limitations of the Study** ..... 53
**3.9 Ethical Considerations** ..... 53
4 RESEARCH FINDINGS AND ANALYSIS ..... 54
4.1.1 Period of Service and Current Position ..... 54
4.1.2 Qualifications ..... 55
4.1.3 Sector Heterogeneity and Years in Current or Managerial Position ..... 56
4.1.4 Participants Attributes ..... 57
4.2 Equity and Inclusiveness ..... 57
4.2.1 Definition of Equity and Inclusiveness ..... 57
4.2.2 Determinants of Equity and Inclusiveness ..... 58
**4.2.2.1 Policies** ..... 58
**4.2.2.2 Public Health Status Information** ..... 59
**4.2.2.3 An Area Population Size** ..... 59
**4.2.2.4 Distance to Health Centre** ..... 60
**4.2.2.5 Disease Burden and Risks** ..... 60
4.2.3 Challenges Encountered in Achieving Equity and Inclusiveness ..... 61
**4.2.3.1 Weak Planning and Implementation** ..... 61
**4.2.3.2 Limited Human Resource Capacity** ..... 61
**4.2.3.3 Unrealised Full Devolution of Health Services** ..... 62
**4.2.3.4 External Influences** ..... 63
4.2.4 Solutions to Equity and Inclusiveness Challenges ..... 64
4.3 Ministry Of Health Decision Making on Resources Allocation ..... 65
4.3.1 Ministry Of Health Decision – Making Process ..... 65

4.3.2 Determinants of Decision – Making in the Ministry Of Health ..... 65
**4.3.2.1 Country Policies and Available Data** ..... 65
**4.3.2.2 Donor Funds** ..... 66
4.3.3 Strengths and Weaknesses in MOH Decision – making ..... 66
4.4 Governance Trends and Strategies in the Ministry of Health ..... 69
4.5 Conclusion ..... 75
5 RESEARCH DISCUSSIONS ..... 76
5.1 Factors leading to the problem of Inequity and exclusion ..... 76
5.2 Governance Trends and Strategies ..... 79
5.3 Solutions to Inequity and Exclusion ..... 80
6 CONCLUSION AND RECOMMENDATIONS ..... 82
6.1 Conclusion ..... 82
6.1.1 Purpose Statement ..... 82
6.2.2 Factors behind Inequity and Exclusion ..... 83
6.1.3 Strategies and Trends ..... 84
6.1.4 Implications ..... 85
6.2 Recommendations ..... 86
6.3 Recommendations for Future Research ..... 87
6.4 Conclusion ..... 87
References ..... 88
APPENDICES ..... 91

## LIST OF FIGURES AND TABLES

### LIST OF TABLES

Table 1: Solutions for Challenges Identified 61

Table 2: Strengths, Weaknesses and Solutions to Decision Making 64

Table 3: Secondary Data Analysis 67

Table 4: Health Budget from 2000 – 2017 69

Table 5: Summary of Key Issues and Findings 70

### LIST OF FIGURES

**Figure 1:** Years of Service and Period in Current Position 53

**Figure 2:** Participants Qualification 53

**Figure 3:** Participants Attributes 54

**Figure 4:** Age and Data 55

## GLOSSARY OF TERMS

| | |
|---|---|
| CDC | Centre For Disease Control |
| CHAL | Christian Health Association of Lesotho |
| DHS | Demographic Health Survey |
| DOTS | Directly Observed Treatment Short Course |
| GOL | Government of Lesotho |
| HIMS | Health Information Management System |
| HSSP | Health Sector Strategic Plan |
| LRCS | Lesotho Red Cross Society |
| MDGs | Millennium Development Goals |
| MOH | Ministry of Health |
| MOU | Memorandum of Understanding |
| NGO | Non – Governmental Organisation |
| OOP | Out – Of – Pocket |
| PAU | Project Accounting Unit |
| PHC | Primary Health Care |
| PSI | Population Services International |
| PPP | Public Private Partnership |
| WHO | World Health Organisation |

**ACKNOWLEDGEMENT**

I would like to thank my family for the support throughout my studies. Mom, you are a pillar very child needs for strength. To all you my friends, each role you played for making this a success did not go unnoticed and above all, your patience.

Prof. Pundy Pillay, many thanks to you for believing we could pull this through within such a short space of time. We made it! Malesia Thoahlane, I hope this is a lesson to you, that you can do just anything if your heart and mind is in it.

Thank you all

# 1 INTRODUCTION AND BACKGROUND

## 1.1 Introduction

As fashionable as it is now, the concept of “governance” is as old as human history (Weiss, 2000). According to Weiss (2000), this simply means that the origin or history of governance is as old as the creation of mankind and to many practitioners, governance meant a complex set of structures and processes, in both public and private, while more popular writers tend to use it synonymously with ‘government’. Weiss (2000) further notes that governance can also be defined as the sum of the many ways individuals and institutions, public and private, manage their common affairs. Van Doeveren (2011) indicates that it was however reintroduced in the 1980s as part of the process “bringing the state back in”. van Doeveren (2011) states that the concept was, however, no longer primarily associated with government, that is, the exercise of political power; rather, governance referred to the process of decision making in which sovereignty is dispersed among governmental and non-governmental actors who together participate in political decision making processes that cannot be controlled from the centre.

According to Gisselquist (2012) there is no single definition of governance and this is evident from views on governance by various authors and international organisations. However, as noted by Gisselquist (2012) there are clear similarities across working definitions and major differences but most of the definitions include common elements that points towards a minimal understanding of governance as the process through which power is exercised to manage the collective affairs of a community (or a country, society or nation). Additionally, as indicated by van Doeveren (2011) since the definitions vary so much, scholars adopted any definition that pleased them, as long as it pertained to decision making process or the outcome of the decision making process.

Grindle (2008) indicates that in many developing countries in Africa, governments were failing and were characterised by attributes of bad governance with millions of people throughout the world living in conditions of public insecurity and instability, corruption, abuse of law, public service failure, poverty, and inequality. Good governance was seen as a mighty beacon of what ought to be; hence its introduction which is used interchangeably with governance. Grindle (2008) reckons the idea of good governance owes much to the intellectual resurrection of the state as a positive "player" in economic and political development.

According to Van Doevaeren (2011) in Africa, the concept "good governance" was introduced around 1989 and the purpose was to protect and promote the wellbeing of people. Van Doevaeren (2011) indicates that the Western Principle of Political Sovereignty was under pressure because the acute suffering of states like Rwanda and Somalia required humanitarian intervention, and these sufferings were regarded as the result of bad governance due to failure of developmental aid. Van Doevaeren (2011) further notes that donor or aid institutions began a campaign on good governance to preserve their own legitimacy.

Van Doevaeren (2011) indicates that there are various characteristics of good governance and they differ with scholars. Van Doevaeren (2011) identifies a remarkable convergence around the five principles of governance namely accountability, effectiveness and efficiency, openness or transparency, participation and rule of law, and are common to most scholars. The implication of this commonality is a shared meaning of good governance and what it stands for. According to the United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP) (2006) good governance has 8 major characteristics. UNESCAP indicates that it is participatory, consensus oriented, accountabiliyy, transparency, responsiveness, effectiveness and efficiency, equity and inclusiveness and lastly the rule of law. UNESCAP (2006) further notes that it assures that corruption is minimized, the views of minorities are taken into account and that the voices of the most vulnerable in society are heard in decision-making and also responsive to the present and future needs of society.

The mandate of all public services is service delivery and it is important that all individuals in society have equal access to available resources hence the concepts of equity and inclusiveness are central to good governance practice. The World Health Organisation (WHO) (1946) indicates that every individual has a right to enjoy the highest attainable standards in their society thus no individual or groups should be excluded from benefiting from services delivered by government.

The Government of Lesotho is constitutionally obligated to provide health care services to all Basotho. Ramashamole and Thamae (2015) indicate that the Government of Lesotho (GoL) delivers health services through the Ministry of Health with the help of development partners and the private sector. However, health service provision in Lesotho is skewed towards urban areas. Despite increases in health expenditure overtime, service provision in the rural Lesotho has not increased. According to Ramashamole and Thamae (2015), despite the health budget increases, both internal and external stakeholders are concerned with Lesotho's under expenditure of very limited allocated health budget especially capital investment projects.

### 1.1.1 Socioeconomic Overview of Lesotho

As cited by Downs, Montagu, da Rita, Brashers & Feachem. (2013), local currency is the Maloti, which is pegged at a value equal to the South African Rand. They further indicated that, 70% of the population is employed in subsistence agriculture. Other local industries include limited diamond mining and textile factories. According to Downs, Montagu, da Rita, & Brashers (2013), the national unemployment rate is 25.3% and many seek work in surrounding South Africa. Downs, Montagu, da Rita, & Brashers (2013) added that, Lesotho earns a significant portion of its national revenue through a share in regional customs receipts distributed through the Southern African Customs Union (SACU) and the export of water from the Lesotho highlands to South Africa. The stated sources of the country's revenue are not sufficient to deliver all essential services hence reliance on loans from World Bank and grants from international organisations.

Additionally, Oxfam 2014, views Lesotho as one of the most unequal countries in the world with a Gini Coefficient of 0.531. Oxfam further states that the richest 10% of households account for more than half of total consumption and that more than 57% of its population live below the poverty line. According to Oxfam 2014, poverty is 50% higher in rural areas than in urban areas and that Lesotho has the world‘s third highest burden of HIV and AIDS, with prevalence of 26% for women and 19% for men.

Oxfam 2014, indicates that life expectancy has fallen from 60 years in 1990 to just 50 years in 2011, and infant and maternal mortality rates are rising. Oxfam 2014 notes that under-five mortality is 40% higher for the poorest quintile than for the richest, and the variations in mortality rates between those living in the capital region and those in rural areas are as wide. Oxfam 2014, views poor households as less likely to seek healthcare, citing cost and distance as the major barriers. Oxfam 2014, indicates that the poorest of people who live in rural areas have more than three hours to travel to their nearest health facility.

This report explores the factors behind the problem of inequity and exclusion in the delivery of health services in Maseru.

## 1.2 Background of the Study

Equity and inclusiveness form an integral part of good governance. It is not “good governance” if it does not equally encompass all members of society. As a result governments have to make a commitment to tackle existing inequities in health distribution and access. However, Goddard & Smith (2001) state that making this policy operational will be difficult without a clear picture of what is currently known about equity of access to health. Thus, it is important for each country to identify and define what inequity in health care is for them.

Whitehead & Dahlgren (2006) indicate that for some countries, the concept of equity in health is central to human rights and hence it is important that the inequalities are eliminated and health is availed to all. Whitehead & Dahlgren (2006) note that it is

quite crucial to work out what social differences are fair and unfair. They further indicate that to them, all systematic differences in health between different socioeconomic groups within a country are considered as unfair and are categorised as health inequity. Whitehead & Dahlgren (2006) indicate that the most disadvantaged groups here are due to economic and geographical reasons and in their journey to tackle the inequities in health, the causes of the disparities in health access are a priority, with the belief that knowledge of what causes are, will lead to solutions and ultimately addressing them.

Africa is not an exception; and has joined the world in trying to ensure preventive and curative health care for all. The African Union makes an emphasis on an integrated, prosperous and peaceful Africa. Prosperity, means a better, developed and healthy continent that is, healthy Africans. In the pursuit to increase better health for all, global strategies such as the Millennium Development Goals 2000 and Abuja Declaration on Health 2008 were adopted in multiple African countries.

According to Wagstaff and Doorslaer (2000) a common interpretation of equity in medical care delivery is that medical care ought to be allocated on the basis of medical need rather than on the basis of, say, income, race or area of residence. The interpretation should apply to all countries worldwide, inclusive of Lesotho a small country, completely landlocked by the republic of South Africa. The country is divided into ten (10) administrative districts with a total area of about 30,355 square kilometres and it is divided into four ecological zones: Lowlands, Foothills, Mountains, and Senqu River Valley.

The Lesotho Demographic Health Survey of 2009 indicates that Lesotho has a population of approximately 2.074 million. According to Lim, van Loggerenberg & Chater (2016) the population of Lesotho is mostly rural, with nearly three-quarters living outside urban areas, and life expectancy is 49 years largely as a result of HIV and AIDS, and other diseases.

Ramashamole and Thamae (2015) indicate that the Government of Lesotho through the Ministry of Health is constitutionally required to ensure improved public health and create accommodating environment in situations of illness by providing medical

services and medical attention to all. However, the country is faced with various challenges which include among others, poverty, draught and the HIV/Aids pandemic. The Lesotho Health Strategic Plan (2013) states that the government is responsible for health related issues in the country inclusive of, the development of health policies, development of standards and guidelines, mobilization of health resources and monitoring and evaluation of health sector interventions. Ramashamole and Thamae (2015) indicate that the achievement of all these obligations and constitutional mandate is through the Ministry of Health, Donors, Development Partners and Private Sector. Ramashamole and Thamae (2015) notes further that, although the Basotho community is large and diverse, the health service providers are limited to government working together with CHAL and very limited private sector provision thus depriving Basotho access to equitable to healthcare services.

In carrying out its mandate, the Ministry has adopted among others, the Health Sector Strategic Plan 2012 – 2017 which has been largely informed by the Ouagadougou Declaration on Primary Health Care (PHC) and Health Systems in Africa 2008. This declaration calls on African countries to rededicate to Primary Health Care (PHC) as a model to delivering health services. According to the Primary Health Care (PHC) Revitalisation Action Plan (2011-2017), Lesotho through the Ministry of Health previously adopted Primary Health Care in 1979 as the focal strategy for attaining health for all by the year 2000 and due to failure to achieve this, it embarked on a comprehensive health sector reform process that has been implemented for a period of ten years from 2000. As stated by the Plan, the aim of the reform process was to attain affordable, universal coverage and equity in health services delivery. However, almost two decades later, there is still high prevalence of inequity in health care delivery and it is important to evaluate the role the Primary Health Care Revitalization Plan has played or contributed to the problem.

Globally, governments have adopted decentralization as a way of shifting decision making to local authorities and bringing services closer to the people. Through its line Ministries, Lesotho is no exception. Decentralisation was adopted in 2005 to provide guidance on decentralization of health care and health care delivery. According to the Health Sector Strategic Plan 2013/14-2016/17, the implementation of the

decentralisation strategy has not been a success as most health sector services are still centralized. All the health related decisions for the whole country are made by the board of directors at Health Headquarters in Maseru. For instance, the Ministry still decides the quantity and type of medication to be provided for each community or clinic and how they should be dispensed. The Health Sector Strategic Plan further notes that the lack of progress with implementation of decentralisation has affected delivery of services.

Times are changing and so is the quality of services provided. Trying to meet the demands of the overwhelming growth and changing patterns of diseases, the Ministry of Health continued with reform processes. These reforms were designed to achieve sustainable increases in access to quality health care services at all levels and achieve universal coverage and equity in the process. The Ministry of Health engaged in various Public Private Partnerships (PPP's) such as the partnership between MoH and Christian Health Association of Lesotho (CHAL) and Lesotho Red Cross Society (LRCS). These partnerships enabled the Ministry to implement changes such as abolishing user fees at health centres, providing grants to purchase services from CHAL and the use of a common quality assurance system to accredit health facilities.

The partnerships were not limited to the above another PPP was established for the management of Queen Mamohato Memorial Hospital, the National Referral Hospital. The government further partnered with the private sector to implement the DOTS (Directly Observed Treatment Short-course) programme and offer Antiretroviral Therapy services. However, these partnerships are informal due to absence of a public private partnership (PPP) framework for the health sector. A Memorandum of Understanding (MOU) between Lesotho and South Africa exists and enables collaboration with South Africa on cross-border referrals, HIV/AIDS and disease surveillance. For development partners a common funding mechanism has been developed that enables financial support through the Project Accounting Unit (PAU) using the GoL disbursement and procurement procedures in line with the Accra Agenda.

Health services in Lesotho are provided at three levels namely: primary, secondary and tertiary. There are 372 health facilities in Lesotho and they are made of 1 referral

hospital, 2 specialty hospitals, 18 hospitals, 3 filter clinics, 188 health centres, 48 private surgeries, 66 nurse clinics and 46 pharmacies. Health centres are the first point of care and are aimed at making the patient load at district and referral hospitals lighter. In total 213 of these facilities belong to MoH and Christian Health Association of Lesotho (CHAL). 42% of the health centres and 58% of the hospitals are owned by the MoH and CHAL owns 38% of the health centres and the same proportion of the hospitals.

According to the Lesotho Diagnostic Report 2014 CHAL is a privately owned organisation made up of six different religious denominations, for the provision of healthcare services. They provide health care services mostly in rural areas where government health workers are reluctant to work. As stated in the report, in 2007 CHAL together with the Government of Lesotho, signed a memorandum of understanding with the aim of making health services more accessible to ordinary Basotho who could not afford even the nominal fees by CHAL-run health facilities charged. Consequently, patients get free medical services and drugs at health centres, and subsidised medical care and drugs at hospitals

The remaining facilities are privately owned. About 90% of the private for profit health facilities are situated in the four large districts of Maseru, Berea, Mafeteng, and Leribe. There are also nongovernmental organizations (NGOs) which provide health services and these include Lesotho Planned Parenthood Association which has nine clinics located in urban centres around Lesotho; Lesotho Red Cross Society (LRCS) which operates four clinics; and Population Services International (PSI) operates five voluntary counselling and testing (VCT) centres.

**a. Primary or Community Level**

The primary level of health care includes health centres, health posts and all community level initiatives including all staff working at this level. This network of clinics each serves between 6,000 and 10,000 people provide basic health services. These facilities are staffed by clinicians, nurses or nursing assistants who diagnose and treat common conditions. The GoL and CHAL health centres provide services free of charge after the abolition of user fees in 2008 which has subsequently led to a

significant increase in the utilization of health services by clients. CHAL provides services to at least 30% of the population and its facilities are situated in remote rural areas where coverage by public facilities is limited. There is a Memorandum of Understanding (MoU) between CHAL and MoH which aims at harmonizing service provision, provide salaries and user fees and the need for GoL to register and certify CHAL facilities.

At community level there is also a network of more than 6,000 village health workers (VHWs) based at health posts. There are also other categories of community-based health workers such as traditional birth attendants, community based condom distribution agents and water minders. VHWs are volunteers and receive an incentive from the GoL. They mainly provide and promote preventive and rehabilitative care. Nurses at health centres supervise and train VHWs. VHWs also organize health education gatherings and immunization efforts within the communities they serve. The link between community and health centres provided by VHWs has remained informal despite their huge contribution. The VHWs programme is coordinated by the Division of Family Health at the MoH headquarters. Inadequate funding and acute shortage of health personnel to adequately train and supervise VHWs has hampered the growth of this community initiative. VHWs refer cases to health centres. Health centres are the first point of professional care.

**b. Secondary Level**

In each district there is a district hospital which is a referral facility for all health centres within each district. In Maseru, however, there is no district hospital hence the National Referral Hospital also acts as a district hospital and experiences congestion of clients. The district hospitals, only provide District hospitals refer cases to the National Referral Hospital for further management.

**c. Tertiary Level**

At tertiary level there is only one National Referral Hospital and two specialized hospitals namely Mohlomi Mental Hospital and Bots'abello Leprosy Hospital. Patients are referred to South Africa for quaternary care through the national referral hospital. There are other specialized health care facilities like Senkatana for HIV and AIDS Management, Botšabelo for MDR TB and Baylor's Paediatric Centre of Excellence.

### 1.2.1Health Sector Financing and Expenditure

There are two major sources of funding for the Ministry of Health namely the GoL and Development Partners. Other sources of funds include out of pocket direct payments to health services providers and contributions to private health insurance schemes and insurance schemes arranged by employers. The Ministry of Health Strategic Plan (2013) indicates that Lesotho allocates a significant proportion of its financial resources to the health sector. It notes that between 2004/05 the GoL spent 7.7% of its GDP on health and this is above WHO Afro region average of 5.6% in 2006. It further indicates that over the same period GoL spent US$54.6 per capita per annum on health which was also above the US$34 per capita per annum recommended by WHO for providing a minimum package of cost effective interventions in African countries.

In 2011, Lesotho entered into a Public Private Partnership (PPP) project with Netcare to build a referral hospital called Queen Mamohato Memorial Hospital (QMMH) as a replacement for the dilapidated Queen Elizabeth II (QE II) in Maseru. The rationale behind the adoption of the PPP was that the private partner would provide services at a similar cost as the old QE II. However QMMH is more costly due to continued referral of patients to the Republic of South Africa to access services that QMMH does not provide as well as increasing numbers of walk – in patients. All services are paid for by Government of Lesotho.

Oxfam 2014 stipulates that figures by the Lesotho Ministry of Health suggest that in 2013/14 the cost of the new private hospital had escalated further to between 3 and 4.6 times what the old public hospital would have cost today. It further states that the figures suggest that the PPP now accounts for as much as 51% of the total health budget, or $67m per year. Oxfam 2014 indicates that the real cost of the new privately run hospital is already nearly two and a half times the amount that was agreed as affordable between the Government of Lesotho and the International Finance Corporation before the contract was awarded(Oxfam, 2014). The implication of this

arrangement is that more than half of health services expenditure is on one health facility. This has resulted in less expenditure towards services in other facilities countrywide. This is a clear indication that this arrangement is a key driver and an indicator of the existence of inequity and exclusion in health service delivery.

### 1.2.2 Population and Geographic Context

Lesotho is a small country in physical, demographic, and economic terms. It has a Population of just short of 2 million and a land area of 30,355 square kilometres. The Lesotho Diagnostic Report (2014) indicates that the country has a high elevation and the terrain is largely mountainous and although distances are not large, the mountainous terrain makes transport and communications difficult. The report further notes that many people live in areas that are considered “remote” due to inaccessibility and they are unable to access markets, schools and even health facilities

The Lesotho National Population Housing Census Report (2016) reveals that the population of Maseru has risen from 228,000 in 2006 to 519,186 in 2016. According to the Census Report 2016, the increase is a result of multiple factors, however with urbanisation as the leading factor. The Census Report 2016, indicates that numbers of people have moved from the highlands to the lowlands seeking employment, resulting in congestion in Maseru, as well as inequity and exclusion in service delivery. This is where the Ministry of Health headquarters is located and all major healthcare decisions are made. It is divided in both urban and rural and it is in the rural part where the majority of the population resides. This research is based on the Maseru district and the researcher aims to identify the factors behind the inequity and exclusion in public health service delivery in this district.

## 1.3 Problem Statement

Lesotho is a small, mountainous country divided into 10 administrative districts. Olowu (2014) indicates that the diversity of the country, both in terms of demography and geographical terrain, makes it difficult to communicate with rural communities resulting in difficulty of residents to access social services. The Government of Lesotho (GoL)

and Christian Health Association of Lesotho (CHAL) health centres provide services free of charge after the abolition of user fees in 2008 which has subsequently led to a significant increase in the utilization of health services by clients. CHAL provides services to at least 30% of the population and its facilities are situated in remote rural areas where coverage by public facilities is limited. According to the Bureau of Statistics 2006 urban areas constitute only 23.8% of the population therefore resulting in, inequity and exclusion problems in the distribution of health services.

Although it is constitutionally obliged and has a mission to ensure that access to care is based on need, rather than affordability, the Ministry of Health has not been able to provide equitable and inclusive health care services for all Basotho. There are two hospitals, fifteen Clinics and a referral hospital in Maseru. Service delivery is however skewed towards urban based tertiary care and primary health care as out of 3 hospitals and 15 clinics; only five clinics are rural based despite the majority of the population residing in rural Maseru.

Urban based health centres offer better quality services as they have improved and well equipped facilities with laboratories, operating theatres and pharmacies. This is however not the case with rural based clinics where buildings are dilapidated, there is lack of human resources and commodities. Due to shortage of human resources, nurses undertake multiple functions within the health centres and this results in poor quality of service. In many instances, drugs are unavailable in health centres and patients have to purchase from retailers or visit the urban based facilities.

There is limited research in Lesotho that establishes the factors behind the problem of inequity and exclusion in the delivery of health services. This study aims to identify such factors that result in inequity and exclusion in health services.

## 1.4 Purpose and Significance of the Research

The purpose of this research is to explore the factors that result in inequity and exclusion in the delivery of health services in Maseru Lesotho. The study aims to

present governance trends and strategies of Ministry of Health and their implication on inequity and exclusion.

## 1.5 Research Questions

The research study will investigate the following questions:

- What are the factors leading to the problem of inequity and exclusion in health access in Maseru?
- What are governance trends and strategies of the Ministry of Health and what are their implications for inequity and exclusion accessing health services?

# 2 LITERATURE REVIEW

## 2.1 Introduction

There is a problem of inequity and exclusion in the delivery of health services in Maseru Lesotho. It is important to investigate the factors behind the problem. Wagner, Garner & Kawulich (2012) defines literature review as an interpretation of a selection of relevant published and/or unpublished information that is available on a specific topic from either the documents, talks, observations, photographs or videos and that optimally involves summarisation, analysis, evaluation and synthesis of the information. According to Bless, Higson-Smith & Sithole (2013) literature review is important to get a researcher acquainted with the problem and the questions of other researchers but most importantly, to avoid duplication of existing efforts, to deepen and widen them. They further note that it also helps identify gaps in knowledge as well as weaknesses in previous studies.

This chapter provides an overview of Lesotho's geographic, demographic and health sector context. The chapter then discusses available studies undertaken on Lesotho and other countries on inequity and exclusion in health service delivery. Services delivery is a policy issue and this chapter also covers public policy theories their evolution, the views of their supporters and commentators and all forming part of the theoretical and conceptual framework.

## 2.2 The Country Lesotho

The Lesotho Demographic Health Survey (2009,) states that Lesotho is a small, mountainous kingdom situated in the southern part of Africa completely surrounded by the republic of South Africa. The country is divided into 10 administrative districts with a total area of about 30,355 square kilometres and Less than 10% of the land is arable. The Lesotho Demographic Health Survey (2009) indicates that the country is divided into two residential areas, urban and rural, with a population of 1,876,633 where almost 23% of the population live in urban areas.

Lesotho gained its independence from Britain on 4 October 1966. The country has battled with worsening trends in morbidity and mortality that weakens the country's human resource thus imparting negatively on production and growth.

## 2.3 Lesotho's Health Sector

According to the Health Sector Strategic Plan (2013) the Ministry of Health is the line ministry of Government of Lesotho (GoL) that is responsible for health issues including the development of health policies, standards and guidelines, mobilization of health resources and monitoring and evaluation of health sector interventions. It is also responsible for providing a legal framework within which health services are delivered.

Ramashamole & Thamae (2013) indicate that Lesotho is constitutionally mandated to ensure improved public health care and create accommodating environment in situations of illness by providing medical services and attention to all. Health services are provided at three levels namely primary, secondary and tertiary levels. There are 372 health facilities in Lesotho: 1 referral hospital, 2 specialty hospitals, 18 hospitals, 3 filter clinics, 188 health centres, 48 private surgeries, 66 nurse clinics and 46 pharmacies.

Health centres are the first point of care and aim to reduce the patient load at district and referral hospitals. In total 213 of these facilities belong to Ministry of Health (MoH) and Christian Health Association of Lesotho (CHAL). 42% of the health centres and 58% of the hospitals are owned by the MoH and CHAL owns 38% of the health centres and the same proportion of the hospitals. The remaining facilities are privately owned. About 90% of the private for profit health facilities are situated in the four large districts of Maseru, Berea, Mafeteng, and Leribe. There are nongovernmental organizations (NGOs) which provide health services. These include theLesotho Planned Parenthood Association with nine clinics located in urban centres, Lesotho Red Cross Society (LRCS) which operates four clinics, and Population Services International (PSI) operating voluntary counselling and testing (VCT) centres (Ramashamole & Thamae, 2013).

Lesotho has a “no fee” policy, making transport the only costs incurred by patients in health care access. Lesotho faces various health challenges which include high prevalence of HIV and AIDS, high maternal and infant mortality, poor sanitation infrastructure, and high out-of-pocket (OOP) expenditure for households that use private health-care services.

## 2.4 Health Care Related Studies in Lesotho

Lesotho’s health sector is diverse and is made up of both the private and public sector. Various studies have be undertaken with regard to the health sector, and most available and published studies are on HIV/AIDs and health care cost in Lesotho. On hospital and health care costs Pepperall, Garner, Fox-Rushby, Moji and Harpham (1995) indicate that hospital outpatient clinics in developing countries are overburdened and some policy experts were proposing a new intermediate tier of advanced health centres between hospitals and health centres to solve the problem. In Maseru, Lesotho Pepperall, Garner, Fox-Rushby, Moji and Harpham (1995) indicate that hospital congestion has led to the Ministry of Health to build health centres and to delineate precisely how the health centres were going to operate, utilization, quality and costs between health care centre and hospital outpatients care. Pepperall, Garner, Fox-Rushby, Moji and Harpham(1995) note that throughput per clinician at the hospital and the city health centres was similar, that the technical care quality was similar and that the health care centre staff took longer with patients and had higher interpersonal consultation score. Pepperall, Garner, Fox-Rushby, Moji and Harpham (1995) further notes that the average costs were 39%higher but calculated net costs to the provider at the hospital and government centre were very similar once user fees has been taken into account. The results of the study by Pepperall, Garner, Fox-Rushby, Moji and Harpham (1995) questioned the assumption underlying the decision to build reference centres in Maseru and also the relevance of a new tier to solve health service delivery problems in the city. The study highlighted the need for national and municipal planners to examine carefully existing health services with respect to utilization, quality and costs before adopting the urban reference centres as a standard solution to congested hospitals. However it is important to understand the factors behind the congestion in hospitals and this study attempts to address this by

investigating factors that result in inequity and exclusion in health services. It is plausible that hospitals are congested due to uneven and skewed distribution of health facilities in communities. Therefore, the built of more referral centres may address the problem of patient congestion in facilities due to skewed service delivery.

Ramashamole and Thamae (2015) undertook a study that assessed the factors behind the growth of health expenditure in Lesotho over the period 1980 - 2011. Ramashamole and Thamae (2015) revealed that income is one of the important factors explaining the growth of health expenditure in Lesotho, with public health expenditure being more responsive to changes in income than private health spending. Ramashamole and Thamae (2015) indicate that although the government's role in mitigating the disease burden maybe overshadowed by increased external funding, their findings highlight that the government is committed to improving the overall health of Basotho. Ramashamole and Thamae (2015) also note that public and private health expenditure follow different paths, with the ability of citizens to pay for their healthcare needs reducing the pressure on the government to offer more services. Ramashamole and Thamae (2015) further note that external aid programmes seem to have impacted positively on Lesotho's public health spending while reducing the burden on privately financed health services.

In summary, Lesotho is a developing country, with limited resources and most researchers are interested in just service delivery. The researcher intends to take a different angle of investigating inequity and exclusion in health service delivery.

### 2.5 Is There a Distinction Between Equity And Exclusion?

Whitehead & Dahlgren (2006) indicate that when investigating inequity and exclusion in health services delivery, it is important to establish the differences that prevails and are widely considered to be unfair as, they are generated and manifested by what are often referred to as unjust social arrangements and they offend common notions of fairness. Whitehead & Dahlgren (2006) note that equity and inclusiveness are seen as encompassing all members of society in the distribution of resources and making the most vulnerable groups a priority. There is inequity and exclusion where disparities

in the delivery of services due to social status, political affiliation, race or location exist. Not every member of society benefits from the delivered services and more so, the most vulnerable groups in society (the poor, orphans, elderly and vulnerable children).

UNESCAP (2006) indicates that equity on the other hand is concerned with what the final distribution of some good is therefore equity requires that goods be distributed according to principles that respect people's humanity. This is not specific to just individuals but should encompass all members of society. UNESCAP (2006) further notes that equal and inclusive governance is the one whose society's wellbeing is a priority and ensures that all its members feel that they have a stake in it and do not feel excluded from the mainstream of society.

Gisselquiet (2012) indicates that equity and inclusiveness is an initiative to include all groups in the decision-making process, and a result of the acknowledgement that minority groups have specific needs that have to be considered just as important as those of the majority. All members of society will be included in decision making process as the involvement of just the majority, symbolises exclusion of the minority. UNESCAP (2006) notes that, the most vulnerable communities have to be put on the same level as the majority in what regards to the gravity of their demands and facilitates finding solutions that apply to all levels and to all members of the society.

As reflected in the discussions above, there is little or no distinction in the definition of both inequity and exclusion and for the purpose of this study the researcher has concluded not to separate the two words but rather give inequity and exclusion a single meaning or definition.

### 2.6 Barriers to Inequity and Inclusiveness

In their study of overcoming barriers to health access Ensor & Cooper (2004) suggest that demand barriers maybe important as supply factors in deterring patients from obtaining treatment yet, little attention is given by both researchers and policy makers on ways of minimizing their effect. Ensor & Cooper (2004) indicate that these barriers are likely to be more important for the poor and other vulnerable groups, where the

costs of access, lack of information and cultural barriers impede them from benefiting from public spending.

Ensor & Cooper (2004) reviewed demand barriers present in low- and middle-income countries and evidence on the effectiveness of interventions to overcome these obstacles. The evidence by Ensor & Cooper (2004) suggests that interventions can be successful in raising demand, provided that supply is also improved. It suggests that in designing interventions, the communities should be fully involved in order to ensure that the resulting solution is socially acceptable.

Ensor and Cooper (2004) indicate that the focus of much health policy intervention has been on reducing supply barriers, particularly improving the quality of staff skills, protocols of treatment, availability of supplies and environment of health facilities. These interventions according to Ensor & Cooper (2004) are indeed essential for health services delivery but important also is ensuring that communication with the people to facilities is improved, provision of health education to avoid cases of shyness and objection by family and spouses and more involvement of traditional and religious leaders.

Ensor & Cooper (2004) further indicate that besides the policy priorities on supply barriers, there are multiple reasons why people fail to access health services and these includes difficulty by patients to get admission, doctors not available when needed, facilities too far from home, relatively high costs of services, a not very friendly attitude of service providers to clients and required medicines not always available. It is essential that these barriers be addressed as they impede people from accessing health services.

Szczepura (2005) reviewed the research evidence on access to health care by ethnic minority populations, and discussed what might need to be done to improve access to service. Szczepura (2005) presents evidence on access by ethnic minority populations, and considers what might need to be done to improve the situation. According to Szczepura (2005), the disparities in access to healthcare services for ethnic minority populations are similar in different parts of the world. Szczepura (2005) notes that healthcare organisations and their staff need to be culturally, as well as

linguistically, competent when delivering services. Szczepura (2005) stresses that improved responsiveness to the health beliefs, practices, and cultural needs of patients are clearly required to provide equitable access to health care for diverse populations. In conclusion, to fully address issues of access, inequalities in the quality of care received, as well as disparities in uptake of care, need to be examined and addressed.

Szczepura (2005) indicates that the main factor here to the disparities that exist in health care access is due to ethnicity. However, Szczepura (2005) notes that ethnicity is looked on here as the only barrier to health access and this research study aims to investigate multiple reasons. According to Szczepura (2005) for a particular ethic group, the believes may deprive an individual from enjoying certain services but for the case of this study, individuals are willing to access the services but there are difficulties in delivery, that is, some areas are services overloaded whereas others are inadequate. It is therefore important to explore other factors that lead to the existing problem of inequity and exclusion.

## 2.7 Equity Studies

The extent of inequity and exclusion is on the increase within countries thus equitable service delivery should be a priority for governments. Balarajan, Selvaraj & Subramanian (2011) in their study on health care and equity in India state that India's health systems face the ongoing challenge in responding to the needs of the most disadvantaged members of Indian society. They note further that, despite progress in improving access to health care, inequalities by socioeconomic status, geography and gender continue to persist and this compounded by high out-of-pockets expenditures and rising financial burden of health care. Balarajan, Selvaraj & Subramanian (2011) identified challenges to equity and they included imbalanced resource allocation, limited access to quality health services, inadequate human resources for health, out-of-pocket health expenditure, health spending inflation and behavioural patterns that affect the demand for appropriate health care. Balarajan, Selvaraj & Subramanian (2011) emphasise the need for the application of equity metrics in monitoring, evaluation and strategic planning, developing a rigorous knowledgebase of health

systems research, development of more equity focused processes of deliberative decision making in health reform and redefinition of the specific and accountabilities of key actors. In conclusion, Balarajan, Selvaraj & Subramanian (2011) indicate that the implementation of these principles, together with strengthening of public health and primary care services provides an approach for ensuring more equitable health care for India's population.

Balarajan, Selvaraj & Subramanian (2011) indicate that the challenges are a result of the use of supply-demand framework for health services. They indicate that in the supply-side, the critical issues related to achieving equity in service delivery include ensuring access to appropriate level of well-resourced services and on the demand side the critical issue was equity in health financing and financial risk protection and consideration of how the costs of seeking care may limit utilization, especially when out-of-pocket expenditures are extremely high.

The recommendations for strengthening health systems provided by Balarajan, Selvaraj & Subramanian (2011) are tangible solutions in all health systems failing to reduce inequities in health services delivery. Balarajan, Selvaraj & Subramanian (2011) discussed the factors leading to lack of equity in India's health systems. This study will investigate the factors leading to inequity and exclusion in the delivery of services in Lesotho, a country with a different context to that of India.

Smith & Goddard (2001) indicate that the pursuit of equity of access to health is a central objective of many health care systems. Smith & Goddard (2001) examined the extent to which research evidence has been able to detect systematic inequity of access in the United Kingdom, where equity of access has been the central focus in the National Health Service since its inception in 1948. Smith & Goddard (2001) studied assess inequity between different socio-economic groups and the extent of inequity in access in five service areas being general practitioner consultations, acute hospital care, mental health services, preventive medicines and health; and long-term health. Smith & Goddard (2001) undertook a document analysis where ten bibliographical databases were searched electronically using key words and phrases associated with access to and utilisation of health care services. Their search strategies were designed by staff of the National Health System centre for Reviews

and Dissemination at New York to locate published material relating to equity of access to the five service areas of interest. Smith & Goddard (2001) also included unpublished material, including studies in progress and those undertaken at regional and health authority level with no intention of being published. Smith & Goddard (2001) conclude that there were important inequities in access of some types of health care in the United Kingdom. Smith & Goddard (2001) indicate that however, it was difficult to establish the causes of inequity which in turn limited the scope for recommending appropriate policy to reduce inequity of access. Smith & Goddard (2001) focused on inequity in access to health services between different socio-economic groups and their area of focus differs from this study as it focuses on inequity and exclusion I health care delivery for all, not being specific to any socio economic group.

Doty & Schoen (2004) focused on inequity in access to medical care in five countries. Their objective was to examine the inequity in access to health care and quality experiences associated with income and to determine whether the inequity persist after controlling for the effect of insurance coverage, minority and migration status, health and other important co-factors. Doty & Schoen (2004) undertook a multivariate analysis of a cross sectional 2001 random survey of 1400 adults in five countries. Doty & Schoen (2004) conclude that the five nation survey demonstrated that the reliance on private coverage to supplement public coverage in Australia, Canada and New Zealand can result in access inequity even within the health systems that provides basic health coverage for all.

According to Schellenberg, Victoria, Mushi, de Savigny, Schellenberg, Mshinda & Bryce (2003), few studies have been undertaken to assess socioeconomic inequity in African countries. They sought evidence of inequity in health care by sex and socioeconomic status for young children living in a poor rural of Southern Tanzania. Schellenberg, Victoria, Mushi, de Savigny, Schellenberg, Mshinda & Bryce (2003) conducted a baseline household survey of a cluster sample of 2006 children younger than 5 years in four rural districts. The questions of the survey focused on the extent to which carers' knowledge of illness, care-seeking outside the home and care in health facilities were consistent with IMCI guidelines and messages. Schellenberg, Victoria, Mushi, de Savigny, Schellenberg, Mshinda & Bryce (2003) indicate that their findings demonstrate care seeking behaviours being far worse in poorer than in

relatively rich families, even within a rural society that might be assumed to be uniformly poor.

Schellenberg, Victoria, Mushi, de Savigny, Schellenberg, Mshinda & Bryce (2003) indicate that a possible explanation on their findings is that health care information is not well disseminated to households or rather not disseminated at all. Schellenberg, Victoria, Mushi, de Savigny, Schellenberg, Mshinda & Bryce (2003) further notes that health care centres or facilities are very remote, leading to individuals having a little or no knowledge at all of them. Consequently, it is crucial that this study investigates the factors behind inequity and exclusion that exists in the distribution of health services. The results may assist in eliciting why care seeking behaviours are poor for poorer families which are mostly situated or found in rural communities.

In South Africa Harris, Goude, Ataguba, McIntyre, Nxumalo, Jikwana & Chersich (2011) undertook a study on equity in access to health care in South Africa, where little was known about access barriers to health care for the general population. Harris, Goude, Ataguba, McIntyre, Nxumalo, Jikwana & Chersich (2011) explored affordability, availability and acceptability of services through a nationally representative household survey that covered utilization, health status and reasons for delaying care, perceptions and experiences of services and health care expenditure. Harris, Goude, Ataguba, McIntyre, Nxumalo, Jikwana and Chersich (2011) indicated that understanding access barriers from users' perspective is important for expanding healthcare in South Africa and in other low and middle - income countries.

Mills, Ataguba, Akazili, Borghi, Garshong, Makawia, Mtei, Harris, Macha, Mehues and McIntyre (2012) undertook a study on equity in financing and use of healthcare in Ghana, South Africa and Tanzania. Their focus was on equity implications of different financing mechanisms and patterns of service use. Mills, Ataguba, Akazili, Borghi, Garshong, Makawia, Mtei, Harris, Macha, Mehues and McIntyre (2012) used primary and secondary data to calculate the progressivity of each financing mechanism, catastrophic spending on healthcare and the distribution of healthcare benefits. They collected qualitative data to inform interpretation. Mills, Ataguba, Akazili, Borghi, Garshong, Makawia, Mtei, Harris, Macha, Mehues and McIntyre (2012) conclude that

the overall distribution of service benefits in all three countries favoured the richer people although the burden of illness was greater for lower income groups. Mills, Ataguba, Akazili, Borghi, Garshong, Makawia, Mtei, Harris, Macha, Mehues and McIntyre (2012) further notes that access to needed appropriate services was the biggest challenge to universal coverage in all three countries.

Equity is very significant in healthcare, be it health care financing or delivery. Mills, Ataguba, Akazili, Borghi, Garshong, Makawia, Mtei, Harris, Macha, Mehues and McIntyre (2012) interest was more on financing, and wanted to ensure everyone is included in health care access no matter their financial or employment status. However in order to address this problem, it is essential to understand the factors behind it and this justifies the focus of this study.

## 2.8 Summary

The literature covered mainly contains studies closely related to the focus of this study on inequity and exclusion in the delivery of health services. The focus was mainly on inequity in access, which is on the inability to receive health care by individuals, and the disparities identified were mainly by income and between different socio-economic groups. Health care delivery is a supply issue and it is important to investigate the factors behind the problem of inequity and exclusion in health care delivery by service providers. , Further, there seems to be a convergence around income as a contributing factor to the unfair disparities that exist in health care access as demonstrated by the survey undertaken among the households in South Africa by Mills, Ataguba, Akazili, Borghi, Garshong, Makawia, Mtei, Harris, Macha, Mehues and McIntyre (2012). This study aims to establish whether access would not be a problem at all if services were brought closer to the people, well-resourced and affordable.

The literature also demonstrates that health financing is another major problem to equitable and inclusive health service delivery. However, as limited as health resources are for many countries, the financing of health care needs to be equitable, that is, all citizens should receive similar care and distribution should be even at all times.

The literature also highlighted difference in access to services or care in communities among different groups and the need for care is highest among poor people, the least educated, women, youth, and rural based and yet these groups have low access to appropriate services. This study will further add to the existing knowledge by focusing on factors that are behind the inequity and exclusion in health services in Maseru, Lesotho.

## 2.8 The Academic Field of Study Driving the Research

Parsons (1995) indicates that service delivery is a state role and a policy issue thus the study is situated in the field of public policy. According to Parsons (1995) public policy has to do with the spheres which are designated as public as opposed to those regarded as private. To Parsons (1995) the public comprises the dimension of human activity that requires government or social regulation or intervention or at least common action. Parsons (1995) further notes that public policies are generally concerned with how, why and to what government pursue particular courses of action and inaction that is, what governments do, why they do it and what difference it makes.

In their course of action, governments follow policy processes which involve identification of public issues and problems. To identify problems, policy makers need to touch base with the people, hear what their problems are and the problems forms part of policy. However, identified problems are in most cases many and have to be prioritised during implementation. During implementation of plans, there is need for monitoring and once it is complete there is need for evaluation to ensure all set goals are achieved.

In policy decisions, policy processes are essential but often governments fail to adhere to all the processes and this often results in failure to accomplish the intended or best result. For instance, when problems are identified, often beneficiaries are exempted and as a result, government's delivers what is not a need of the people or addresses what is not regarded a priority area by the people. The researcher is aware of all

essential steps to follow but is however more interested with implementation as it is the core of service delivery.

## 2.9 Theoretical Framework

There are various theories and models of public policy that can be applied to this study. This section reviews some of the theories that drive the research. Particularly, the discussion on theories focuses on the events that led to the development of the theories, what they explain, their advantages and disadvantages and their limitations. Also to be outlined are the views of the supporters and commentators of the theories.

### 2.9.1 Rational Choice Theory

Ham and Hill (1993) indicate that the Rational Choice Theory dates as far back as 1945, when the pioneer of rational models, Herbert Simon published his book Administrative Behaviour which contributed to decision making within organisations. Ham and Hill (1993) note that Simon argues that administrative theories have to be concerned with the processes of decision making, the processes of action and must take decision making as a central focus. According to Ham and Hill (1993) there might be a number of ways of reaching decisions in organisations but when faced with the need to make a choice, rational decision makers should choose the alternative that is most likely to achieve the desired results. Ham and Hill (1993) indicate that rational decision making involves the selection of the alternative which will maximise the decision maker's values, the selection being made following the comprehensive analysis of alternatives and their consequences. Ham and Hill (1993) further indicate that the selection of the best alternative is conducive for the achievement of organisational goals and objectives.

Ham and Hill (1993) identified several difficulties with this approach and are listed below:

- It is important to establish whose values and objectives are to be used in the decision making process as organisations are not homogeneous entities

and the values of an organisation may differ from those of individuals within it.

- It makes little sense to refer to goals as organisational goals since such goals are implemented by individuals and groups who have discretion in interpreting the goals. And it is plausible to argue that such policies or goals may undergo reformulation as they are implemented.

- The application of this is not as logical as it sounds to be. In practice, it is almost impossible to consider all available alternatives during decision making processes, knowledge of alternatives consequences is necessarily incomplete and evaluating these alternatives involves considerable uncertainties.

Parsons (1995) indicates that amongst the notable responses to rational choice theory is by Charles Lindblom who sets out his initial objection to the notion of decision making as a rational process. According to Parsons (1995) Lindblom and Simon have much in common when it comes to analysis of rationality but Lindblom diverges from Simon due to the belief that decision making can or ought to be improved in ways that Simon's managerialism suggests. Parsons (1995) indicates that Linblom criticises both the notion of rational decision making and rational analysis. According to Parsons (1995) Lindblom's works have nothing against analysis but are hostile to the ideology that rational analytical techniques could in some way supplant the need for political agreement and consensus. In addition Parsons (1995) states that, for rationalist's decision making ought to conform to some neat set of steps in which improvements are possible by virtue of the growth in knowledge and technology. According to Parsons (1995) defining goals, selecting alternatives and comparing options results in good decision making that meets the objectives.

As stated by Neuman (2005) the Rational Choice theory orients around the idea that all action is fundamentally 'rational' in character and that people calculate the likely costs and benefits of any action before deciding what to do. Neuman (2005) indicates that Rational Choice Theory denies the prevalence of others actions except those that

are seen as purely rational and calculative. Neuman (2005) argues that all social action can be seen as rationally motivated, as instrumental action however much it may appear to be irrational or non-rational. The theory is therefore much applicable when looking at the rationality over the decisions made.

According to the rational choice theory as stated by Scott (2000) the individuals or groups are seen as motivated by the wants or goals that express their 'preferences' meaning, the people are informed of what the services available are and what options are open to them hence the expectation is for them to be calculative in making a choice. Scott (2000) further indicates that the theory sees individuals as acting within specific limits or boundaries portrayed, on the basis of the information that they have about the conditions under which they are acting, that is the stipulated rules of the game. Scott (2000) notes that for rationalists, information is important and the rural based individuals are less informed and therefore are in no state to make informed decisions.

In the case of this research the decision maker is government making choices for society at large. In relation to this theory factors behind inequity and exclusion in the delivery of health services relates to exclusion of the needs of the less informed individuals in decision making and their preferences. The theory is not suitable for this study as it focuses on the satisfaction of individuals' needs and preferences and government is about service delivery for the common good of all its members.

### 2.9.2 Elite Theory

According to Parsons (1995) the Elite Theory challenges the view that power is distributed in the manner described by the pluralists. Parsons (1995) indicates that the theory was developed by the classical elitists Pareto and Mosca who argue that the existence of the political elite is a necessary and indeed inevitable feature of all society. Parsons (1995) notes that according to the theory decision making is a process which works at the advantage of the elites. Parsons (1995) further notes that Pareto and Mosca state that all societies from those meagrely developed and have barely attained the dawning's of civilization, down to the most advanced and powerful, two classes of people exist, a class that rules and a class that is ruled. According to Pareto and Mosca

as noted by Parsons (1995) the first class is always the less numerous, performs all political functions, monopolises power and enjoys all the advantages power brings. Parsons (1995) citing Pareto and Mosca indicates that the second class is however the more numerous, directed and controlled by the first, in a manner that now is more or less legal, now more or less arbitrary and violent. Parsons (1995) notes that to them elitism is inevitable, a classless society is a myth and democracy is a little more than a sham.

Ham and Hill (1993) indicate that later there were writers like C. Wright Mills who pointed to the concentration of power in the hands of the minority of the population. Ham and Hill (1993) note that Mills' book The Power Elite draws attention to institutional position as a source of power, and suggests that the United States of America's political system is dominated by a powerful military industrial complex.

According to Lopez (2013) the concept of 'elites' is based on the notion that every society holds a ruling minority, a group that controls and disputes the most important power sources. Lopez (2013) indicates that not only do elites dispute power but new elites also enter the game through different mechanisms of elite recruitment.

> *"In modern societies the power of elites, small and increasingly professionalized ruling minorities is constrained by legal-constitutional rules and practices, yet elites usually have enough autonomy to interpret laws, modify rules, and alter public responsibilities in ways that protect their interests" Higley andPakulsk (2012)* .

Higley and Pakulski (2012) indicate that the elites in society are normally the wealthy and the learned, and they generate the support of non-elite populations by employing formidable coercive machines of states, persuasive powers of mass media, and payoffs to discontented groups. Higley and Pakulski, (2012) further points out that the elites mostly rely on persuasion; and coercion is always a possibility if their vital interests are threatened.

Neverauskas and Tijūnaitienė (2015) view the elite theory as based on the hierarchical conception of society and maintains that very powerful group of people exercise

disproportional influence on policy formation. Neverauskas and Tijūnaitienė (2015) indicate that the “very powerful group of people” is the ruling elite and makes influence on either the municipality and local policy on the backstage. Neverauskas and Tijūnaitienė (2015) note that the picture of this society displays power of the local authority being concentrated in the hands of the privileged minority, and leaves the majority even more disadvantaged. Neverauskas and Tijūnaitienė (2015) argue that the roots of the elite authority can be its personal wealth-being, political position, employment position or social class.

The elite theory is about decision making for a few and ignoring the interests of the majority. Only a selected few have a say in decisions that affect the whole society and it does not resonate with the objectives of this research. If the Elite Theory was to be employed here to elicit the factors that lead to the problem of inequity and exclusion in the delivery of health services, the answers will be the exclusion of the majority in decision making. Consequently, the theory will be applicable where decision making favoured the interests of the few and not society at large.

### 2.9.3 Institutional Theory

Parsons (1995) indicates that the Institutional Theory was first developed by Philip Selznick and its role was setting the agenda of micro analysis in terms of a functionalist perspective of how institutions really worked on the inside as opposed to what their structures presented as their formal outside rationale. According to Parsons (1995) Selznick indicates that organisational life appeared to be a rational like tool on the outside and adopting the Structural Functionalist Model organisations could be revealed as far more complex “living”, organic systems that adapt to their external environment in order to maintain their existence as institutions, rather than the goals and purposes for which they are established. Parsons (1995) citing Selznick indicates that consequently there is a tension between the rational formal goals of an organisation and the capacity of human beings who actually make decisions to be concerned with the maintenance of the irrational and informal goals of systems maintenance. Selznick as cited by Parsons (1995) argues that as we inspect formal structures we begin to see that they never succeeded in conquering the non-rational dimensions of organisational behaviour. Parsons (1995) indicates that the focus of

Institutional analysis should therefore be the way in which organisations interact with their environments so as to adapt and thrive. In conclusion, Parsons (1995) citing Selznick indicates that the decision making which takes place in organisations is influenced by its dependence on the environment on which it is situated rather than formal, rational considerations.

Scaraboto and Fischer (2013) refer to institutions as persistent practices, understandings, and rules shared by actors in an organizational field. Scaraboto and Fischer (2013) indicate that the organizational field involved produces related outputs and uses related resources such as those in the health care and accounting. Scaraboto and Fischer (2013) further note that Institutional Theory has been used by various scholars to examine organizational fields and understand how individual actors, firms, or entire markets gain or maintain legitimacy. Scaraboto & Fischer (2013) further emphasise that legitimacy is a central notion in Institutional theory. They note that it takes various forms, in particular regulative, normative, and cultural-cognitive legitimacy. Scaraboto and Fischer (2013) explain the forms of legitimacy in the following manner:

- Regulative legitimacy as referring to being sanctioned by explicit rules or policies.
- Normative legitimacy referring to congruence between the social values associated with or implied by actors and the norms of acceptable behaviour in the larger social system and cultural cognitive legitimacy being the degree of fit with existing cognitive and cultural schemes.

According to Carpenter (2001) Institutional Theory assumes that organisations adopt structures and management practices that are considered legitimate by other organisations in their field regardless of their usefulness. Carpenter (2001) indicates that such structures and practices can be transmitted into organisation traditions, imitation by coercion or through normative pressures.

Institutional Theory is about the organisation, individual's behaviour and how they carry out common activities. According to the theory, there are rules and regulations,

procedures and objectives within organisations and these institutions are to shape the behaviours of the individuals in pursuit of a common goal. This theory is applicable when focusing on the impact of institutions in delivery of equitable and inclusive health services. However, this theory is not applicable to this study as it aims to identify the factors leading to the problem of inequity and exclusion in the delivery of health services.

## 2.10 Conceptual Framework

A conceptual framework is defined as an advanced outline of how a research should proceed after interrogating key literature on a research interest. The Pluralist Theory was adopted to guide how this study would be undertaken and is discussed below.

### 2.10.1 Pluralist Theory

According to Ham and Hill (1993) Pluralist Theory is a theory of democracy and central to it are group activities. Ham and Hill (1993) indicate that the theory was first developed by Dahl who argues that power in Western industrialised societies is widely distributed among different groups and no group is without power to influence decision making, and equally no group is dominant. Ham and Hill (1993) indicate that the theory insists that any group can ensure that its political preferences and wishes are adopted if it is sufficiently determined. According to Ham and Hill (1993) the importance of pluralist theory is demonstrated by the fact that implicitly its assumptions and arguments now pervade much Anglo-American writing and research on politics, government and the state.

According Parsons (1995) citing Dahl the United States' political system did not constitute a homogenous class, with well-defined class interests. Parsons (1995) indicates that in New Haven the political system was easily penetrated by anyone whose interests and concerns attracted them. Parsons (1995) notes that in the Pluralist Haven participation  the great game of politics was open to all and central to this was conflict.  Parsons (1995) argues that although all groups and interests do not

have the same degree of influence, but, even the least powerful are able to make their voices heard at some stage in the decision making process.

Central to Pluralist Theory is participation and the theory advocates more in voicing the voices of the voiceless in this decision making. Through group work, members of communities can make their voices heard by government and ultimately have their needs implemented. In cases where participation is not easy, protests can be made until the voices of the people are heard.

Parsons (1995) citing Schattschneider challenges the Pluralist liberal view and argues that ; “it is not necessarily true that people with greatest needs participate in politics most actively – whosoever decides what the game is about also decide who gets in the game”. Schattschneider as cited by Parsons (1995) argues further that an essential power of government is the power to manage conflict before it starts. According to Parsons (1995) for Schattschneider the scope and extent of conflict is limited and framed by the dominant players in the political game and the political domain is not as open as the pluralists maintain. Parsons (1995) citing Schattschneider explains that the game played is the game structured by rules which suit the top players: pressure groups, political parties and institutions.

Parsons (1995) criticized Dahl, and citing Bachrach and Baratz (1994) argues that the pluralist case had failed to appreciate the extent to which those with power can actually exclude issues and problems from decision-making agenda. Parsons (1995) citing Bachrach and Baratz (1994) further states that politics are not simply about who gets what, when and how but also who gets left out, when and how. According to Parsons (1995) Bachrach and Baratz (1994) developed a term, non-decision making which involves the constriction or containment of decision-making so as to focus on safe issues by manipulating the dominant community values, myths and political institutions and procedures. Bachrach and Baratz (1994) according to Parsons (1995) state that bias against certain interests in society maybe routinized and make it very difficult for certain demands to penetrate the black box of the political system. Parsons (1995) further notes that power is not simply the control of observable behaviour and decisions. Non-decision making suggests that policy makers with power have a capacity to keep issues off the agenda which they control.

According to Neverauskas (2015) the Pluralist Theory was first developed as a reaction to the Elite Theory and its criticism as de Socio maintains. Neverauskas (2015) indicates that in this theory power decentralisation is considered to be a desirable component of representative democracies. Neverauskas (2015) further notes that people or groups of people are inclined to make political commitments in problem areas within their interest and/or competence. The pluralist theory is about giving power to the people so that, even those at grassroots level makes decisions based on their needs.

Neverauskas (2015) states that actions are constructive in the pluralistic decision-making theory and based on the influence of group power on authority. According to Neverauskas (2015) influence or power is divided among groups with rival interests resulting to the process of municipal governance and city development, which may seem to be chaotic but in fact shows what he refers to as “the wonders of democracy” in terms that political control is effectively revealed by a necessity to react to a big group of electors.

Schumaker (2013) views pluralist theory as a theory of city politics that has receded from being a primary to a tertiary approach used by political scientists in the study of city politics. Schumaker (2013) views pluralist politics as involving such things as the key roles of political leaders, significant “indirect influence” by the unorganized public, and a “democratic creed” comprising basic normative principles that both influenced political outcomes and constrained group struggle. Neverauskas (2015) indicates that most disciplinary understandings of orthodox pluralism emphasize the importance of group activity, conflict, and influence and separation of decision-making processes and unpredictable results of negotiation processes between rival groups helps to bind people and groups to democratic processes. Mouffe (2016) notes that because groups are involved pluralist democracy demands a certain amount of consensus to make decisions.

This research study aimed to identify the factors that hinder equal distribution of health services in Maseru. The study investigated whether all members of the community take part in decision making that concerns them, decision making processes and

whether their decisions form part of policy. Representation is important in decision making and is debated between rivals resulting in consensus. Ultimately, the decisions reached should represent the interest of all members of society.

# 3 RESEARCH METHODOLOGY

## 3.1 Introduction

According to Wagner, Kawulich and Garner (2012), research methodology is where assumptions about the nature of reality and knowledge, values, theory and practice on a given topic comes together .It involves all the processes, the kind of tools and procedures employed in order to gather data. Detailed in this chapter are the processes and tools employed when undertaking this research. The researcher investigated the factors behind inequity and exclusion in the delivery of health services in Maseru, Lesotho.

Multiple studies have been undertaken on equity in health in different countries and for their study Smith and Goddard (2001) indicate it was difficult to establish the causes of inequity which in turn limited the scope for recommending appropriate policy to reduce inequity of access. Therefore it was important to carry out the study on factors behind the prevailing inequity and exclusion in the delivery of health in Maseru, Lesotho, where a policy of no fee for primary health care exists, to be able to determine which policies can be formulated and strategies implemented to ensure equitable and inclusive delivery of services.

This section will provides the details of research approaches adopted to address the research issues stipulated above. The chapter provides details on the research approach, design, sampling methods, data collection tools, data analysis procedures, study limitations, validity and reliability and significance of the study.

## 3.2 Research Approaches

There are two approaches in social science research namely qualitative and quantitative research.

### 3.2.1 Quantitative Research

Maree (2007) indicates that quantitative research is a process that is systematic and objective in its ways of using numerical data from only selected subgroup of a universe or population to generalise the findings to the population that is being studied. Maree (2007) notes that whereas it has been defined differently by many authors, what is most essential to quantitative study is numerical data, objectivity and generalizability. According to Wagner, Kawulich and Garner (2012) quantitative research can be defined as a type of research which aims to describe social phenomena through systematic numerical means such as the application of mathematical or statistical processes). Bless, Higson-Smith & Sithole (2013) citing Biggam (2008) indicate that it can also be referred to a more scientific way of carrying out research since it is concerned with quantities and measurements.

Wagner, Kawulich and Garner (2012) and Babbie (2001) view quantification as an advantage as it often makes observation more explicit. They argue that it also makes it easier to aggregate, compare and summarise data. Quantitative data usually comes from different sources and captured on different scales. There are various measurement scales which are but not limited to nominal, ordinal, interval and ratio and each one is based on the amount of Information or the characteristics of the information in the data.

Wagner, Kawulich and Garner (2012) indicate that quantitative approach is associated with the positivism paradigm which holds that scientific method is the only way to establish truth and objective reality. According to Wagner, Kawulich and Garner (2012) positivism is based upon the view that science is the only foundation for true knowledge. Wagner, Kawulich and Garner (2012) further indicate that it further holds that the methods, techniques and procedures used in the natural sciences offer the best framework for investigating the social world. Wagner, Kawulich and Garner (2012) note that the paradigm reflects a strict empirical approach in which claims about knowledge, are based directly on knowledge, emphasises facts and causes of behaviour. Wagner, Kawulich and Garner (2012) indicate that positivism is typically applied in the scientific methods to the study of human and it is viewed as an

objectivist, that is, objects around us have existence and meaning independent of our consciousness of them.

Wagner, Kawulich and Garner (2012) indicate that the quantitative approach collects data in the form of numbers to explain social phenomena, determine the relationship between variables and look for the cause and effect. Wagner, Kawulich and Garner (2012) note that the scientific reasoning the approach undergoes can be inductive, deductive or reproductive. Wagner, Kawulich and Garner (2012) indicate that if the reasoning is inductive, the explanation of the phenomena is made by first gathering information about a sample of people and then generalising the findings to a similar larger group. Wagner, Kawulich and Garner (2012) further note that deductive reasoning is used to test a social theory which involves generating research hypothesis from a theory and collecting evidence to support or reject its explanation of a phenomena.

There are various concepts in quantitative research that a researcher needs to familiarise with and they include the sampling unit, population, sampling frame, sample, variables, validity and reliability. According to Nueman (2014) quantitative research puts more emphasis on precisely measuring variables and testing hypothesis and usually tries to falsify or verify the relationship between variables.

Wagner, Kawulich and Garner (2012) indicate that quantitative research is prescriptive in nature and its methods are unique to a particular study and/or context According to Wagner, Kawulich and Garner (2012) the kind of data produced or collected here offers advantages that numbers have over words as measure of quality but they also carry the disadvantages that numbers have, inclusive of potential loss in richness of meaning. As noted by Wagner, Kawulich and Garner (2012) there are even rules concerning the most appropriate sample sizes in quantitative research and they are often bigger than those of qualitative research.

### 3.1.2 Qualitative Research

Wagner, Kawulich and Garner (2012) indicate that qualitative research is the type of research that seeks to interpret or make sense of phenomena in terms of the meanings they have from a participant. Wagner, Kawulich and Garner (2012) further note that qualitative research describes the phenomena as per the respondent point of view. It is concerned with understanding the processes and the social and the cultural contexts which shape various behavioural patterns. Wagner, Kawulich and Garner (2012) note that the believe here is that truth lies within human experience and strive to create a coherent story as it seen through the eyes of those who are part of the story, to understand and represent their experiences and actions as they encounter, engage with, and live through situations. According to Wagner, Kawulich and Garner (2012) qualitative research employs a wide range of data gathering techniques, (inclusive of interviews, focus groups, observations etc.) and seeks insights through structured, in-depth data analysis that is mainly interpretative, subjective, impressionistic and diagnostic.

Biggam (2008) indicates that qualitative research is linked to in-depth exploratory work where the opportunity for quality responses exists. According to Wagner, Kawulich and Garner (2012) it is also due to its intense and in-depth nature that sample sizes tend to be small. Maree (2007) indicates that qualitative research is flexible, involves smaller sample sizes and often continues no new themes that emerge from data collection processes. According Wagner, Kawulich and Garner (2012) the selection of qualitative sample size is determined by the method used in data collection but should however not be too small as it will be difficult to achieve data adequacy.

According to Wagner, Kawulich and Garner (2012) researchers often employ qualitative research in instances where they are looking at deep and rich research data collected overtime in context. Qualitative research according to Biggam (2008) involves studying things in their natural setting, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them. Biggam notes that it is important on qualitative to interpret the problem from the respondents point of

view as the subject of the study are the most familiar with the problem and live within the context.

The researcher investigated the factors behind lack of inequity and exclusion in the delivery of health services in Maseru and employed qualitative research approach as it relies mostly on participants' responses. The approach assisted the researcher to obtain answers to what the factors are behind the existing inequity and exclusion in the delivery of health services in Maseru, Lesotho. Qualitative research allowed for an in-depth study that permitted the researcher to seek and arrive to an understanding of the problem from the perspective of those experiencing it unlike with quantitative approach where only numbers could be revealed as it is about quantifiable data. Qualitative research according to Maree (2007) is based on a naturalistic approach that seeks to understand phenomena in context or real world setting, and in general, the researcher does not attempt to manipulate the phenomena of interest.

Qualitative approach has been linked with positivism. According to Babbie and Mouton (2001) it is objective nature, offers the advantages that numbers have over words as measures of some quality. Babbie and Mouton (2001) further indicate that it also requires a researcher to use scientific methods of gathering data to achieve objectivity. Wagner, Kawulich and Garner (2012) indicate that the purpose of quantitative research is to predict results, test a theory or find the strength of relationship between variables and therefore was not useful to this research as it is more about individual's perceptions and knowledge of the problem. Additionally, qualitative research is aligned to Interpretative paradigm and is related to concepts that address understanding the world as others experience. The belief here is that knowledge is subjective because it is socially constructed and mind dependent. And most importantly, qualitative research purpose is to understand peoples experiences hence was employed in this research and helped find out the factors behind inequity and exclusion in the delivery of health services in Maseru, Lesotho.

## 3.3 Research Design

As stated by Badenhorst (2008) research design involves choosing a research paradigm, a methodology, and data collection methods and data analysis. Badenhorst (2008) indicates that there are various designs that can be employed in qualitative data collection, analysis and presentation. For this study the researcher employed Basic Interpretive Study as it exemplifies all the characteristics of qualitative research. According to Merriam (2002) Basic Interpretive Study is based on the researcher's interest in understanding how participants make meaning of the situation or phenomenon, and this meaning is mediated through a researcher as an instrument. The strategy is inductive and the outcome is descriptive.

According to Merriam (2002) in conducting a basic interpretive study, a researcher seeks to discover and understand a phenomenon, a process, the perspectives and worldviews of people involved or a combination of these. Merriam (2002) states further that data is collected through interviews, observations or document analysis. The data is inductively analysed to identify the recurring patterns or common themes that cut across the data.

As reflected, the researcher intended to understand what factors are behind inequity and exclusion from the supply side that is, the people who are delivering health services, and find out the possible barriers to the provision of equitable or fair allocation of health care services to all Basotho. The research subjects are health sector management as the decision making body, made up of departmental and sectional heads of the Ministry.

Furthermore, secondary data comprising ministerial documents such as strategic plans, Budget Estimates Books and reports were used. In these documents, the researcher explored the ministerial plans and budget allocated for implementation of equitable and inclusive health care services.

### 3.2.1 Sampling

According to Maree (2007) there are two major classes to which sampling methods are categorised and these are probability or non-probability. Maree (2007) notes that probability sampling is a random process in which everyone in the population has an equal chance of being selected whereas non-probability sampling is non-random, that is, people are included in the sample because they are available and willing to participate in a study. Maree (2007) states that probability methods as based on the principles of randomness and probability theory while non-probability methods are not thus, probability samples satisfy the requirements for the use of probability theory to accurately generalise the population while this not case with non-probability .

The intension of the study was to obtain information from people that are available, resourceful and knowledgeable on the subject matter under investigation. The researcher engaged Purposive Non- Probability Sampling as according to Wagner, Kawulich and Garner (2012) it relies on the researchers' experience on previous research or ingenuity to find the participants in such a manner that they can be considered to be representative of the population and usually uses specific selection criteria to identify the most suitable individuals

Babbie and Mouton (2001) indicate that purposive sampling is mainly based on researcher's judgement and purpose of the study. The individuals selected were purposeful as they form part of the decision making team at the Ministry of health and the researcher trusts his knowledge helped him yield the desired results. The sample is built of the health Management team. These are individuals involved in the planning, Implementation and evaluation of health services delivery in the country.

### 3.4 Data Collection

According to Maree (2007) the primary goal of qualitative research is to explore and understand a central phenomenon, which is the concept or process explored in qualitative study. Maree (2007) indicates that qualitative researchers collect words or

texts and imagines about the central phenomenon. The researcher was an instrument of data collection and semi-structured interviews were conducted.

According to Maree (2007) the main types of qualitative data include among others individual and focus groups interviews, observations, documents and audio-visual material. These types are defined by Maree (2007) as the transcripts of interviews from participants, notes and pictures taken by the researcher during interview, public and private documents about the problem and pictures and audio recordings of people, places and events under study.

Babbie and Mouton (2001) indicate that data is classified into two, primary and secondary data. Babbie and Mouton (2001) note that primary data is what a researcher has collected from the field, through the use of interviews, questionnaires and observations whereas secondary data is data that existed when research began. Babbie and Mouton (2001) further explain that secondary data include the already existing recordings, both public and private. For the purposes of this study, the researcher employed both primary and secondary data.

### 3.4.1Primary Data

For primary data collection, the researcher conducted semi-structured interviews and the instrument was specifically designed to elicit information that will be useful for analysis. According to Maree (2007) the aim of interviews is always to obtain rich descriptive data that will help one understands the participant's construction of knowledge and social reality.

Open ended questions which are defined as questions which a respondent is asked to provide his or her own answers are mostly used in qualitative in depth interviewing as noted by Babbie (2013). However, this was not an option for this study as the researcher needed to probe in cases where responses were not clear. In this case semi-structured interviews were used as they enabled probing and clarification of answers as indicated by Maree (2007).

### 3.4.2 Secondary Data

Document analysis involves the use of paintings, historical writings, reports based on official statistics, government records, mass media, novels, drawings, personal works such as dairies and biographies, archaeological remains and the World Wide Web. Together with the use of semi-structured interviews, the researcher employed available records such as the National Health Policy, National Health Strategic Plans and budget estimate books to elicit the ministries plans on equitable and inclusive health service delivery. These are governance strategies and trends within the Ministry of Health thus are important for this study.

## 3.5 Data Analysis and Presentation

Neuman (2014) indicates that data analysis refers to a search for patterns in data such as recurrent behaviours, objects, phases and ideas. Neuman (2014) notes that analysis involves examining, sorting, categorizing, comparing, synthesizing and contemplating the coded data as well as reviewing the raw and recorded data.

Wagner, Kawulich and Garner (2012) indicate that thematic analysis is a general approach to analysing qualitative data that involves identifying themes or patterns of data. Thematic analysis was used to analyse the data collected from the interviews. Data collected was organised through the processes of reading, coding, writing and theorising and these are key phases in data analysis as indicated by Tuckett (2015).

## 3.6 Reliability and Validity

Reliability and validity in qualitative research refers are concepts used to ensure the quality of the research process. For data collection, semi-structured interviews were conducted and this called for triangulation which according to Wagner, Kawulich & Garner (2012) involves multiple strategies to ensure what is presented as research findings is credible and authentic.

## 3.7 Significance of the Study

This research aimed to identify the factors leading to lack of inequity and exclusion in health service delivery in Maseru, present findings of the study and provide recommendations on how better can the Ministry distribute the resources.

## 3.8 Limitations of the Study

The study was conducted among the Management of the Ministry of Health and data is collected using interviews thus the following were the limitations identified and should be taken into account when considering the findings of this research.

- The research focused on the factors behind inequity and exclusion and some of the health management (from other sections) were not willing to participate hence such departments were not represented.
- The context and setting of this research was in Maseru Lesotho, and it is characterised by both urban and rural. This study was focused only on Maseru and did not take into account other districts thus hinders the findings generalizability.

## 3.9 Ethical Considerations

The participation into this research process is voluntary and the researcher assumed responsibility to protect the interest of participants. Privacy, anonymity and confidentiality were ensured.

# 4 RESEARCH FINDINGS AND ANALYSIS

This chapter presents the main findings from the interviews. It provides an analysis of findings derived from interviews conducted with eleven (11) participants. The interviews focused on addressing the main research questions, namely a) **establishing the factors leading to the problem of inequity and exclusion in health access in Maseru district**, b) **identifying and assessing governance trends and strategies in the Ministry of Health and** c) **implications for inequity and exclusion particularly with respect to access to health services**. The analysis and findings are presented based on the following categories: description of participants, inequity and exclusion, decision making and citizen's participation. This chapter ends with a conclusion on the main findings.

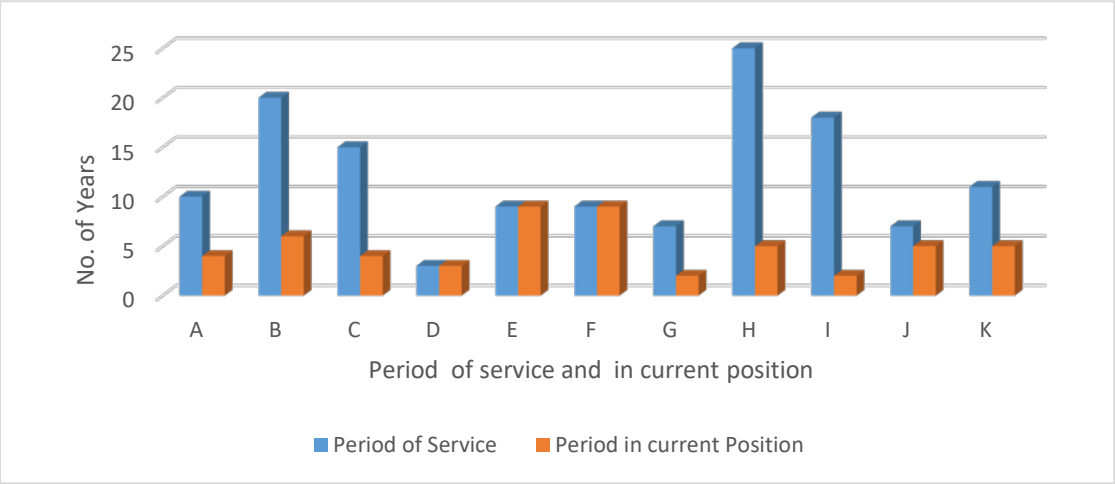
## 4.1 Description of Participants

Interviews were conducted with key officials that lead the decision making bodies and processes of the Ministry of Health. This section provides information on the composition of the participants based on age, gender, and period of service in the sector and in current position, qualifications and sector heterogeneity.

### 4.1.1 Period of Service and Current Position

Figure 1 below depicts the interviewees' years of service in the Ministry of Health and the period of occupying the current managerial position.

**Figure 1: Years of Service and Period in Current Position**




The majority of respondents have more than ten (10) years employed by Ministry, and this demonstrates the organisational memory and experience they possess. This further indicates that the sample is appropriate to provide information on the questions under investigation. The long service also illustrates that the participants have been involved in various health sector reforms and decisions over the past decade. Figure 1 also illustrates that the majority of participants have been in managerial positions for more than 5 years, and this further indicates their experience and capacity to provide valid responses for the study.

### 4.1.2 Qualifications

**Figure 2: Participants' Qualifications**

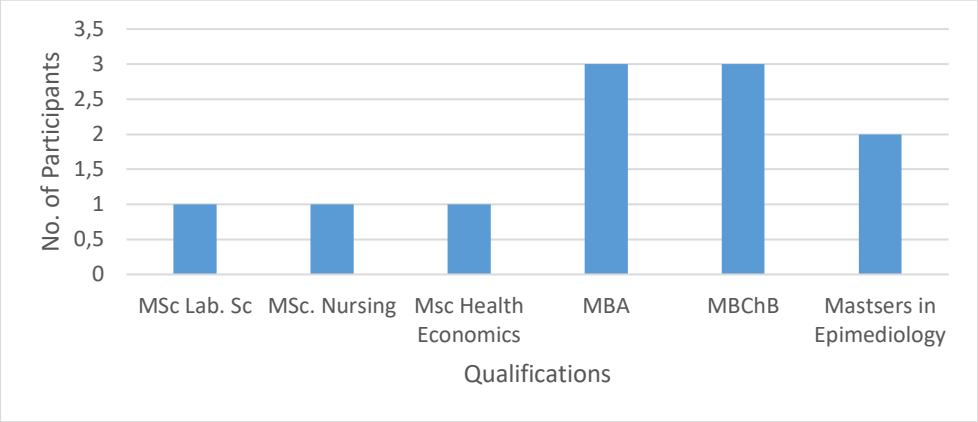



Figure 2 indicates the qualifications of the interviewees and shows that all officials interviewed had post – graduate qualifications relevant to the health sector. This is

important for the study as the interviewees have the capacity and understanding of the policy, technical and practical issues of the health sector.

### 4.1.3 Sector Heterogeneity and Years in Current or Managerial Position

Figure 3 below illustrates participants' heterogeneity based on areas of service and years in managerial position. This indicates that the interviewees were from various sector departments, speciality areas and have more than 5 years of service as managers. Based on these the interviewees provided in depth and varying perspectives on the issue under investigation.

**Figure 3: Participants Section and Years in Managerial Position**



### 4.1.4 Participants Attributes

**Figure 4: Age and Data**

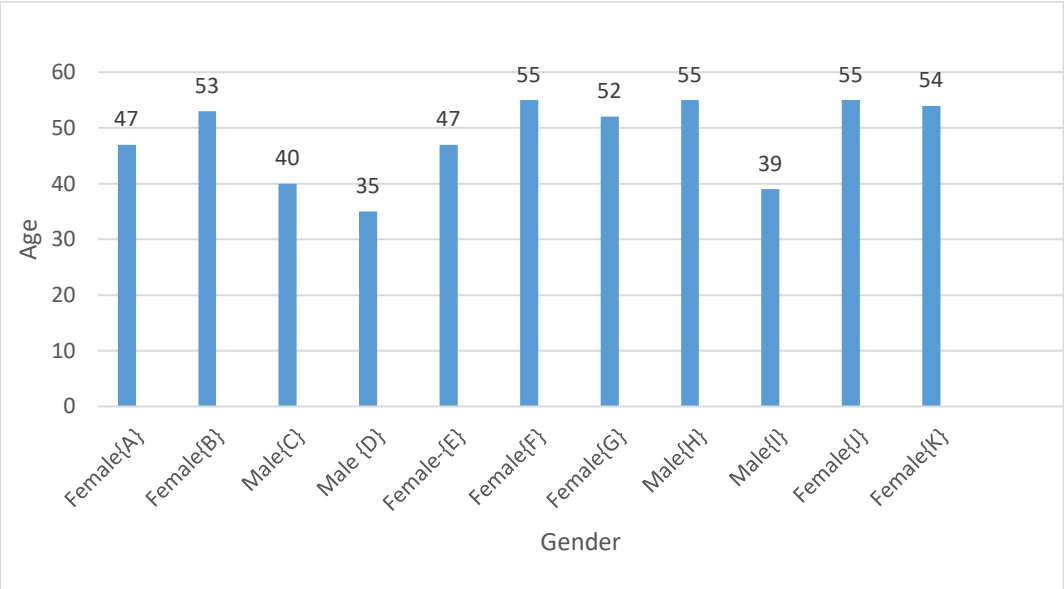



Figure 4 above illustrates the respondents' attributes and it shows the representation of both males and males, with more females than males.

## 4.2 Equity and Inclusiveness

Inequity and exclusion are two separate terms but for the purpose of this research, they are treated as one. Besides the definition of the two terms this section presents the interviewees perspectives on determinants of inequity and exclusion, their challenges and solutions to equitable and inclusive health care service delivery.

### 4.2.1 Definition of Equity and Inclusiveness

The definition of equity by the Ministry of Health derived from the majority interviews was that equity and inclusiveness is the provision of health services without any form of marginalization. The interviewees stated further that all citizens should be treated fairly regardless of their geographical location, affordability or religious belief. Respondents indicated that this generally translated to the fact that essential health services should be made available to all citizens and the distribution should be considered as fair. That is, the respondents indicated, that no citizens should receive

better quality services than others, services should be uniform and the majority of the respondents' view was that the poor must be given priority to access health services A respondent indicated that:

*'Health is a basic need and it is classified as a Constitutional right in Lesotho. Every citizen has a right to the best health care regardless of their socio-economic status. The rich and poor should access the same care and there should not be any differences observed in their access to health care services.'*

### 4.2.2 Determinants of Equity and Inclusiveness

#### 4.2.2.1 Policies

According to most respondents, the policies adopted by the Government determine the distribution or allocation of resources and it is from these policies that strategies for fair distribution of services are formulated. The interviewees indicated that, there are various key policies adopted by the MOH that determines and guides strategy for inequity and exclusion of health services. They stated that the policies are but not limited to the Health and Social Welfare Policy 2003, Health Management Information System Policy 2003, The Human Resources for Health Policy 2005-2025, Health Sector Policy (HSP) of 2011, the National Reproductive Health Policy of 2008, the National Adolescent Health Policy of 2006, the National HIV and AIDS Policy of 2006, the National Population Policy and the National Health and Social Welfare Research Policy of 2007. The respondents also indicated the adoption of a "No fee policy" in primary health care and minimum fees at secondary care and together with it was free services for pensioners.

To ensure the implementation of the above policies, the respondent indicated the Ministry of Health has formulated a number of strategies that include the Lesotho health sector reforms of 2000/1- 2010/11, Human resource strategic plan 2005-2025, HMIS Strategic Plan 2013-2017, Nursing and Midwives strategic Plan 2011-2016 Health Sector Strategic Plan 2012/13-2016/17. All these according to the respondents

are among the tools formulated by the Ministry of Health to ensure equitable and inclusive health services delivery.

The respondents further indicated that Lesotho is signatory to global, regional and continental agreements that informed policy direction and cited agreements such as the Millennium Development Goals (MDG's) 2000, Sustainable Development Goals, Global Fund and the Ouagadougou Declaration on Primary Health Systems in Africa 2008, the Abuja Declaration, Libreville Declaration on Health and the Environment, the Paris Declaration on Aid Effectiveness and the Accra Agenda for Aid Effectiveness 2008. According to the respondents these agreements have influenced the Government of Lesotho's policy direction to ensure equal access to essential health care.

#### 4.2.2.2 Public Health Status Information

The respondents indicated that equity in health services was informed by information collected through surveys that focused on the population's health status and level of services available. They cited the Demographic and Health Survey as a key source of information used to identify the health status of the population and based on it, inform decision making on distribution and provision of services. They noted that other processes such as the Ministry of Health's Annual Joint Review also provided critical information are used to inform strategies and plans and allocation of resources However, some respondents indicated that despite the systematic collection and availability of data, it is not properly used to inform planning and budgeting and this has had negative implications when considering equitable and inclusive allocation of resources.

#### 4.2.2.3 An Area Population Size

In their definition of equity, the respondents defined it as access to services regardless of one's geographic location or socio-economic status. The respondents indicated that the allocation of services was also determined by the number of people that are covered or benefit from the service. They noted that population density was a major

determinant of situation of health facilities, services and personnel as areas with more density had the highest demand for services. The respondents indicated that the urban and peri – urban areas received the largest share of health resources due to their high population densities. The respondents indicated that despite the high population densities in urban and peri – urban areas, rural areas were more populated, however with scattered small settlements, mountainous terrain and limited roads infrastructure. The respondents added that, due to these factors and limited financial resources, rural areas were not provided with adequate health facilities, services and personnel.

#### 4.2.2.4 Distance to Health Centre

Linked to the issue of population density is the issue of distance to health centre. In this instance, the respondents indicated that the National Health Policy 2011 dictates that patients should not travel for more than thirty (30) minutes walking distance or more than 5km to reach a health facility. However, they pointed out that due to mountainous terrain in rural areas this was not possible. They noted that it was very difficult to construct health centres in some areas and therefore citizens had to travel longer distances to access health centres. The respondents indicated that due to lack of road infrastructure most patients had to walk or go on horseback to reach the nearest centre and at times they had to travel for more than a day. They noted that women due to give birth often gave birth at home as a result of difficulties in accessing health centres. They indicated further that the Ministry is attempting to address the problem by providing 'Care Homes' for women as this allows them to arrive days before they are due and be accommodated at clinics.

#### 4.2.2.5 Disease Burden and Risks

The respondents indicated that another determinant of equity was the disease prevalence and risk. They stated that disease prevalence and risk were informed by disease surveillance processes that enabled the Ministry to identify the disease problem, its intensity, geographic location, population group mostly affected etc. The respondents indicated that the surveillance information was used to inform response

strategies, plans and allocation of resources. However they noted that the responses in most cases did not consider issues of equity due to the limited resources available and their skewed allocation. They indicated that in most cases referrals were made to the two main health facilities in Maseru city, and this created a burden and pressure in these facilities.

### 4.2.3 Challenges Encountered in Achieving Equity and Inclusiveness

The interviewees highlighted challenges that hinder the realisation of equity in health service provision and they are stated below**.**

#### 4.2.3.1 Weak Planning and Implementation

The respondents indicated that the policies adopted by the Ministry adequately addressed the issue of equity in provision of health services. They however indicated that planning for implementation of the policies was generally weak and resulted in ineffective implementation of the policies. Reasons for the weak planning were noted as fragmentation of planning processes within the Ministry of Health as well as other Ministries such as Ministry of Local Government and limited or non – use of critical information on the population's health status for planning, budgeting and monitoring. Some respondents indicated that there were pockets of good practice in planning within the health sector and noted that the challenge emerged at the decision – making level, particularly in relation to allocation of resources for implementation of plans. They indicated that from an equity perspective, allocations were based on predetermined Ministry of Finance budget ceilings, preferences and interests of the political management and influence of various departmental heads. This situation as indicated by the respondents resulted in skewed allocations and adversely affected implementation.

#### 4.2.3.2 Limited Human Resource Capacity

Another challenge indicated by the officials was the limited capacity of human resources in terms of adequate numbers to achieve equity. They indicated that the health sector had experienced severe shortages of health care workers, particularly

doctors and nurses across the country. Some respondents referred to the recruitment of nurses from Zimbabwe over the past decade and doctors from Cuba in order to address the problem. They indicated that however these attempts had not resulted in achievement of equity as the shortages still existed. The respondents indicated that the shortages were severe in both rural and urban areas, in particular in government facilities. They noted that the shortages resulted in not all facilities having the capability to provide the prescribed set of services and quality levels where they are available. They noted that in some health facilities some services are not rendered due to lack of personnel.

They indicated that the available health workers preferred working in urban areas over rural areas due to lack of accommodation, transportation to clinics, schools, security and other basic amenities, and this negatively impacted on efforts to provide equitable healthcare services.

#### 4.2.3.3 Unrealised Full Devolution of Health Services

The respondents indicated that the Ministry of Health's decentralisation of services had not yet achieved full devolution of authority in particular for resource allocation and operation of health facilities. They noted that this had a negative impact on achieving equity across and within districts because local authorities just performed the planning function but made no decisions on budgetary allocations and management of resources. They also noted that decisions were made at the centre and generally based on political agendas and other interests of decision makers. The respondents further indicated that apart from the devolution issue, the local authorities were also not adequately capacitated to perform functions such as monitoring of health centres and providing feedback to the Ministry of Health; and noted that this could be a reason for not transferring full authority to them.

They also stated that due to decentralisation of services, Village Health Workers were introduced to assist in villages and although they are not professionals, they offer basic care like child birth and regular check-ups on patients to ensure they take their medication.

However some respondents were against the availability of Village Health Workers as they are of the view that their existence causes health professionals to ignore their responsibilities. One respondent further stated that, the Village Health Workers are incentivised for the work and these has shifted their focus, that is, they are no longer interested in carrying out the work if it does not come with incentives.

#### 4.2.3.4 External Influences

The respondents stated that the influence of development partners/donors was one of the key challenges to the achievement of equity. They noted that due to the fragmentation within the Ministry, weak political leadership, political and career interests, external players such as donors had been able to establish 'parallel' processes and systems for health resource allocation and service provision. The officials indicated that the donors influenced the Ministry on which services they preferred to support, in which areas, preferred funding modalities and levels of quality and standards. They noted that such practices hindered equity and in the long term also affected sustainability of services as the Government at times could not afford to take over services previously provided by donors and international NGOs. They also indicated that apart from the provision of services through their parallel structures, development partners/donors largely influenced the policy direction taken by the Ministry as well as reliance on donors for funding of health services.

The respondents cited the Millennium Challenge Corporation support to the Ministry of Health which provided funding for construction of new health centres and refurbishment of some existing facilities. They indicated that the Ministry officials had identified some preferred geographic locations for the works to be carried out but the Corporation made the final decision on project sites. They also noted that the Ministry raised concerns about construction of new facilities without complementary support to ensure that the facilities were adequately staffed; and the political heads of the Ministry dismissed this concern and the project proceeded.

### 4.2.4 Solutions to Equity and Inclusiveness Challenges

The respondents provided the following solutions for the challenges identified and they are depicted in Table 1 below.

**Table 1: Challenges and Solutions**

| Challenges | Solutions |
|---|---|
| Weak Planning and Implementation | • Strict adherence to use of available evidence on population health status and other sources to inform planning and budgeting.<br>• Ensure integrated planning, budgeting and implementation within the Ministry of Health and with other Ministries to address fragmentation.<br>• Strengthen systems and practices for monitoring implementation and progress. |
| Limited Human Resource Capacity | • Increase intake of students (nurses and doctors) at training institutions and establish health specific scholarship fund.<br>• Create incentive scheme for health workers posted in rural areas and review overall incentive packages for health workers.<br>• Implement clinical mentorship programmes for nurses to enable them to provide the minimum complement of services where there are shortages.<br>• Provide accommodation and security for health workers. |
| Unrealised Devolution | • Fully implement the devolution of power to local authorities and at the same time ensure the authorities are adequately equipped to undertake the devolved functions and decision making. |
| External Influences | • Improve the coordination and management of development partners in the health sector.<br>• Develop donor partnership policy and guidelines and ensure adherence to them. The key is to ensure that development partners only invest in the Ministry's existing priorities reflected in plans and budgets. |

## 4.3 Ministry Of Health Decision Making on Resources Allocation

This section presents the decision making processes of the Ministry of Health on resources allocation and the strengths and weaknesses in the decision making process.

### 4.3.1 Ministry Of Health Decision – Making Process

As per the respondents, the Decision making in the Ministry of Health first start at the departmental and sectional level where each decides on what is essential to them. Once this is complete, the respondents stated the directorate level as the next phase, where all the requirements (Human and Financial resources) are sanctioned, compiled and presented to the Chief Accounting Officer and the Minister. Lastly, the respondents indicated that both the Minister and Chief Accounting Officer then discusses the requirements with the relevant ministries (Ministry of Finance and Ministry of the Public Service) who then allocate resources according to the ceiling for each Ministry.

### 4.3.2 Determinants of Decision – Making in the Ministry Of Health

#### 4.3.2.1 Country Policies and Available Data

According to the respondents, it is the policies that give direction to what should and should not be done. The political leaders come with agendas from their constituencies and these are used to formulate policy. Besides the political agenda, the Ministerial decision making is informed by the progress reports and research they undertake. After every 5years DHS is undertaken to make available information that indicates health areas that need immediate attention. Together with Demographic Health Survey information, the Ministry utilises data from clinics obtained from patients' daily visits at clinics.

However some respondents argued that the available data is incomplete thus, does not give a clear direction on where urgent need for resources is or where they should be directed.

#### 4.3.2.2 Donor Funds

According to the respondents, international organisations such as WHO, provide funds to undertake health care services. However, they note, whenever funds are provided, they most of the times come with conditions (guidelines to be followed). As a result decisions made are not the Ministry's but external actors. Besides WHO, they continue, there is Centre for Disease Control which is also donor and their funds comes with attachments of what is to be done and what should not. They come with clearly stated objectives of diseases to be addressed, type of research to undertake and sometimes with location given. Under the circumstances, the Ministry has no alternative but to oblige.

### 4.3.3 Strengths and Weaknesses in MOH Decision – making

Table 2 below represents the respondent's views on strength and weaknesses in decision making for equity and inclusiveness and the possible solutions.

**Table 2: Strengths, Weaknesses and Solutions to Decision making**

| Strengths | Weaknesses | Solutions |
|---|---|---|
| The ministry adheres to the guidelines by international organisation such as WHO and CDC but are able to customise them to their context, Lesotho. | • Donor influence- the donor funds restricts the Ministry as to what to execute, when and where. Hence it makes it impossible for the Ministry to use such funds to what maybe a priority and a pressing for them. | • The Ministry should formulate guidelines that regulate their relationship with donors for them to adhere to the existing ministerial plans. |
| The donors conditions offset the decision making based on political mandate and enable direct provision of services | • Some of the decision though they are political based, promote equity hence will be hindered. | • More involvement of donors in Ministerial decision making processes. |
| The Ministry conducts surveys whose data or results are used to inform policy and ministerial plans | • Decision makers lack direction and often fail to use the available data to inform their plans. The respondents further stipulated that, during the times when management decides to use available data, it is often inaccurate. | • The Chief Accounting officer should have relevant skills to run the Ministry and someone should be appointed to man the data office |
| Each Department gets the opportunity to raise their needs and decision making at the lower level (Departmental) is based on essential health Information. | • There is no linkage across departments or sections leading to fragmented decision making.<br>• There is partial involvement of management at this level | • There is need for coordination by departments to avoid fragmented decisions and duplication of services |
| There are different phases and people involved before the final decisions are on resource allocation. | • Management make decision on fragmented decisions made at lower level and with little engagement on critical issues.<br>• Often, decision making at Minister and Chief Accounting Officer level is often political, non-interrogative and not detailed. | • There is need for departmental coordination and more involvement by directors<br>• Decisions should be based on the needs of the Ministry |

| | | |
|---|---|---|
| Decentralisation of health services | • No full devolution that enables full participation of citizens | • The Ministry needs to fully decentralize its services to allow more citizen engagement in decision making |

### 4.4 Governance Trends and Strategies in the Ministry of Health

Presented below on table 3 is the secondary information analysis.

**Table 3: Trends and Strategies**

| Governance Element | Period | Key Issues |
|---|---|---|
| Policy making | 2000 - 2017 | All these policies and plans of the Ministry of Health are in accordance with the Constitution of Lesotho 1993, which state that all Basotho shall have equal access to basic health care services and the National Strategic Development Plan (NSDP). Amongst others, the adopted policies to ensure equitable and inclusive health care were:<br>• Health and Social Welfare Policy 2003 whose guiding principles among others was a commitment on primary health care approach to service delivery, that relies and focuses on community participation and equal access to basic health care and social welfare. These principles ensured the availability of qualified human resources in all clinics, distribution of resources according to need and involvement of citizens in decisions of their own affairs.<br>• The National Health Policy 2011 was undertaken to review the 2003 policy. It focused amongst others on Decentralisation of health services, addressing severe health system weaknesses, particularly the shortage of and inequity in distribution of key qualified health professional, leadership, fragmented health information, supply chain management for essential medicines and vital supplies and poor budget execution.<br>• The Human Resources Development and Strategic Plan 2005-2025 whose focus is to man the health offices with qualified personnel.<br>• Decentralisation Plan 2005- the plan helped the Ministry devolve little power to districts and here community councillors are involved in decision making hence more inequity and exclusion. |

| | | |
|---|---|---|
| | | • Health Revitalization Plan 2011-2017 which seeks to promote the institutionalisation of primary healthcare and partnerships with communities, as well as strengthening the operational effectiveness of community health workers. The plan has extended health care services to the remotest areas through the help of VHW. |
| Planning | 2000 - 2017 | • The Ministry of Health has over the years been developing strategic plans and they were all aligned to the National Strategic Development Plan and the Constitution of Lesotho. And during the implementation of the Health Sector Strategic Plan, the Ouagadougou declaration on health was adopted and the Primary Health Care Revitalisation Plan and both these treaties are plans to ensure equitable and inclusive health care.<br>• The Ministry with data obtained from surveys undertaken makes future plans on what needs more attention. Through what is called the Budget Framework paper (BFP), the Ministry before budget allocation presents before parliament what their future plans are, what's to be achieved and how much is needed to deliver services that ensure equitable health care delivery. |

| | | |
|---|---|---|
| Budgeting | 2000 - 2017 | • The Ministry of Health budgets annually for recurrent (i.e. daily expenses such as salaries and maintenance of equipment) and capital (Ministerial Projects). The recurrent is made of governments' funds while capital is made of both government and donor funds. Until the year 2009, the Ministry of health was using what is referred to as Incremental Budgeting. With this budgeting method, the base year budget was used as a ceiling and 3% will be added to the amount to form the current budget.<br>• In 2004, Medium Term Expenditure Framework (MTEF) was introduced, allowing the Ministry to do budget estimates for period of 3years instead of just the next financial Year. This method of budgeting allowed forecast and plan based on the estimates available. For instance, in financial year 2014/15, budget allocated was M1, 697,955,707 and there were projections made for 2015/16 and 2016/17. This allowed the Ministry to plan with boundaries thus be able to prioritise.<br>• In 2009 Programme Based Budgeting was introduced and it entailed provision of money based on what was intended. With this method, Ministry of Health through the BFP presents their plans and if approved, funds are allocated. Approval is on condition the plans are aligned to the NSDP. This method is still in use and does not promote inequity and exclusion as managers fail to plan properly and lack funds to implement for equitable and inclusive health care. However, it has helped the Ministry to prioritise on their main objectives, starting with the most critical ones. |

**Table 4: Health budget from the Year 2000 – 2017**

| Years | Recurrent | Capital | | |
|---|---|---|---|---|
| | | Government | Donor Grants | Donor loans |
| 2000/01 | 4,533,580 | 7,452,000 | 22,562,000 | 5,200,00 |
| 2001/02 | 11,708,150 | 8,100,000 | 25,259,000 | 7,487.000 |
| 2002/03 | 12,233,310 | 20,000,000 | 454,548,000 | 11,000,00 |
| 2003/04 | 246,464,430 | 12,000,000 | 38,300,000 | 22,100,000 |
| 2004/05 | 13,001,580 | 11,854,000 | 31,790,000 | 16,300,000 |
| 2005/06 | 321,126,150 | 12,500,000 | 19,800,000 | 19,300,000 |

| | | | | |
|---|---|---|---|---|
| 2006/07 | 386,453,060 | 13,250,000 | 29,526,000 | 37,000,000 |
| 2007/08 | 530,123,230 | 190,700,000 | 85,288,000 | 32,000,000 |
| 2008/09 | 697,952,560 | 110,000,000 | 87,400,000 | 45,000,000 |
| 2009/10 | 1,132,299,144 | 230,000,000 | 145,000,000 | 32,000.000 |
| 2010/11 | 1,209,744,974 | 400,000,000 | 289,174,000 | 41,000,000 |
| 2011/12 | 1,042,410,752 | 500,600,000 | 380,092,000 | 46,500,000 |
| 2012/13 | 1,132,299,144 | 159,901,944 | 466,534,344 | 0 |
| 2013/14 | 1,407,561,153 | 155,000,000 | 248,658,732 | 0 |
| 2014/15 | 1,697,955,707 | 21,477,500 | 112,020,127 | 0 |
| 2015/16 | 1,780,984,494 | 50,147,253 | 133,661,200 | 0 |
| 2016/17 | 1,768,858,870 | 37,800,000 | 155,755,999 | 0 |
| 2017/18 | 1,959,025,474 | 79,300,00 | 167,868,301 | 32,909,697 |

The figures above are in Maloti (M). The Ministry expenditure is more on operations (recurrent) than it is on projects (capital). Demonstrated again is, there was more spending with incremental budgeting hence the Ministry had to resort to loans. Just after the introduction of programme based budgeting, the Ministry of Health ceased to get loans but spending remained high.

## Table 5: Summary of Key Issues and Findings

| Factors Identified | Solution | Trends /Strategies | Implications |
|---|---|---|---|
| **1. Policies** | • Involvement of all stakeholders during the formulation process. | • Essential health information<br>• Sectional plans<br>• Departmental Plans<br>• Ministerial Plans | • No citizens participation in decision making |
| **2. Weak Planning and implementation** | • Strict adherence to use of available evidence on population health status and other sources to inform planning and budgeting.<br>• Ensure integrated planning, budgeting and implementation within the Ministry of Health and with other Ministries to address fragmentation.<br>• Strengthen systems and practices for monitoring implementation and progress. | • Health Strategic Development Plan which is reviewed every 5years<br>• Demographic Health Survey<br>• Budget Framework Paper<br>• Performance based Budgeting<br>• Medium Term Expenditure Framework | • Takes longer to review thus implementers loose interest and focus<br>• Misallocation of funds<br>• Limited Financial Resources<br>• Poor Infrastructure<br>• Duplication of services |
| **3. Limited Human Resources Capacity** | • Create incentive scheme for health workers posted in rural areas and review overall incentive packages for health workers.<br>• Implement clinical mentorship programmes for nurses to enable them to provide the minimum complement of services where there are shortages.<br>• Provide accommodation and security for health workers. | • Recruitment of foreign officers | • Underperforming health centres<br>• Overpopulated urban health centres |
| **4. Population density** | • Health services should be provided based on the needs on demand | • Partial Decentralization of health services | • Unclear roles to perform by local authorities<br>• Poor infrastructure<br>• People walk long distances to health facilities |

| | | | |
|---|---|---|---|
| **5. External Influences** | • Improve the coordination and management of development partners in the health sector.<br>• Develop donor partnership policy and guidelines and ensure adherence to them. The key is to ensure that development partners only invest in the Ministry's existing priorities reflected in plans and budgets. | • Increased investment by donor (Focused on infrastructure development, service delivery, equipment and capacity building.<br>• Global Fund<br>• Millennium Challenge Corporation<br>• Public-Private Partnership | • Continued support on HIV/AIDs and Tuberculosis initiatives by the Ministry<br>• Improved infrastructure with no Human Resource to man it<br>• Burden on health Budget due to loan repayments and service cost |
| **6. Unrealised Full devolution of Health Services** | • Fully implement the devolution of power to local authorities and at the same time ensure the authorities are adequately equipped to undertake the devolved functions and decision making. | • Planning at local level and decision making at central (managerial Level)<br>• Centralised budget | • Local authorities with unclear roles<br>• Delegation of services to deliver and lack of manpower to perform roles. |

## 4.5 Conclusion

There is a relationship between the factors identified. Some can be regarded as causes of others and vice versa. The important issue to raise is that, they all have a bearing on inequity and exclusion independently.

There have been changes overtime with governance and strategy aimed at ensuring inequity and exclusion. However, the trends indicate fragmentation and weak implementation of strategies. They also demonstrate the high influence of external actors.

# 5 RESEARCH DISCUSSIONS

The main objective of this research was to establish the factors behind lack of inequity and exclusion in health service delivery in Maseru. Specifically, the research focused on a) **establishing the factors leading to the problem of inequity and exclusion in health access in Maseru district,** b) **identifying and assessing governance trends and strategies in the Ministry of Health** and c) **implications for inequity and exclusion particularly with respect to access to health services**. This chapter presents discussions on key findings under investigation and conclusions

## 5.1 Factors leading to the problem of Inequity and exclusion

As per the literature, the researcher did not establish any major differences in definitions of inequity and exclusion thus for the purposes of this study, inequity and exclusion will not be used as separate terms. Studied is factors behind lack of Inequity and exclusion in the delivery of health services. However, Ensor & Cooper (2004) suggest that demand barriers maybe as important as supply factors in deterring patients from obtaining treatment yet, little attention is given by both researchers and policy makers on ways of minimizing their effect.

There are various factors leading to the problem of inequity and exclusion in Maseru and according to the findings, they are as follows:

- **Policies**: The formulation of policies has to involve citizen participation, then the local authorities, the Member of Parliament where policy decisions are reached. However, the formulation of policies by the Ministry of Health does not adhere to the attributes of the Pluralist theory which is for citizen's participation in decision making. As stated in to Hill (1993) the theory advocates more for voicing the voices of the voiceless in this decision making. Through group work, members of communities can make their voices heard by government and ultimately have their needs implemented. In cases where participation is not easy, protests can be made until the voices of the people are heard (Hill, 1993). However, policy formulation in the Ministry of Health does not include the voices of the voiceless and in instances where they are

incorporated, they are usually over written by the political agendas or donor influence.

- **Weak Planning and implementation of policies and plans**: As stated in the Health Strategic Plan 2012/13-2016/17, research is important as it generates evidence which can be used in the health sector to inform policy and programming. However, the management fails to plan based on available evidence resulting in the existing inequity and exclusion in health care service delivery. Planning has to inform budgeting and vice versa and according to the results, poor planning has resulted into insufficient financial resources for implementation for equity. On the Contrary, Ramashamole & Thamae, (2013) states that stakeholders in Lesotho, both internal and external have been concerned about Lesotho's under expenditure of the very limited health budget. Further, the time frame allocated for achievement of a plan is often 5years at most resulting in implementers losing interest and focus from the task in hand.

Further, revealed by the results is, there is less coordination within the Ministerial structure which has resulted in duplication of services, and there is also unrealised full devolution of health services and it has resulted in misallocation of limited funds and poor infrastructure in rural areas.

- **Limited Human Resource Capacity**: the findings revealed that the Ministry of Health lacks enough Human resources personnel to achieve equity. This has resulted in underperforming rural Health Centres and overpopulated urban health centres. Lesotho has few Health Human resources and this is evident in most health centres where majority of Doctors are expatriates. Due to poor infrastructure, lack of schools, transport and security in rural areas, the results revealed that even the few available health personnel's, are reluctant to work in rural area as a result, patients move to the resourced urban clinic, thus overpopulation.

- **Population density of area**: the findings revealed that health resources are allocated to areas with the highest population density and since the urban and

peri-urban area are densely populated, they get more resources whereas their rural counterparts are more but dispersedly populated. Priority in resources allocation should be given to areas with higher population and in the case of health, it should be rural Maseru where population rate is higher though dispersed. As per UNESCAP (2006) article, equitable health resources allocation assures that corruption is minimized, the views of minorities are taken into account and that the voices of the most vulnerable in society are heard in decision-making. It is also responsive to the present and future needs of society. And as stipulated by the findings, allocation based on population density does not adhere to equitable distribution of resources as they are allocated to areas densely populated, leaving behind the rural poor.

- **External Influences**: the findings revealed the Ministry of Health is a signatory of multiple regional and international treaties and the donors have been able to influence the Ministry of Health on which services they preferred to support. As a result, this put a halt to the Ministerial plans for equitable and inclusive service provision. However, the external influences are against the Pluralist theory of power decentralisation as it is considered to be a desirable component of representative democracies. As noted by Neverauskas (2015), people or groups of people are inclined to make political commitments in problem areas within their interest and/or competence.

- **Unrealised Full Devolution of Health Service:** The findings stipulated that the Ministry of Health decentralisation has not achieved full devolution. There are authorities at local level, who plans on behalf of the people but the decision are still centralised. At the Management level where decisions are made, local authorities are not represented and often the local decisions are exempted from the decision making. Failure for full devolution is against the Pluralist theory advocacy for participation. According to Hill (1993), the theory advocates for voicing the voices of the voiceless in this decision making. Through group work, members of communities can make their voices heard by government and ultimately have their needs implemented. In cases where participation is not easy, protests can be made until the voices of the people are heard.

There is a relationship between the above factors, some are the casual factors of the others but they all have an influence towards the inequity that prevail in health service delivery.

## 5.2 Governance Trends and Strategies

The Ministry of Health has over the years been formulating policies and plan and there were strategies adopted for their implementation. However, the plans were not informed by the essential health information thus failure to plan more equitable and inclusive health service delivery. Further, in cases where the available data was incorporated, there were inaccuracies identified thus not giving a clear or an exact picture for planning.

Planning informs budgeting and from the Ministerial budgets over the years (2000-2017) there has been an increase each year in funding by both government and donors but due to weak planning and budgeting, planning and implementation for inequity and exclusion failed. Additionally, established is, most government funding is directed to the operational expenditure of the Ministry and not service delivery, whereas donor funds are directed only on service delivery expenditure not operational expenditure.

In operation with the Ministry of Health, development partners' select their preferred health areas to finance regardless of the available Ministerial annual plans. However, there isn't any policy available to ensure that the donors adhere to the already in place policies and plans for ensuring equitable and inclusive delivery of services.

Amongst the adopted policies is the decentralisation Policy 2003, which has by far made little or no difference as the decision making powers are still centralized. The officials at the local level plans for equity but since they are not represented at the decision making level, often their plans are not included. Regardless of having decentralized, decision are still made at the headquarters and local authorities do not have clear roles to perform.

## 5.3 Solutions to Inequity and Exclusion

- **Use of Essential Health Information**

The Ministry of Health needs to incorporate the available evidence on health population status and other health information sources to inform planning and budgeting. This is a way of ensuring participation at all spheres. Central to Pluralist Theory is participation and according to Hill (1993) although all groups and interests do not have the same degree of influence, but, even the least powerful are able to make their voices heard at some stage in the decision making process.

- **Institutional Coordination and Integration**

There is need for coordination within the Ministry of Health. Decision makers need to be in touch with all the decisions made at sectional level and ensure they are included in Ministerial plans. Further, there is need for more integration with the development partners and other Ministries to avoid duplication of service and ensure there is equitable and inclusive health care delivery at all times. In critique of the Pluralist Theory, Bachrach and Baratz as cited by Parsons (1995) developed a term, non-decision making which involve the constriction or containment of decision-making so as to focus on safe issues by manipulating the dominant community values, myths and political institutions and procedures. It is essential for the Ministry to oversee proper planning and implementation of health plans at all level and ensure non decision making does not occur.

- **Formulation of Regulatory Laws**

Bachrach and Baratz as cited by Parsons (1995) argues that the pluralist case had failed to appreciate the extent to which those with power can actually exclude issues and problems from decision-making agenda. It is essential that the Ministry formulates policies and guidelines that will ensure donor partners aligns to the Ministry's plans instead of donor partners selecting preferred areas to finance and ensure implementation of all plans.

- **Full Devolution**

The Ministry of Health needs to fully decentralise its services to allow local authorities' to plan for the people. If the authorities' at local level and the councillors are given

authority to make decisions, they will be able to plan for equitable delivery of service. The will be making plans of issues they experience and are a part of. This is in accordance with the pluralist theory where decentralisation is considered to be a desirable component of representative democracies. As indicated by Neverauskas (2015) people or groups of people are inclined to make political commitments in problem areas within their interest and/or competence.

### 5.4 Conclusion

The factors identified behind the existing inequity and exclusion in the delivery of health services are but not limited to the formulation of policies, weak planning and implementation, limited human and financial resources, an area population density and failure by the Ministry to fully decentralize.

There are number of strategies and trends in the Ministry of Health and these have implications on inequity and exclusion. The Ministry has undergone among others surveys, planning and budgeting and policy adoptions and ultimately these has implications such as a poor participation, limited financial resources, poor infrastructure development and underperforming health care centres.

# 6 CONCLUSION AND RECOMMENDATIONS

The research study objective was to establish the factors behind inequity and exclusion in health service delivery in Maseru. Specifically, the research focused on a) **establishing the factors leading to the problem of inequity and exclusion in health access in Maseru district,** b) **identifying and assessing governance trends and strategies in the Ministry of Health** and c) **implications for equity and inclusiveness particularly with respect to access to health services**. This chapter presents the conclusions drawn from the findings and recommendations as per the results. It further provides recommendations for further research areas established from the research limitations.

## 6.1 Conclusion

This section presents the conclusions with regard to the findings.

### 6.1.1 Purpose Statement

The purpose of this research was to explore the factors behind inequity and exclusion in the delivery of health services in Maseru Lesotho. The aim of the study was to present governance trends and strategies in the Ministry of Health and their implication on inequity and exclusion.

As stipulated in multiple literatures, the inequity that prevails in access can be a result of many factors and both from the demand and supply side. According to Schellenberg, Victoria,Mushi, de Savigny, Schellenberg, Mshinda and Bryce (2003) care seeking behaviours are stated to be worse in poorer families even in uniformly rural communities. The possibility is health care information is not well disseminated to them or rather not disseminated at all. Another possible explanation by Schellenberg, Victoria,Mushi, de Savigny, Schellenberg, Mshinda and Bryce (2003) is that maybe health care centres or facilities are very remote, leading to individuals having a little or no knowledge at all of them. A qualitative study was undertaken and interviews conducted to elicit the factors behind the problem of inequity and exclusion in the delivery of health services in Maseru, Lesotho. The focus of the study was on resources allocation and decision making with regard to resources. A purposive

sampling was used with focus on the Ministerial decision makers made of both Departmental and sectional heads. This are individual responsible for decision making on Ministerial resources allocation. Further, employed was thematic analysis method for data analysis and interpretation. Identified is a number of factors behind the inequity that exist and that there is a relationship between the factors, that is, some are the casual factors of others and visa-versa. There are various strategies and trends within the Ministry of health aimed at reducing the existing inequity in health service delivery but fail thus it was essential to undertake this study. Stipulated below are the conclusions drawn from the findings.

### 6.2.2 Factors behind Inequity and Exclusion

The conclusion drawn from the research analysis is that there are inequities and exclusion in the delivery of health services and this is as a result of multiple reasons. First, is poor planning and implementation of policies and plans. The Ministry has a number of good policies and plans to reduce inequity and exclusion but fails to plan properly thus poor implementation. Secondly, the formulation of policies lacks citizen's participation and as a result, most of what is implemented is not what the people want but rather, driven by political mandate.

Further, concluded is, the limited human resource capacity within the country has a bearing on the inequities that prevails. In most remote health centres, there is lack of human resources personnel. Lesotho lacks to be specific doctors and due to the poor infrastructure, low remuneration and poor transportation, even the few available are reluctant to work in rural areas.

The Ministry of Health has to date failed to fully decentralize its decision making powers. There are local authorities with no clear roles to perform. Amongst others, they do planning for their local councils but are not involved in decision making and as a result, most of their plans are not included in the decisions made. Besides failure to fully devolve, the Ministry of Health decisions making on resources allocations is influenced by politics and external influences such as donors, regional and international treaties resulting in inequity and exclusion that exist. Lastly, Maseru is divided into urban and rural and due to the rural topography, it is hard to reach thus

difficult to allocate resources. Additionally, rural areas have the highest population though dispersed but more resources are allocated to urban areas with more clustered population thus the inequity in health service delivery.

### 6.1.3 Strategies and Trends

The following are the governance strategies and trends for equity and inclusiveness in health service delivery.

- **Policy making**: The Ministerial policies and plans of the Ministry of Health are in accordance with the Constitution of Lesotho, 1993 and the National Strategic Development Plan (NSDP). 1993. The developed policies are inclusive of Health and Social Welfare Policy the National Health Policy 2011, The Human Resources Development and Strategic Plan 2005-2025, Decentralisation Plan 2005 and Health Revitalization Plan 2011-2017. All these are developed towards achievement of equitable and inclusive health care. However, there is interference by political influence and donor funds, diverging the available Ministerial plans thus inequity and exclusion.

- **Planning:** The Ministry of Health has clear strategies in place for planning purposes. Utilised is the National Strategic Development Plan and the Constitution of Lesotho and there are strategies in place for their implementation. Besides strategic plans, available are the treaties such the Ouagadougou declaration on health and Primary Health Care Revitalisation to ensure equitable and inclusive health care.

  The Ministry undertakes a number of surveys and among them is the Demographic Health Survey and the Health Annual Report whose data is used to inform planning. However, as stated in PHC Revitalisation Plan, 2011, the available information is often incomplete and inaccurate thus poor decision making and planning.

- **Budgeting:** Over the years, the Ministry of Health has focused on both recurrent (i.e. daily expenses such as salaries and maintenance of equipment) and capital budgets. The recurrent is made of governments' funds while capital is made of both

government and donor funds. Until the year 2009, the Ministry of health was using what is referred to as Incremental Budgeting. With this budgeting method, the base year budget was used as a ceiling and 3% will be added to the amount to form the current budget. In 2004, Medium Term Expenditure Framework (MTEF) was introduced, allowing the Ministry to do budget estimates for period of 3years instead of just the next financial Year. This method of budgeting did not focus on the available plans hence failure by the Ministry to reduce the inequity and exclusion in service delivery. The Medium Term Expenditure Framework failed to put into consideration effects of inflation on the budget hence under budgeting.

In 2009 Programme Based Budgeting was introduced and it entailed provision of money based on what was intended. There has been increases in budget but there has never been change in the provision of services due to poor planning. Further, the method itself does not promote equity as service provision is depended on managerial discretion

### 6.1.4 Implications

Stipulated below are the implications as a result of identified factors behind inequity and exclusion and the trends and strategies in the Ministry of Health.

- Due to lack of coordination between departments, between Ministry of health and other Ministries and the Ministry and the development partners, there is duplication of services thus waste of insufficient resources.
- There is poor infrastructure, underperforming rural clinics resulting into overpopulated urban clinics.
- There are limited financial resources due to poor planning.
- Since health centres lack resources, patients walk longer distances to access health care.
- Donors continue to fund projects, leading to improved health facilities with no human resources to man them.

## 6.2 Recommendations

The findings stipulated that there is inequity and exclusion in health service delivery and this is due to weak planning and poor implementation of policies and failure by the Ministry to fully devolve its services. Thus, below are the recommendation provided to improve health service delivery and mitigate the problem of inequity and exclusion.

1. There is need for strict adherence to use of population health status and other data sources to inform planning and budgeting. The Ministry has to ensure the office is manned by the competent personal to ensure accuracy of the stored data in the Health Management Information System. This will result to proper planning and budgeting for resources.

2. The Ministry of Health needs to strengthen and implement the Monitoring and Evaluation strategy to ensure implementation and achievement of plans for equitable and inclusive health care. The strategy will ensure there are time frames aligned to every plan thus timely implementation and completion of plans.

3. The Ministry needs to fully implement the devolution of power to local authorities and ensure they are equipped to undertake devolved functions and decision making. This will assist in ensuring full citizenry participation in decision making thus plans that are for the people and by the people. Consequently, people will walk less distances to access health care and there will be more inclusive and equitable delivery of services.

4. Established is limited human resource capacity thus the Ministry has to establish a strategy to retain all Basotho doctors and an incentive scheme for rural based health workers and review the overall incentive packages of all health workers. This will help ensure that the few available doctors do not leave looking for greener pastures and to motivate workers to work in rural areas.

## 6.3 Recommendations for Future Research

1. Established was that the factors behind the inequity and exclusion in the delivery of health services in Maseru influences one another thus a research can be undertaken to establish the Main Factor behind the inequity that exist.

2. The context and setting of this study was based on Health Management (Central Unit) thus a similar study can be undertaken with decision makers at local level where there is more integration with the people and health problems that occurs.

3. The study contends for the use of the Pluralist theory thus a similar study can be undertaken to compare the Pluralist theory with other theories.

4. This study identified factors behind inequity and exclusion in the delivery of health services thus a similar study can be undertaken to assess factors behind the problem of inequity and exclusion in health access and focus on the recipients of services.

## 6.4 Conclusion

Central to this study was equitable and inclusive allocation of resources. Looking at the problem of equity on pluralist view, the factors behind the problem of inequity and exclusion were identified as poor planning and implementation of plans, formulation of policies, failure to fully decentralize services and external influences. There are strategies adopted for implementation towards equitable health care services delivery but are hindered by political and other external influences. The Ministerial trends indicate that there is policy making, planning and budgeting within the Ministry and since all of them are poorly done, they lead to inequity and exclusion in health care service provision. However, there are recommendations made for reduction of inequity and exclusion in health care delivery.

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## APPENDICES

### APPENDIX A: Consent Form

The researcher intends to establish the factors behind the problem of inequity and exclusion in the delivery of health services in Maseru, Lesotho. As a participant, you are kindly requested to respond to the interview questions, thus assisting the researcher to establish the factors behind the problem. The research is conducted in partial fulfilment of a Master's Degree of Management in Public Policy at the University of Witwatersrand. The objectives of the research are:

1. To establish the factors leading to the problem of inequity and exclusion in health access in Maseru
2. To identify and assess governance trends and strategies in the Ministry of Health and the implications for equity and inclusiveness particularly with respect to access to health services

It is essential for every participant to go through this consent form and you are kindly requested to sign at the end as a confirmation for your agreement to respond to the questions.

If you do agree to participate, you are humbly requested to answer all questions which will take approximately 30 minutes of your time.

**If you decide not to participate:**

There is no penalty for deciding not to take part in this study. Participation is entirely voluntary.

**Confidentiality:**

Participant anonymity is ensured, as names of respondents are not required and if provided, will not be associated with their responses

**Benefits and Risks:**

- There are no material benefits attached to participating in this study. However, your participation is crucial as the information you provide could help to develop strategies for a more equitable and inclusive delivery of health services.
- There are no risks associated with participating in this study but if you feel uncomfortable with certain questions, feel free not to respond to that specific question.

## APPENDIX B: INTERVIEW GUIDE

**Researcher's contact details:**

For questions and clarifications with regard to the questionnaires, you are free to contact Ms. Malesia Thoahlane on, 62440044/57886787 and malesiathoahlane@yahoo.com

Participant's signature _____ Date _____

Questionnaire

**Demographics**

1. Name of organisation……
2. Department or Section……
3. For how many years have you been working for the organisation? ……..

**EQUITY AND INCLUSIVENESS**

4. How is equity and inclusiveness defined by the Ministry of health?
5. Identify areas in the health services where equity and inclusiveness have been achieved or have not been achieved (what has worked and what has not worked).
6. What are the factors or reasons for achieving them or not achieving them?
7. What strategies are in place to achieve equity?

**DECISION MAKING**

8. What are the main drivers that determine decision making for equity and inclusiveness in ensuring access to services?
9. Identify the strengths and weaknesses in decision making for equity and inclusiveness
10. How can decision making on equity be improved?
11. Are the citizens or recipients of services involved in making decisions on equity and access to health services? If so, how are they involved?
12. Does their involvement add value to decision making? If yes, how and if not, why?
13. What can be done to promote citizen engagement?