THE GOVERNANCE CHALLENGES IN THE MINISTRY OF HEALTH IN LESOTHO

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ABSTRACT

For centuries governance has been the buzz word amongst governments aimed at administering both economic and development initiatives. In Lesotho, governance has been regarded as the mechanism to help reduce poverty and reduce disease burden. The Government of Lesotho (GoL) implements the governance initiatives through the reform programmes. In order to oversee the execution of these reforms, it established a secretariat to oversee the implementation of the governance initiatives at the Ministry level. In no evidence of the existence of such secretariat, this study explores the governance challenges in the Ministry of Health in Lesotho in carrying out its mandate to provide quality health care to all Basotho. It examines the barriers to health system functioning and governance trends in the Ministry of Health.

The research approach for this study is qualitative in nature. It carries an enquiry into the governance challenges within health systems. A purposive sampling was used to select the informants to this study. Data was collected using a questionnaire and document analysis in order to obtain a broader perspective of the prevailing situation. The main purpose of the study is to report findings on perceived governance challenges in the Ministry of Health in Lesotho by examining system components that could lead to the problem of escalation of deficits and governance trends.

Major findings of the study revealed there is a problem of escalation of deficits and in governance in the Ministry of Health. It therefore argues the network theory of governance as a mechanism that could be used to source dispersed resources amongst different actors for escalations of limited resources and effective system functioning. This study further provides possible reasons for these challenges.

DECLARATION

I declare that this report is my own unaided work. It is submitted in partial fulfilment of the requirements of the degree of Master of Management (in the field of Public and Development Management Sector Monitoring and Evaluation) in the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination in any other university.

Mosa Bernice Theko

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DEDICATION

I dedicate this report to my late father Hlasoa Gerard Theko, the man with no formal qualification who worked so hard to make sure I receive something he never had; and to my recently lost mom, ’Manthati Laetitia Theko. Thank you for all the support you provided throughout my studies. I am who I am today because of you. I am sorry you didn’t get to see the end of this one. I will forever cherish the love and support you gave me.

To my sisters, Nthati, Ntšepase and Malieke, thank you for your support. Your inspirations made me look forward to a new day each day. To my nieces and nephews, please learn from this and make it far in life. Thank you all for your unconditional love.

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LIST OF ABBREVIATIONS

AJR	Annual Joint Review
AU	African Union
CHAL	Christian Health Association of Lesotho
CSO	Civil Society Organisation
GoL	Government of Lesotho
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IFMIS	Integrated Financial Management Information System
IMF	International Monetary Fund
LHSA	Lesotho Health System Assessment
MDG	Millennium Development Goals
MoF	Ministry of Finance
MoH	Ministry of Health
MOU	Memorandum Of Understanding
MPS	Ministry of the Public Service
MTEF	Medium Term Expenditure Framework
NDSP	National Development Strategic Plan
OECD	Organisation for Economic Cooperation and Development
PBF	Performance Based Financing
PHC	Primary Health Care
PPP	Public Private Partnership
PRS	Poverty Reduction Strategy
PSIRP	Public Sector Improvement and Reform Programme
RMC	Regional Member Countries
SACU	Southern African Custom Union
SADC	Southern African Development Community
TB	Tuberculosis
UNAIDS	United Nation Programme on Aids
UNFPA	United Nation Population Fund
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 Introduction

Governance continues to be the cornerstone for success of different government's economic and development initiatives. The concept dates as far back as the fourteenth century, and has been adopted due to unsatisfying conditions that dominated the social and economic development models. In the development world governance became more popular in the 1980s due to the decline in state capabilities. At the international level the concept came about around the 1970s and 1980s with the dissatisfaction of international relations students due to the realists and liberal-institutionalists theories that failed to capture the growing number and influence of non-state organisations in the age of globalization (Daly, 2003; Weiss 2000).

Governance is a multi-disciplinary concept that emanates from multiple disciplines and levels. Its origins are from institutional economics, international relations, organisational studies, development studies, political studies and public administration. It therefore draws from the local, national, regional and supra-national levels (Stoker, 1998; Lyall & Tait, 2005). Despite its multiple disciplines and multi levels, the notion aims to encourage the bottom-up approach to governance that encourages involving multiple actors in governing and do away with the traditional top-down way of governing.

To date, there is no agreed upon definition for governance. However, it is increasingly considered critical for development and economic growth. It is widely accepted to include the state, private sector and civil society organisations (CSO) in delivery of public services (Fukuyama, 2013; Panday and Rabbani, 2011; Mkandawire, 2007; Weiss 2000). International organisations such as the United Nations (UN), Organisation for Economic Cooperation and Development (OECD) and World Bank regard governance as a driving force behind every nation's development. In Africa, sound governance has been regarded critical for economic growth and welfare of the citizens. Nation states found it imperative to get governance right for their economic development. Governance has therefore formed part of the strategic initiative in the international and national arenas such as the Millennium Development Goals (MDGs) and the Poverty Reduction Strategies (PRS) and other ongoing development initiatives internationally, continentally and nationally (Mekolo & Resta, 2005). Getting governance right has therefore been a major concern for development agencies, government and much investment have gone into research on governance.

With the passage of time and more research, governance gained an adjective ‘good’. Making it ‘good governance’. Under this auspices governance became an evaluative concept with a list of indicators to be adhered to that focused on state capacity. It emphasised more on getting people involved in decision-making holding accountable representatives in governance matters, the rule of law and government capacity amongst others (Bevir, 2010). It is under this new concept that good governance began to dominate the international organisations such as the World Bank (WB), International Monetary Fund (IMF) between the 1989 and 1990 when the World Bank, in its report, declared the underlying problem to Africa’s development to be the problem of governance (Mkandawire, 2007). Since then governance has been adopted as one of the conditionalities for the developing world to qualify for aid. Although governance and good governance have been used distinctively in governance literature, there is no clear demarcation between these concepts hence they can be used interchangeably. Good governance is therefore any mechanism aimed to address the societal problems.

1.2 Background to the study

Globally, organisations such as UN, OECD and Commonwealth Association for Public Administration and Management (CAPAM) direct governance practices (Naidoo, 2011). They have worked largely with African organisations through the Millennium Development Goals (MDGs) to address poverty eradication issues in Africa as some of the governance issues facing the continent. In Africa, governance challenges have emerged since the independence from slave trade and colonisation. Ranking high in the continent are issues relating to poverty and HIV/AIDS, all regarded as lack of good governance. Since then, African countries have decided to work in solidarity to face the governance challenges in Africa. This unity saw the birth of the Organisation of African Unity (OAU) in 1963 (Mekolo & Resta, 2005), which has paved way for other regional organisations such as African Union (AU) and its programmes such as the New Partnership for African Development (NEPAD), that have made development and welfare through good governance in Africa their major focus. Organisations such as AU, Southern African Development Community (SADC), and East African Community (EAC) continue to reaffirm their commitment to improved governance as their main priority in Africa. This commitment is evident in the implementation of the Millennium Development Goals (MDGs) in support of United Nations (UN) to help Africa address poverty eradication issues. Attaining these goals was faced with not only resource limitations but other governance intervention areas were needed. Four

governance areas needed intervention, including those relating to strategic planning, and central government guidance, rule of law and conflict management amongst institutions (Mekolo & Resta, 2005). International efforts have collaborated with both continental and regional efforts such as Southern African Development Community (SADC) to address socio-economic issues, economic growth and addressing citizens' health and welfare issues as governance challenges.

As a member of both the global and regional communities, Lesotho has to comply with the governance mandate set by these organisations. In Lesotho, governance issues date as far back as 1966 since Lesotho gained her independence. However, in recent years under the democratic leadership, governance initiatives have also transformed. Governance issues rank high in GoL agenda and have formed a corner-stone to government strategic documents such as the National Vision 2020 and the National Strategic Development Plan (NSDP), including signed treaties that prioritise and regard governance as a missing link in achieving development. These include membership to organisations such as Southern African Development Community (SADC), Southern African Customs Union (SACU) and Regional Member Countries (RMC). These organisations have made governance a priority in their objectives in addressing poverty and achieving economic development. In order to address the governance challenges in Lesotho, the GoL has therefore established a secretariat to oversee governance reforms within the public sector. It embarked on a rapid multi-dimensional reform package – Public Sector Improvement and Reform Programme (PSIRP) aimed at improving the effectiveness and efficiency of public service delivery and enhancing public finance management. The composition of this secretariat, the policy that govern it and whether this secretariat is an independent body from the government and who it reports to could not be established by the researcher. Also the reporting channels of the line ministries on governance issues need to be clearly articulated.

Generally, in Lesotho, efforts to implement governance reforms have included partnerships with development partners in the form of working groups and inter-sectoral dialogues. These working groups are guided by terms of references that guide the committees. The sustainability and accountability of these working groups however is very questionable considering inter-ministerial transfers that happen from time to time. Regional governance rankings on Mo Ibrahim Index of African Governance (IIAG) scale on governance ranked Lesotho tenth on governance out of fifty-two African countries with an average score of 62.3%. This showed a positive increase of 3.8% within a five year period ranging from 2009

to 2013 (African Development Bank, 2013). However, considering the recent political instabilities that included an attempted coup in 2014 that ended with the country holding premature elections in 2015, these rankings may be lower.

The GoL declared access to health a priority and a right. Declaring health a priority proves political commitment of the higher levels of government on governance for health. As such, sector level efforts have also followed the trend. The health sector has thus been structured and organised in a way that enhances the GoL to achieve its objectives as laid down in the PRS and Vision 2020, including those aimed at achieving the health Millennium Development Goals (MDGs). At Sector level, policies and strategic documents have also made governance their priority area of focus. Such is the health policy, the Primary Health Care (PHC) Revitalisation Plan 2011-2017 and the Human Resource Strategic Plan 2005-2025. However, despite all these efforts, in general, the health systems assessment indicates Lesotho is still facing quite a number of challenges on the overall governance framework. These include challenges relating to good governance interventions articulated to be common globally such as accountability, transparency, stakeholder participation, combating corruption amongst others. Specifically, governance challenges facing Lesotho include those relating to highly centralised system in decision-making processes, weak monitoring systems, loss of qualified staff and political fragmentation (Mwase, Kariisa, Doherty, Hoohlo-Khotle, Kiiwanuka-Muchibi & Williamson, 2010).

The 2010 Health System Survey has revealed major governance concerns relating to equity, access, efficiency, sustainability and quality of health care in Lesotho. The study shows lack of health advocacy as impeding equal distribution of both financial and human resources. Hence access to health care has been reported uneven due to regional inequalities and distribution of health facilities. These include limited access to information for planning and policy processes purposes. With the limited human resources the sector has, the available are not efficiently used at both facility and district levels. In general the health system was found to be unsustainable with major programmes like HIV/AIDS dependant on donor funding, thereby making the country's fight against HIV/AIDS highly vulnerable in case of donor withdrawal (Mwase, et al., 2010). As a result, the quality of health care in Lesotho is adversely affected. Governance is therefore regarded as a central issue to understanding these dysfunctionalities within health systems and the poor health outcomes (IDRC, 2011). All these point to the need for focused governance within health systems functioning.

Studies have shown a relationship between governance and health measures and output (Kaplan, Dominis, Palen, & Quain, 2013; Lewis, 2006). According to Lewis (2006), where health care is not governed well, there are a lot of governance discrepancies which need to be addressed. Failure to address these challenges results in poor outcomes. This relationship makes the health system a governance issue in that failure to manage health system problems results in poor outcomes for health. Adding the prefix 'good' to governance has also added to this relationship, indicating the need to measure governance based on output. International and regional reviews have ranked Lesotho high on governance indicators including those that impact on health and government effectiveness.

On health, Lesotho ranked twenty-seventh out of 52 African countries within the continent with a score of 71% on health governance indicators such as maternal and child mortality, immunisation, anti-retroviral treatment provision, under-nourishment, disease (TB) and access to sanitation. This had a positive increase of 3.4% change within a five year period closer to that of governance as indicated earlier. Government spending on health amounts to $109 per capita with the total expenditure of 11% of the country's GDP (Downs, Montagu, da Rita, Brashers , & Feachem, 2013).

1.2.1 A snapshot into Lesotho health profile

The Ministry of Health is the GoL line Ministry charged with the responsibility provide health care services to all Basotho. The Ministry's strategic objectives are aimed at addressing the health mandate as outlined by the country as a member of the international and regional organisation on health.

Lesotho is a small landlocked country with a population of approximately 1.8 million according to the 2006 census. Although international and regional reviews have ranked Lesotho high on governance issues relating to health, statistical data on health show alarming results. The 2006 census showed a sharp decrease of 15% in the population growth. The reason for this sharp decline was high mortality rates and low fertility rates. On Human Development Index, Lesotho ranked amongst the least countries and this slow progress was regarded to be due to high poverty levels and disease burden (Ministry of Health, 2013).The country is faced with the burden of both communicable and non-communicable diseases. The 2009 health survey indicated that diabetes and hypertension account for 7% of female admission while for male admission diabetes and road accidents account for 8%. The 2014 health survey indicated an improvement in infant mortality rates. The infant mortality rates is

recorded at 59/1000 and the under-five mortality rates is 85/1000 dropping from 91/1000 and 117/1000 live births respectively from the 2009 health survey (DHS, 2014).

Despite these recent changes, the health sector is still experiencing major governance challenges that hinder it from carrying out its mandate of providing quality health service to all Basotho[i], including that of combating HIV/AIDS with the country ranking amongst the most adversely affected in the world (Cohen, et al., 2009). During her 2015/16 budget speech, Minister of Finance, Dr Khaketla, indicated although health is allocated the second largest government budget, the quality of health is still unacceptable. She acknowledged access to primary health care and shortage of drugs as some of the major governance challenges facing the country (Government of Lesotho, 2015). It is against this background this study examined the governance challenges in the Ministry of Health.

1.3 Problem statement

There is a problem of the escalation of deficits in governance in the Ministry of Health in Lesotho. Although according to Mo Ibrahim Index, the health sector has gained a steady progress on governance indicators that impact on health, such as governance effectiveness, voice and accountability and corruption. The Ministry has not been able to fully carry out its mandate to provide accessible quality health care to all Basotho.

According to the health system assessment, given that Lesotho spend an average of 7.7% of its GDP on health, although other recent studies indicate an average of 11% (Downs, Montagu, da Rita, Brashers , & Feachem, 2013), which is still lower than the World Health Organisation (WHO) recommended 14%. MoH does not have an absolute inadequacy of financial resources. However, it does have a weak local capacity to finance health. Using the Medium Term Expenditure Framework[ii] (MTEF) to estimate budget requirement against available resource, for the period 2008/9 to 2010/11, this study showed a funding gap of M4, 696,984,848[iii]. Amongst the areas with large resource gap is service delivery (Mwase, Kariisa, Doherty, Hoohlo-Khotle, Kiwanuka-Mukiibi, & Williamson, 2010).

1.4 Purpose statement

The purpose of this research is to investigate governance challenges within the Lesotho health sector. In doing so the study looks at barriers leadings to effective system functioning

[i] Lesotho Citizens (plural form). A singular form being Mosotho
[ii] Activity based budgeting and costing framework
[iii] Amount in Maloti (M) equivalent to South African Rand

within the ministry in terms of escalation of deficits. The study aims to present the findings on what the governance challenges are and present what the governance trends in the Ministry are. It aims to outline an analysis of findings which are perceived to be behind the effective systems functioning and hindering the ministry from its ability to fully execute its mandate of providing quality health care to all Basotho. Finally it aims to formulate the recommendations on possible governance strategies which the Ministry can use in order to overcome these challenges.

1.5 Research Questions

This study will address the following questions:

The primary question is: What are the governance challenges in the Ministry of Health in Lesotho?

In order to come up with the answers to the primary question above the following secondary questions will be used:

- What are the factors leading to the problem of escalation of deficits in the Ministry of Health in Lesotho?
- What are the governance trends in the Ministry of Health in Lesotho?
- What are the possible governance strategies the Ministry can employ to escalate its deficits?

1.6 Outline of the research report

Chapter 1: Introduction and Background

This chapter provides the introduction and background of governance in Lesotho. It starts by presenting the governance concept and its challenges, the organisations that have been identified as key drivers of the concepts and how it has come to be a priority for the government of Lesotho. It provides a snapshot into the Lesotho health profile which is the unit of analysis for this study. It highlights the problem statement which shows what the matter of concern is for this study. It also provides the purpose for conducting this research, the research questions and objectives and finally, it outlines the research report sections.

Chapter 2: Literature Review

This chapter provides a stock of knowledge on governance. It presents the stock of documented knowledge that exists relative to governance challenges. It is directly linked to

the problem statement, purpose statement and research questions that have been posed in chapter one above. It is also linked to the findings of the study. It therefore provides a critical analysis of major arguments and similarities on governance and its challenges. Finally it presents the conceptual framework for this study.

Chapter 3: Research Methodology

This chapter provides the methodology used in carrying out this research. It includes the research approach, design, data collection techniques (primary and secondary data), sampling and data analysis methods. A qualitative study with in-depth questionnaires for collecting primary data was used in carrying out this research.

Chapter 4: Research Findings

Chapter four presents the profiling of participants, findings from the respondents of questionnaires distributed and what the documents analysis provided. It also gives a synopsis of the existing situation within the Ministry of Health. Finally, it presents a summary of these findings.

Chapter 5: Interpretation and Analysis

Chapter five provides an interpretation and analysis of primary data. It provides answers to the primary research question of this study on what governance challenges in the Ministry of Health in Lesotho are. A descriptive analysis is used to present and analyse the findings.

Chapter 6: Conclusions and Recommendations

This chapter provides the research conclusions drawn from the findings above and recommendations on what strategies the Ministry of Health could employ in order to overcome the challenges identified. These are based on findings of both primary and secondary data. It addresses the last objective of this research which is to come up with recommendation for the Ministry of Health.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Literature review is a thorough critical analysis of existing research done by the researcher on the topic of interest. The aim is to establish the arguments and conclusions that have already been made on the subject so as to identify the gaps and make recommendations for new research (Babbie & Mouton, 2008; Levy & Ellis, 2006). It brings awareness to the researcher on the arguments that have been brought forward on the area of study (Randolph, 2009).

For the purpose of this study, the literature review was conducted to provide a conceptual understanding and critical analysis on governance. It thus provides some of the arguments and criticisms levelled against governance. The first section defines governance while the second section gives the history of governance and how it has evolved. Governance theories are discussed as part of the study's theoretical framework, followed by the conceptual framework.

This section explains the historical background of the concept and how it has evolved over the years. Later it discusses some of the debates that have been posted against governance and the criticisms subjected to the concept.

2.2 Governance

There is no agreed upon definition for governance in literature due to the fact that it depends on the context in which the concept is being used. However, the concept appears to be the backbone for development. It is used in corporate, international, national and local governance (Panday & Rabbani, 2011). It is regarded as the government's power in managing the nation's affairs irrespective of the type of political regime (Fukuyama, 2013; Mkandawire, 2007; Panday and Rabbani, 2011). In this view, government is regarded as the sole player in managing the nation's affairs.

Weiss (2000) defines governance from a different perspective. That is, from global use of the term as adopted by organisations such as World Bank, OECD, UNDP and other international institutions, to the traditional use of the term from the dictionary to mean "the type of political regime, the way of managing economic and social resources and arrangement to formulate and implement policies" (Weiss, 2000, p. 796). In this view, governance includes different actors from public and private institutions and the government, with a common goal in management of nation's affairs. From this perspective, government is therefore not the sole

player in managing and delivering the nation's affairs. It includes different stakeholders with a common goal. For Fukuyama (2013), there is more to governance than the state's ability to make and enforce rules, and to deliver services hence it is used in corporate, international, national and local governance. This notion therefore, implies that governance prevails in any system.

Despite the differences in definition of the term, commonalities do exist, that include the existence of government, different players with common interests in managing and providing services to the nation. This study examines governance to refer to the degree of state involvement in managing the nation's affairs effectively. In the context of health, this study views the state and its stakeholders' power to manage the nation's health issues and deliver health services. It takes cognisance of all role players in health matters. The state (government) in this context is the central player. However, the state's power in this context is not the Foucauldian perspective of state's power – governmentality as it relates to the sovereign power of the state to manage the nation's affairs (Gupta, 2001 as cited in Foucault, 1991, p. 102).

Governance has been studied by organizational scholars who were concerned about the role of the boards of directors and concerned with protecting the interests of shareholders and their efforts. It also focused on boards of trustees in non-profit making organisations who were viewed to be representing the interests of the community. In public administration governance has been viewed as and studied in relation to "funding and oversight roles of government agencies, especially the activities of private organisations that have been contracted to provide public services" (Provan & Kenis, 2007, p. 230). In this context governance is regarded as a concept that has to deal with theories that take into consideration different actors in governance.

Through its evolution, governance acquired the prefix 'good' making it good governance. This came about partly after studies established the link between policies and institutional arrangements associated with poverty reduction and analysis that found out that corruption and instability hinder development (Grindle, 2004). The practice of good governance has been associated with governments' ability to attain major objectives that involve people in decision-making processes and holding representatives accountable to the people for their actions (Panday & Rabbani, 2011). According to Naidoo (2011) "it implies managing public affairs in a transparent, accountable, participatory and equitable manner" (Naidoo, 2011, p.

32). Good governance and governance have been used distinctively in governance literature, with good governance being treated as a more evaluative concept and aid conditionality compared to governance. Although this is the case, there is no clear demarcation between the two. Therefore, they can be used interchangeably.

Good governance has been defined as one that fulfils certain criteria of analysis (Kakonge, 1998; Panday & Rabbani, 2011) with specific indicators that should be met. They include:

- *Government effectiveness*: the ability of the government to deliver quality services and are independent from political pressures. This includes good policy formulation and implementation.
- *Control of corruption*: pertains to the degree to which public power is exercised for personal or private gains.
- *Rule of law*: is the extent to which the agents have the confidence in the law and abide by the societal rules.
- *Transparency and accountability*: based on the perception that if the public participate in the decision-making processes and policy development, this can have a positive impact on policy outcomes.
- *People's participation*: this denotes the extent to which people participate in the processes of governance and,
- *Equity in governance*: which focuses on equal concern for people's needs.

As an evaluation tool, good governance therefore focuses on effectiveness in policy implementation and whether they bring about happiness in human beings. It focuses on the process of citizen participation in the decision-making process. From the researcher's understanding, good governance is an evaluative measure of governance. It can therefore be used to assess governance by providing certain indicators so it can be classified as either good or bad based on achievement.

Good governance as a concept originated from among African scholars (Claude Ake, Nakhtar Diouf, & Ali Mazrui) and had to do with the state against society relations in Africa (Mkandawire, 2007). Their focus was the problem with state-society relations and they argued that these relations need to be developmental, democratic and socially inclusive. *Developmental* – use and economic management of governance should be designed in a way that enhances economic growth and use of available resources in a responsible and sustainable manner. *Democratic* – which has to do with the citizen's rights and social

inclusiveness, with the citizens being able to fully participate in their own affairs. From this perspective good governance has little to do with issues of transparency and accountability as discussed earlier and as has been assumed in the international financial institutions arena (Mkandawire, 2007).

This paper studies governance from its origins and evolution where it acquired the adjective ‘good’. It thus regards governance to denote state-societal relations with clear measures for attaining equitable delivery of services and any other governance interventions discussed earlier. It disregards any arguments on paradigm shift in adding an adjective ‘good’ to the concept. It therefore studies governance and good governance as complimentary concepts that should be studied concurrently. Secondly, it takes this view because the use of the two separately has been argued as a matter of context (Klijn & Koppenjan, 2000). Furthermore, good governance is regarded as a dependent variable or concept which cannot be isolated from governance. It is against this background that this study examines governance in its entirety and inclusive of good governance. It therefore uses some of the good governance intervention as a basis for identifying the governance challenges in the Ministry of Health at national level.

2.2.1 Key issues in governance studies

One of the major debates around governance circulates around the issue of whether governance is a theory or not. According to Stoker (1998), the theoretical roots of governance are many and range from international relations, institutional economics, organisational development, political science, public administration studies and Foucauldian-inspired theorists. This has led to the criticism posed against governance that it emanates from too many related but different disciplines for it to constitute a theory (Toikka, 2011). However, governance contribution to theory is argued in terms of its ability to provide a framework for understanding changes in processes of governing (Stoker, 1998). As a framework, it therefore does not offer any causal analysis or new normative theory. It can however, be “applied to any policy-making context and could incorporate different competing theories or models…” (Toikka, 2011, p. 8). This study considers governance from this perspective - a theory that provides a framework that can be applied to any policy-making context.

As a framework it provides mechanisms, processes, institutions and relationships through which individual citizens and organisations can express their interests and exercise their rights (Osborne, 2010). It therefore provides the bargaining and mediating platform for

actors. From this perspective governance framework is also a process through which political, economic, social and administrative authority is exercised at different levels - local, national and international. Hence it is about harmonizing the roles, responsibility, accountability and competencies of actors in public, private, civil society organisations and individual citizens at local, national, regional and global level.

Critics of this framework have claimed that authority is spread among too many actors. That no one is actually charged with government responsibility among the public and private and civil society organisations. They further argue that the framework replaces poor public management with private sector inputs rather than providing better public management (Osborne, 2010). Pierre and Peters (2000) state that governance is both a theory and an analytical framework as it is subjective in nature. As a theory, governance is defined as a "proto-theory", that is, it is the body of knowledge that remains observable for a broader theoretical characteristics. As an analytical framework in political studies, governance looks at political institutions, their capacity to govern and the extent to which they exercise their powers to govern.

Stoker (1998, p. 19), draws five propositions that a governance theory should help us answer. First, he states that *governance refers to institutions and actors both from within and outside government*. This means governance has come to recognize the contribution of independent institutions in service delivery and strategic matters. It therefore recognizes government as part of the society than a standalone institution. Secondly, although this is argued to pose the challenge on policy-maker and the public on who is to be held accountable for performance (Ewalt, 2001) thus, leading to scapegoating. Stoker contents, *governance recognizes removal of boundaries for responsibilities for tackling social and economic issues*. This may also be regarded as the "hollowing out of state" where government is pushing some of the responsibilities to the private organisations or non-profit organisations. These organisations are responsible for social and economic issues while government recognizes their contribution for effective economic and political performance.

Thirdly, *governance identifies the power dependence in relationship of institutions involved in collective action*. Because of the power dependence in relationship, no one organisation can command. However, in some instances one organisation can dominate a particular process. Accepting this power dependence means accepting that the outcomes may be different from the intentions. Fourth, *governance is about independent self-governing*

network actors. The most important relationship in governance is about the formation of self-governing networks. Such networks are policy networks which may take over the business of government. Actors in such networks share resources and skills in order to develop policy. The challenge with these self-governing networks are said to be accountability. Finally, *governance is about finding tools and techniques to get things done without government command or use of its authority*. This involves the capacity to develop systems and sub-systems for carrying out government activities. The challenge with this perspective is that it poses the risk of leadership failure (Ewalt, 2001) as the new systems become complex and demanding.

The five propositions allude to and recognize government not as a standalone organisation in carrying out government responsibilities. It recognizes the different actors; private, civil societies and non-profit making organisations operating within the public realm. It thus recognises governance in a form of institutions, networks, systems and subsystems that work together to carry out government activities. From the researcher's understanding, the propositions posed above postulate ways of governing which can be used for analysis purposes. Similarly, Toikka (2011) alludes to governance as a framework that can be applied to any policy context. In view of this study, governance as a framework is about developing tools to carry government activities without the state's direct involvement. Hence it studies the effectiveness and efficiency of health systems' of the MoH and in providing health services to the Basotho nation. The next section therefore focuses on governance challenges.

2.3 Governance challenges

There is a vast amount of literature that addresses governance and its challenges. The concept has been discussed at different levels and has been applied in different contexts. This has therefore made governance a subjective issue depending on the context in which it is applied. Since the 1980s governance has become a major concern even in the international arenas and has been made a priority by international institutions such as the World Bank, International Monetary Fund (IMF). Internationally it became a concern due to the decline in state capabilities and has therefore been used as conditionality for aid (Mkandawire, 2007). Through its evolution over the years, the concept has adopted the prefix 'good' and has since come to be referred to as good governance. The concepts are discussed distinctively in governance literature with good governance regarded as a more evaluative measure.

This section represents a critical analysis of literature on governance challenges. It brings about arguments and debates that address the objectives of this research. The main objective is to establish the governance challenges. In order to find out this, the first step is to discover the reasons behind the systems dysfunction in the health sector and the governance trends. Finally, it will bring about the key arguments and lessons generated from the literature. The last objective of coming up with recommendations will be made based on the literature and data that will be collected in this study.

Governance has been regarded as major solution to many of the country problems. It has been viewed as the key driver behind government effectiveness in providing good services to the citizens (Bevir, 2010). However, the concept comes with challenges that do not just provide solutions but contribute to further strategic and operational challenges within the international and national arenas. It recommends implementation of reforms that have large financial implications especially within the national governments trying to address governance challenges.

Primarily, the governance challenges are concerned with the term itself. Although, the concept has become so popular in the international and national arenas, there is still no agreed upon definition of the term (de Vries, 2013; Khandar, 2009; Lewis, 2011). It has become a subjective concept which changes as per the needs and values of individual contexts. This has therefore made governance inconsistent in the way it is applied. Due to lack of common, agreed upon terminology and adding a prefix 'good' to the term, the concept comes with too many dimensions, levels, territories, institutions and policies; whereby one dimension of governance has so many indicators that it becomes almost impossible to achieve good governance. This is due to the fact that these dimensions lack the priority on what needs to be achieved first (de Vries, 2013). They provide neither short-term nor long-term priorities. Hence it is argued that the concept achieves an all or nothing agenda without due consideration that problems cannot be addressed all at once; whereas priority considerations should be made given the limited resources available and be allocated based on the priority problems. Since there is no agreed upon terminology for governance, it poses the conceptual challenges to the use of the term.

Ideologically the concept emerged as a substitute to government (Crespo & Cabral, 2010; Bevir, 2010). From this perspective it could be argued that governance is a neo-liberal ideology that advocates minimal state intervention in delivery of services. As a neo-liberal

ideology, it joined the development discourse by being used as one of the conditionalities for aid. It therefore joined a long list of conditionalities that have to be met by the developing world in order to qualify for aid. This means it is driven from the international and cultural perspectives of international institutions. This makes governance one of the ticking exercises that have to be cleared before countries can be granted aid without proper in-depth analysis of quality and outcomes. The list is regarded as a ticking exercise as it poses empirical methodological challenges of how these indicators are verified. However, with the passage of time, governance has come to include both government and other actors in providing services. Since the concept has come to be accepted to include government, ideologically, this could also be argued to be the neo-liberal strategy to blame government for its incapacities and inability to deliver services and push for decentralisation of services.

Another challenge relates to governance deliverables. As the aid conditionality for African countries, the governance concept comprises too many unprioritised deliverables that must be achieved at the same time. These makes good governance highly unattainable. Firstly as a driver for development, governance joins the already existing development discourses. Consequently, failure to achieve development is due failure to achieve good governance. All these are evident in lack of agreed upon definition for the term and multiple unattainable indicators that address one dimension of good governance. Governance is hence nothing but a scapegoat for failed initiatives towards development. Therefore, non-progressive initiatives are regarded to be due to deficits in governance.

In Africa, governance challenges run deeper than the concept and ideology debates of the term. These challenges stem from continental, regional to national level. Addressing these challenges has become a priority in international and regional organisations agendas through the Millennium Development Goals (MDGs) and Country Poverty Reduction Strategies (PRS) in pursued for development. Internationally, these challenges have become evident in the country's inability to attain the Millennium Development Goals (MDGs) and poverty reduction. Failure to address these challenges has raised issues related to the leadership of national governments and sector level authorities. The kind of systems employed, institutional strengths and existing capacities to curb the disease burden and improve service delivery (Mekolo & Resta, 2005). Therefore, the need for the national governments to focus on building strong leadership that is at liberty to drive governance agenda cannot be overlooked.

2.4 Governance and health systems functioning

In health, due to globalisation and shared interdependency of disease burden, governance has been viewed as a network initiative. Within this network are international organisations such as World Health Organisation and the national governments. Governance in this context has come to be referred to as global health governance – a concept that acknowledges shared health governance challenges as a result thereof. At the centre of global health governance is national government with their health ministries. Within this context, good governance refers to the ability of government to provide easy and accessible quality health care to its citizens. Consequently global health challenges such as undernutrition, reproductive health, increasing number of infections have been deemed the necessity to have improved governance systems within national governance (Frenk & Moon, 2013).

With the rise of civil society organisations in health, achieving good governance in global health has identified governance challenges relating to accountability and sovereignty, where health is entirely a national government responsibility, with national governments representing the interests of the nations. Moreover, health is affected by policy processes of other sectors such as environment, trade, migration and education, thereby making health governance even more challenging. This necessitates the need to have strong governance systems within nation the health sector. The MDGs and the country PRS with their objectives primarily targeted at health related issues serve as the starting point towards strong governance for health and addressing governance challenges in the health sector.

Globally, governance challenges for health range from communicable diseases such as increased infections, malnutrition and poor reproductive health to non-communicable diseases. These are regarded as systems problems. The answer to these problems is improved governance of health systems at national level (Frenk & Moon, 2013). Consequently, this posits governance as the root problem to dysfunctional health systems and poor health outcomes. Empirical evidence shows there is a relationship between health governance and efficiency. A study into the determinants of health system efficiency in Sub-Saharan Africa indicates a relationship between governance and health efficiency. This relationship indicates that countries with higher ratings on governance are likely to experience efficiency in health systems functioning (Novignon, 2013).Similarly, others have indicated the relationship between increased government spending on health and health outcomes. This means that increased health expenditure results in improved health outcomes (Kim & Lane, 2013; Fryatt, Mills, & Nordstrom, 2010).

Debates and challenges have raged on what constitutes a health system; its elements and functional relationship amongst each other (IDRC, 2011; Kirigia, Mensah, Mwikisa, Asbu, Emrouznejad & Makoudode, 2010; Novignon, 2013). According to WHO (2010), a well-functioning health system is one that responds to the ill-health of the nation, provides equitable access of care to the people and protects the people against the cost of ill-health among others. In order to achieve these, governments need to have a strong leadership and governance that respond to these challenges. Strong policy instruments on financing health for the purpose of addressing the health inequalities are also key. Central to achieving these, is the provision and proper utilisation of human resources for health. A well-performing human resource base is able to address the people's needs. This can be achieved through regulation and employment systems that ensure the right kind of mix through deployment. Within this sphere, good governance can be achieved through good information on health challenges; financing of health including trends and needs on human resources for health. Hence health information system (HMIS) forms the backbone for well-functioning health system (World Health Organisation, 2010). Empirical evidence regards this approach as holistic to attaining efficiency within the health system (IDRC, 2011; Novignon, 2013; WHO, 2010). Experience also suggests that lack of capabilities in health systems in key areas such as human resources, drug supply, health financing, health information may not respond well to other affordable interventions and increasing international assistance to specific diseases (Travis, et al., 2004). Governments, including that of Lesotho, have adopted this approach. As a result, studying governance challenges in the MoH is adopted within a similar system context.

Studies have also shown that chronic health systems result in poor health outcomes including poor and unequal health service coverage which result in poor access to health care. Linked to this problem is governance priority areas as well as the processes and mechanisms used to determine where and how resources are allocated (IDRC, 2011). This challenge raises the question of evidence-based planning and resource allocation mechanisms deployed by national governments. Furthermore, there is the question of cross sectoral resource allocation mechanism for resource allocation between the ministries of Finance and Public service that allocate financial and human resources respectively. Therefore, governance challenges in health systems are evident in addressing disease burden such as HIV/AIDS and maternal health issues. In Africa, on average 1 in every 14 adults is infected with HIV (Lewis, 2006). As indicated earlier, Lesotho ranks second in the world amongst the most adversely infected

countries. This makes HIV/AIDS pandemic one of the worst challenges facing the health sector followed by poverty and an increase in infant and maternal mortality rates (Ministry of Health and Social Welfare, 2010). Sanders, Todd and Copra (2005) assert that this poor state of heath is noticeable through governance. “Fragmented health systems, ineffective health reform policies, corruption, inefficient and uncoordinated donor investment, and under and inappropriately resourced health sector” (Sanders, et al., 2005, p.755) are all challenges of governance. Understanding these challenges helps in addressing challenges of sustainability and efficiency in health systems.

Other challenges of the health system revolve around departmental and functional relationships amongst units within the system. Unsupportive and uncoordinated units that work in silos result in power issues, the consequence of which is a fragmented health system where diseases are addressed independently rather than as a whole and within a system. They also open a gap to donor resources being channelled to addressing single disease. For instance, measures being directed to address HIV/AIDS separately. The problem to this results in vertical and parallel systems that address diseases separately rather than in a system (IDRC, 2011). These pose serious governance challenges relating to the degree of power in decision-making, implementation of plans and financing.

Paramount to the above is the financing of the health system. Studies indicate that the major problem to poor health outcomes is underfinancing or lack of sufficient use of allocated funds (Fryatt, et al., 2010; Novignon, 2013). A recommendation of 15% of overall government budget was made with the aim that this amount would improve health. In countries where this is applied and increased spending on health is incurred, health outcomes have been reported to have improved (Fryatt, et al., 2010). Similarly, a study conducted on government spending and health outcomes in Africa, especially Sub-Sahara Africa, shows governments spent far below this recommended percentage (Novignon, 2013). As such this could be argued to be the reason behind the high disease burden and poor health outcomes in these countries and consequently, deficits in governance. The health system assessment shows the Ministry of Health suffers from this inefficiency. A case is reported where on three consecutive years, MoH failed to fully utilise the allocated budget (Mwase, et al., 2010).

2.5 Theoretical framework

Governance as a concept with theories directs this study to the next section of this paper that deals with theories of governance where the researcher critically evaluates these theories.

Below is a critical analysis of different forms of governance framework that relate to this study. Although these theories may have a relation to the study to be conducted, it outlines the pros and cons of each theory and why they do not form part of the major argument of this research.

2.5.1 Rational choice theory

According to Bevir (2010), rational choice theory is "an organizing perspective or methodology that builds models of how people would act if they did so in accordance with preferences having a certain formal structure" (Bevir, 2010, p. 4). The rational choice theory of governance deals with understanding governance through political systems and through human behaviour. Rational choice is therefore, an analytical theory of individual behaviour under certain jurisdictions or rules.

It is based on the assumption that actors are rational beings and are therefore aware of what they are doing (Pierre & Peters, 2000). The rationality of which is based on the assumption that individuals are aware of their environment and have information available to influence their actions. Individuals can therefore make informed decisions based on that as they are presumed to have all the relevant information at their disposal. It seeks to achieve how the behaviour of an individual affects the society or collective thereby focusing on an individual as the actor. Although criticized for its micro-analysis approach, rational choice theory is regarded a good tool to help develop political institutions and formulate policies (Bevir, 2010). However this may pose some challenges with regard to compliance due to its narrow view in formulating policy.

The rational choice theory (Bevir & Rhodes, 2001) has been argued to be associated with the neo-liberal agenda in that they both draw from neo-classical economics which draws the analytical model form micro-analysis in trying to understand the collective. The individual is presumed an economic being who acts on informed decisions – it is a theory of self-interest. Although the second generation rational choice theorists may regard the context of a collective decisions, in the end, the aim is to see how the outcomes of the collective affect the individual (Feiock, 2007). From the rational choice theory perspective, governance implies the minimal role of state in governing things, whose purpose would be aimed at decentralisation of services.

As cited above, this theory is more interested in satisfying the collective from the individual perspective. It therefore does not echo the purpose of this study. From the perspective of this

school of thought, governance challenges would be having the state as the central player in provision of services. It would therefore recommend the decentralisation of services on the premise that individuals on the grassroots know what is best for them since they have access to information to make informed decisions. This perspective presents the challenges of services being accessed by the selected few who have full information. Failure to access services would be blamed on the individual as the individual is perceived to have all information available. From this perspective, governance is therefore inherently a problem related to rationality. This study aims to look at governance to include different actors with the state as the central player.

2.5.2 Institutionalism theory

In political science, institutions have been praised for their ability to produce positive outcomes politically and socially (Pierson, 2000). However, their origin is still a dilemma. According to Barzelay and Gallego (2006), different institutional perspectives (historical, rational choice and sociological) emerged as a result of behavioural revolution in the 1960s and 1970s. Their focus was to analyse the impact of institutions on social and political outcomes. However they differed in two aspects. Firstly, in how they conceptualized the relationship between the institution and behaviour. Secondly, they differed in how they explained the processes of origin of institutions and how they evolved. How each conceptualized these relationships is beyond the scope of this paper and will not be discussed in detail.

As a theory of governance, institutionalism examines the role institutions play in the process of governance as well as their impact on governance (Pierre & Peters, 2000). Bevir (2010) regards institutionalism as an overarching, broader approach to governance and the study of social science. This approach therefore studies institutions using inductive, historical and comparative models. Hammond (1996), suggests that institutions can be used as theories of policy-making whose studies should be based on empirical research. This is due to their massive experience accumulated over the years. He notes institutions have been at the centre of comparative politics and studies for decades. As a result they have an advantage of being used effectively as a basis for empirical research (Hammond, 1996).

Studies in institutions have diverted into two parts, new and old institutionalism. The deliberations in between the two will not form part of this research paper. However, over and above, the institutionalism emphasizes on rules, traditions and decision-making processes, the

difference between the two is that the old institutionalisms are descriptive, while the new institutionalism places emphasis on routine and socialism in these processes (Kerremans, 1996) and is more concerned with theory development.(Reich, 2000, p. 504) states:

> *It seeks to explain [institutions] as a "dependent variable" and, more importantly, to explain other phenomena with institutions as the "independent variables" shaping policy and administrative behaviour....* (as cited in Guy Peters, 1996, p.206).

Without detailing what each institutional perspective says, in general, the institutional scholars' aim is to understand how institutions influence policy-making and political outcomes. By institutions they refer to "norms, rules of the game, cultural practices" (Berman, 2013, p. 222) or according to the understanding of the researcher, anything that shapes the behaviour of the actors within a particular sphere, either being economic, political or cultural. Critics of institutionalism have been on defining what constitutes the institutions. Berman (2013) indicates institutionalism theorists fail to come up with an agreed upon definition of what constitutes the institutions, why institutions matter and a clear indication of which institutions to focus on. As a result of this, institutions fail to come up with a unified theory.

From the researcher's understanding, institutionalism theory of governance focuses on ways of shaping the behaviour of the actors. These institutions may help shape the self-interest of the actors, through rules and processes within the institution. Governance from this perspective would mean the degree to which institutions are able to develop rules on delivery of services to the citizens. From the institutionalism perspective, governance challenges would be due to weak institutions in providing rules that shape the behaviour of actors in delivery of services. They would therefore focus on the impact of institutions on social life. Remedies to governance challenges would be focused on enhanced institutions. This paper assumes the existence of well capacitated institutions and does not focus on assessing the impact these institutions have on the outcomes.

2.5.3 Principal agent theory

Principal agent theory is mainly used for analysing public accountability (Gailmard, 2012). As an analytic tool, it provides a framework for modelling variations in institutional arrangements of who is accountable to who. In this theory, the actors are labelled as the principal and the agent. Therefore the principals are able to check the performance of their

agents. The principal-agent theory is regarded as the formal model addressing related concerns using similar analysis (Gailmard, 2012). The principal makes the decisions concerning the agent. These decisions may be in relation to the incentives of the agent. Where this is the case, this constitutes a contract between the principal and the agent.

In sociology, political and public administration studies, it is applied as a contractual relationship between buyers and sellers. However it derived from disciplines such as law, finance, accounting and economics. It has since become the basis for studies relating to bureaucracy to elected officials. It is therefore defined as follows (Waterman & Meier, 1998, p. 174):

> "*In its simplest form, agency theory assumes that social life is a series of contracts. Usually, one member, the 'buyer' of goods or services, is designated the 'principal, 'and the other, who provides the goods or service is the 'agent'. The relationship is governed by a contract specifying what the agent should do and what the principal must do in return*" (as cited from Charles Perrow, 1986, p. 224).

The principal-agent theory is more concerned with accountability between 'principal' and the 'agent'. The accountability is achieved through the contractual agreement. With focus on the relations between the two, how the principal gets the work done through the agent. Through the contract, the principal tries to shape the behaviour of the agent in line with the principal's preferences. If governance is defined as the state's power to deliver services, in principal – agent theory, it would mean the degree to which the agent carries out this function on behalf of the principal. From the principal agent theory perspective, governance challenges would be regarded as lack of accountability and bureaucracy; whereby the principals fail to put measures of accountability on the agents and the agents drive their own interests at the expense of the principals. Lack of authority by the agents and the extent to which agents have to consult with the principals for certain actions constitutes some of the challenges.

2.5.4 Systems theory

The word 'system' is derived from the Greek word '*sunistánai'* which means "cause to stand together" (Pieters, 2014, p. 1). Bevir (2010) contends the systems theory views governance as a system within which other systems exists with interrelated processes, coordinated to achieve defined goals. It is characterized by its ability to explore issues of meta-governance, such as the possibility of governing self-governing organisations and how the states try and

might do so (Bevir, 2010). The systems theory can hence be regarded as defined processes which can be regarded as systems of governing networks between public and private interactions.

As a field for enquiry, the systems theory originates from disciplines such as biology, anthropology, physics, psychology, mathematics and management. The systems theory can be traced as far back as the 1920s as the thinking of the biologist Ludwig von Bertalanfy. Bertalanfy was of the idea that organisms, human organisations and societies are open systems; that they have subsystems that are related and interdependent on one another. Also, they function within and linked to and are influenced by the environment in which they operate (Nkuna & Sebola, 2012; Pieters, 2014).In sociology, the concept has a long history whereby society has been viewed as a system. The concept of systems in social science thus emanates from natural science where it refers to specific sets of interactions (Nkuna & Sebola, 2012; Rodrigues, 2009). Its analysis in social science has to do with the role individuals play and their interactions.

The systems theory can therefore be characterized by the interdependence of the subsystems. Because these subsystems are interdependent, it means then that they are linked in terms of how they function. The deficiency of one can affect the other – their interactions affect their survival. Based on the researcher's view, the theory is related to one of the propositions by Storker (1998) that views governance as a framework from which the state finds tools and techniques to get things done without using its authority. Similarly, it may share the challenge of leadership failure under this proposition. From this perspective, governance challenges would be due to uncoordinated subsystems that operate independently not as interdependent units. This view forms part of the broader view of this paper as it studies governance challenges within the health system. The relation will be further explained during the discussion of the conceptual framework. Although this theory encompasses some of the concepts of different theories including the institutionalism which can be regarded as encompassing, due to its complexity, the systems theory poses a challenge of hierarchy within the government system. Hence it resulted in a call for public sector reform in the 1980s and 1990s that called for decentralization of public services (Osborne, 2010).

2.6 Conceptual framework

2.6.1 Introduction

This conceptual framework is informed by the literature review as discussed above. It is also informed by the adopted definition of governance as conceptualized within this paper. Over and above the cited definition of governance, it has also been referred to as self-organising networks or inter-organisational networks (Klijn & Koppenjan, 2000; Osborne, 2010). This study therefore uses network theory of governance as its conceptual framework, primarily because it aligns to the primary purpose of this study as outlined earlier in the paper and the concept of governance as defined and adopted in this study. This section provides a critical analysis of networks governance. It starts by defining the term ‘network’ on its own and continues with a discussion on network as a theory of governance. It later argues the use of this theory as a conceptual framework for this study.

Borgatti and Halgin (2011) defines a network as a set of actors with ties that link them together. These ties may be the friendships. Similarly, from the sociological perspective, network theory refers to interrelated mechanisms and process within the broader structure that work together to yield certain outcomes for individuals or groups (Borgatti & Halgin, 2011). This study moves away from the concept of network as advocated by some of the prominent network theorists (Burt 1992; Granovetter 1983) as they relate to networks of social ties or social networks. Proven and Kenis (2007) describe network as a group of two or three autonomous organisations working together to achieve a common goal. This research views networks form the sociological perspective of networks as processes that interact within a structure or system in order to yield certain outcomes for the group.

2.6.2 Network theory of governance

The network governance has been studied in magnitude for the past decades albeit to date there is no universally accepted terminology regarding the policy network governance. Bevir (2010) denotes network policy of governance emanated from earlier pluralists who challenged the sovereignty of the state. Although the focus was to disaggregate the state and focus on groups, these pluralists have pointed to different interactions, processes and networks that contribute to governing.

In the similar manner to governance, different studies have settled for different definitions which deemed applicable to and within the context of their studies. Similarly, are debates as to whether it is a method, an analytical tool or a theory (Lewis, 2011). The use of networks in

policy science dates as far as the early 1970s. It has then been used to map relations between organisations and assess their influence in policy processes. Through its evolution, policy network has developed its own theoretical framework (Klijn & Koppenjan, 2000). The framework assumes that policy is an outcome of interactive process between different actors from autonomous organisations. Thus, governance network recognizes policy as involving the interactions of different stakeholders. As a result of this, it is a process not fully controlled by government and recognizes the participation of actors from different spheres (Lewis, 2011).

In political science and public administration, networks have been used as a metaphor to describe the government society interactions or interests of interconnected actors which affect policy. As a metaphor, network governance describes the increasing fragmentation of society which needs to be connected through networks. This triggered the criticism that network governance is only metaphorical and not explanatory. Political scientists and public administrators therefore argued network governance should go beyond providing typologies in order to examine causality (Lewis, 2011).

Provan and Kenis (2007), describe network governance as a device of coordination. According to Sørensen and Torfing (2009), network governance can also be referred to as policy task force whereby actors from public and private organisations form strategic alliances or arrangements for the purpose of policy. Network governance is further defined as self-governed interactions between interdependent actors in order to contribute to the public purpose, where actors operate within a self-governing framework but within limits (Sørensen & Torfing, 2007). Toikka (2011,) defines network theory of governance "as a complex policy making situation where a variety of public and private actors collaborate in order to produce and define policy." (Toikka, 2011, p. 3). Trying to understand governance from this perspective often focuses on policy network. And governance from this perspective therefore focuses on the interaction of multiple organisations in network for the purpose of policy.

According to Toikka (2011), network policy places no normative conditions on governance. That is, discussions of good governance do not focus on the external accountability. These organisations have a common goal and are self-governed. Networks undermine the concepts that treat the state as the sole actor in policy. Bevir (2010), contends, they pay attention to different processes and interactions that bring together different individuals, organisations, public or private to produce policy (Bevir, 2010). This paper therefore regards network

governance as units and sub-units of the system that work together and are dependent on one another in order to yield certain outcomes. Different authors used the concept of network governance differently, however, they mainly described them as links between the different actors.

The concept of networks dates as far as the 1950 and 1960s by Heclo to denote public-private linkages involving a number of actors with expert knowledge. He introduced the concept in the United States as an alternative to the 'iron triangle' model that was used as a state-industry relations. He argued that comparatively, networks are open and fragmented, involve a number of actors while iron triangles were characterised by closure and segmentation. Katzenstein used the networks to characterise the link between public and private sector in the implementation of policy (Van Waarden, 1992). Other historical developments trace network analysis as far back as the late 1960s and early 1970s as being aggravated by the demands of globalisation and decentralisation in Public Administration (Bogason & Toonen, 1998).

Lewis (2011) notes these earlier developments of networks in the United States and British literature focused on the micro level of networks. However, the British was more influenced by the European inter-organisational literature. The impact of this was not major on the basis of its unit of analysis. It was argued that the micro level analysis of personal networks would make it difficult to generalise on policy networks. Hence the late 1970s saw social network analysis grow as an inter-disciplinary sub-field focusing on how they can be measured or modelled, making social networks more accessible in other fields of inquiry. The major development on network governance was that of policy analysis where theorists concluded policy was effective if different actors were involved (Lewis, 2011).

Advocates of governance networks (Parijs, 2013), have praised them for their potential to make public policy perform effectively and efficiently due to their involvement with different parties. Some have claimed the communities of policy also benefit from improved access to services, as a result there is improved client satisfaction. This could be due to the fact that governance networks include different independent autonomous organisations and individual citizens. The involvement of diverse parties may be regarded as the source for enhanced client satisfaction in that policy gets to answer the needs of the public hence access to services. However governance networks have been criticized for lack of or inability for individuals to participate and/or influence policy debates formed by networks. This is

because they are regarded as a threat to traditional boundaries of democracy. They have also raised questions regarding political power and responsibility (Parijs, 2013). They have been argued to open room for some actors to use power and resources to further their own interests. This study argues that where networks are utilised to inform policy, units and sub-units or organisations within the network support one policy. This is because these units are part of and support the processes that inform such a policy. Consequently, policy outcomes represent the interests of the majority especially the grassroots level citizens.

Over and above the cited criticism, networks have been criticized for limited or sometimes no accountability at all (Provan & Kenis, 2007). The argument is that in network governance the state does not possess the same authority that public organisations possess. Hence the inter-organisational arrangement poses accountability challenges to the state since such networks comprise the autonomy of organisations. On the other hand, these networks are argued to be used to enhance the capacity of public administration and that they represent the views of the broader society. However, this approach poses a challenge of policies being developed through networks to heavily represent the interest of organisations with strong financial muscle and dominant actors than the needs of the broader society. Although given the state's position of being the central actor for such networks, these challenges could be minimised (Koliba, Zia, & Mills, 2011). This study believes that with strong leadership, well-coordinated donor funding mechanism and strong involvement of civil society participation, the broader societal needs can be addressed. Hence the need for reliable systems that informs policy. Therefore, organisations in a networks can support plan based on evidence.

From the researcher's understanding, networks have been commonly used for policy development. Networks therefore constitute a framework due to the fact that they provide certain assumptions under which they operate. Under policy development network, the assumption is that the resources are dispersed between different actors. It also assumes that due to the involvement of different actors, policy outcomes may represent the broader social. interests and capacity building. Network theory therefore regards policy as an interactive process that does not solely rely on the state. It can also be regarded as the state resource mobilization process aimed at meeting the broad social. interests and increasing the limited resources distributed amongst different players. Despite the criticisms that have been levelled against network governance as discussed above, networks have gained increased recognition over the years as the best and/or preferred strategy for policy development and implementation and have been very common in health.

Despite the gained popularity of governance networks in health, international studies argue the administration dominance discourses in network governance. In the Dutch city of Breda, Kokx and van Kempen (2009) found that networks operated as vehicles for achieving national government objectives. That the leading state and market alliance worked together to exclude other partners. In Mexico, Guarneros-Meza (2008) observed that governance networks generated no trust among actors and institutionalised elite governance making the idea of self-governing irrelevant (Devis, 2012). These shows network governance to enhance hegemony from the governing government and elites excluding other stakeholders. A similar challenge alluded to earlier was raised by Koliba, et al (2011) arguing that policies developed thorough networks may represent the interest of those with actors with financial muscle (Koliba, Zia, & Mills, 2011).

However, the ethos of network governance remain strong in other areas. According to Börzel (2011), a comparative policy and political literature in the 1970s in British by Rhodes showed that network governance might help overcome incapacity problems of government. A similar study in German indicate networks are interaction between government and non-government structures where policy is made. They show government has become independent on cooperation of non-governmental organisations and joint resource mobilisation of other policy actors. The participation of non-governmental actors in policy development helps the government in policy development in terms of both quality and implementation. Such networks allow government to mobilise resources between public and private actors (Börzel, 2011). The major criticism however against these has been that such public-private partnerships are associated with the neo-liberal agendas of new public management which are less interested in enhancing government capacities (Osborne, 2010).

Studies have shown that civil society organisations have a long history in providing health services effectively, hence this paper argues a strong network between CSO, and NGO's can help in escalation of deficits (Ziersch & Baum, 2004; Blas, et al., 2008; Management Science for Health, 2015). Evidence shows that the engagement of target communities or beneficiaries of health to increase the likelihood of effective policies on individual health and being acceptable. In the United Kingdom, in an effort to find if engagement of civil society is good for health, Campbell and Wood found that areas with large networks and better civil engagements had better health outcomes (Ziersch & Baum, 2004). In South Africa, a network of broad-based diverse social movements plays an important role to address inequalities in racial, sexual and HIV/AIDS treatment (Blas, et al., 2008). In Lesotho, a network initiative

between a USAID funded non-governmental organisation Building Local Capacity (BLC), aimed at building the capacity of government, parastatals and civil society organisations (CSO) to effectively address the HIV/AIDS pandemic and a civil society organisation - Phelisanang Bophelong, showed positive results in mobilising the community and therefore increasing the referral of HIV Testing and Counselling (HTC) and Prevention of Mother to Child Transmission (PMTCT) services in 2013-2014 (Management Science for Health, 2015).

This study draws on the network governance from the perspective of public administration where policy is regarded as an interactive process between the different stakeholders, under the belief that policy is an interactive process that is not controlled by governments alone but through the involvement of different actors from different spheres (Lewis, 2011). It focuses on networks as a government strategy for mobilizing resources where they are spread between private and public actors. Resource-mobilization, from the understanding of the researcher in this paper, includes both financial and human resources. The human resource would then include skills and expertise from both the public and private actors; that government sources expertise from the private sector in order to develop policy and also exercise capacity building tactics. The involvement of these actors is assumed to be due to special skills such actors possess in relation to a particular problem (Klijn & Koppenjan, 2000).

Although networks have been used mostly for policy development and all stakeholders regard this as an interactive process. This study argues network are also important applied within the systems (in this case health systems) for execution of policy. The study also argues that the use of networks to support policy based on evidence is paramount for mobilising scarce resources. Hence networks within the system are not important just for policy but for execution and implementation of the policy in the health systems through support of processes within a system. This paper studies the governance challenges within the Ministry of Health in Lesotho and shows how the use of networks can boost limited resources and their allocation in the health systems.

2.7 Conclusion

The literature defines governance to imply processes beyond the state. It also regards governance as a theory that provides processes that can be applied in different policy making contexts. Therefore it focuses on the different actors beyond the state that give meaning to the

process of service delivery. Through its evolvement, governance has come to be one of the aid conditionalities under the auspices of good governance. Since then it has become one of the buzzwords in the international, regional and national arenas. Despite increased interest in governance, there is no empirical evidence on what constitutes good governance, hence it has become a subjective concept.

One of the major arguments pertaining to governance challenges seems to point to the use of the word and its lack of specific meaning. However, three common things are evident in the different meanings across different disciplines and they are: state, market and community. Because of the subjective and inconsistent nature of the term, it also has different typologies which have therefore joined the ideological discourse amongst scholars. This has resulted in the many criticisms against governance. Hence it has so many dimensions that make it impossible to achieve. The concept has come to be widely accepted to include state and different actors in managing public affairs. It has therefore been regarded as the driver for development.

Consequently, governance has come to be regarded as the root problem to many of the government's inability to provide services to the citizens and failure to realise development amongst nation states. Governance challenges manifest themselves through institutional arrangements, systems deployed and their outcomes. These are evident through issues of leadership, resource allocation, decision-making and power distribution within the institutions. It has thus been the priority in the public service domains and the international institutions and gained popularity in research agendas. Prominent is the ideology debates on the concept of governance, whether governance is best pursued with government at the centre or without government involvement. Lack thereof to agreed ideology has resulted in the contextual use of the concepts and its inconsistency over use. Hence the concept has acquired different dimensions based on how it is applied. At the heart of it all, is the need to prioritise governance as it is the source and answer to many of the institutional problems that result in systems problems. As a result, governance poses a challenge on its own to nation state which needs to be addressed. However, these challenges do not postulate an end to governance as, through increased accountability and efficiency, it is argued to achieve the expected outcomes.

The conceptual framework views the network theory of governance for policy formulation. This theory mainly recognizes the role of different actors in policy formulation. It is also

regarded as a capacity building strategy where government sources resources amongst different actors with shared interests with the purpose of enhancing policy and outcomes thereof. Although networks have been criticised for lack of accountability, this paper aims to go beyond the issue of accountability and study how networks can be used to increase deficits in the Ministry of Health in Lesotho. And how networks can therefore be beneficial for increased efficiency in delivery of services as a result. Thereby overcoming the existing governance problem of the escalation of deficits by mobilising resources between both public and private organisations.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

Research methodology is the delineation of how the researcher wants to conduct the study (Wagner, Garner, & Kawulich, 2012)in order to come up with possible answers to the research question. There are three approaches to social research namely: quantitative, qualitative and mixed methods approaches. In mixed method approach, also referred to as multi-methods, the researcher uses both quantitative and qualitative approach as a way to come up with answers to the research questions. The purpose is to add more depth and detail to the findings (Maree, 2007). This chapter provides the difference between two elements of enquiry, quantitative and qualitative approaches. It further provides and justifies the approaches followed in this study. Finally, it explains the data collection processes and the techniques used.

3.2 Approaches to Research

As mentioned earlier, there are three approaches to social research. These approaches are the basis of how the researcher symbolises the social reality. There are three ways in which the researcher may choose to view the social reality and that is through numbers (quantitative), through words or visuals (qualitative) or through the mixed approach, where the research uses both quantitative and qualitative approaches in a study (Wagner,et al., 2012). Creswell (2003), differentiates between the two approaches (quantitative and qualitative) in terms of their "philosophical assumptions to social reality, epistemology, values, the rhetoric of research and methodology" (Creswell, 2003, p. 4). Wagner, et al., (2012) refers to these as a paradigm that helps us understand certain assumptions and beliefs about the problem and how it is to be investigated. Maree (2007) further contends that each approach has its own methods and strategies for obtaining knowledge and criteria for assessing the quality.

The epistemology has to do with theory of knowledge that informs the research, while philosophical assumptions deal with the theoretical perspectives behind the methodology. The methodology then indicates the plan of action linking methods to outcomes. Techniques that are used in each approach are also signals of the difference between the two approaches. All these contribute to the research approach that is either quantitative, qualitative or mixed. Below is a brief explanation that sets out the difference between quantitative and qualitative approaches.

3.2.1 Qualitative Research

Qualitative research is defined as a context-specific research that collects rich descriptive data on a particular phenomenon with the purpose of understanding what is being studied (Maree, 2007). It is concerned with understanding the social and cultural settings behind any behavioural patterns. According to Wagner, et al., (2012), it is a process of understanding the social and cultural context which shape the behavioural pattern based on experiences. Qualitative research can therefore be defined as a social and cultural study aimed at understating the behaviour of research subjects under study. As a result, qualitative researches tend to be more interpretive in nature. Similarly to quantitative research, qualitative research resonates within a particular paradigm with different epistemological beliefs and ontological assumptions from those of quantitative research (Wagner, et al., 2012).

According to Maree (2007), qualitative research was initially regarded as the sub-discipline of sociology and anthropology. However, in the 1970s it gained its popularity into other social science disciplines as a research paradigm. It was recognised in research methodologies of studies in the fields of feminism, psychology, education, organisational management and nursing. Growth and popularity of qualitative approaches was further seen in other philosophical theories of structuralism, post-structuralism, constructivism and post-modernism. From these new developments, research is seen as a means of generating theory not just verifying or refuting theory. Hence qualitative research is an over-arching term for research approaches and methodologies such as, naturalistic, subjective, interpretative, etc. (Maree, 2007). Creswell (2003) contents that the popularity of qualitative research was aggravated by those that felt constructivism did not go far enough to cover marginalised people. Thereby arguing that the research has to go hand in hand with politics and political agenda (Creswell, 2003). In this view, this is where the subjective and context nature of qualitative research lies.

Unlike quantitative research which emphasizes use of science in the representation of social reality, qualitative research focuses on the context in which things happen and the interaction among individuals. It therefore draws from constructivism school of thought that believes the uniqueness of each particular case. As a result, it is concerned with addressing the why question of research. Constructivist approaches are subjective in nature since they focus on the uniqueness of the situation (Maree, 2007). Wagner, et al., (2012) content this approach is subjective in nature because researchers believe knowledge is developed socially and is

mind-dependent; that the truth is based on human experiences (Wagner, et al., 2012). Similarly, Maree (2007) notes the view of the reality of the world comes from how individuals have constructed it. He argues that understanding human life comes from within therefore, researchers tend to focus on the quality and depth of information provided in research rather than its breadth (Maree, 2007).

In qualitative research, theory is used to explain the behaviour or attitude. Alternatively, it is used to guide the researcher's study on what issues are important to observe and raise other questions to be addressed in the study (Creswell, 2003). Therefore it tends to give the specifics of the research study. Qualitative researchers use inductive reasoning to analyse their data (Wagner, et al., 2012). They note, this type of reasoning works well in single cases or where a specific phenomenon is to be explored. According to Neuman (2011), in inductive theorising, the researcher starts first by observing the world around and reflects on making a clear picture thereby starting to theorise and make propositions based on these reflections (Neuman, 2011). Creswell (2003), states that unlike the deductive process where information is collected to refute or test the theory, the inductive process starts with the research gathering information, which is then organised into categories or themes that are then developed into theories. These theories are then compared with personal experiences and existing literature on the topic (Creswell, 2003). Therefore, theory in qualitative study is an end point to the study. Wagner, et al.., (2012) contents it is a process that moves from the specific to a broader view. In qualitative research, theory is thus made by making comparisons, hence their subjective and explorative nature.

In terms of language, contrary to the quantitative researchers that speak the language of variables and hypotheses, "qualitative researchers speak the language of cases and contexts" (Neuman, 2012, p. 151). They focus on examining cases that happen in the natural setting of social life and presenting interpretation to specific historical contexts. They examine themes, differences and ideas, thereby adopting an inductive approach of grounded theory, which develops theory from the data and developing insights. Their focus of inquiry is therefore on the individual and can then be applied to the broader societal perspectives (Creswell, 2003; Neuman, 2012 &Wagner et al., 2012). This language of cases and contexts is associated with constructivist or interpretative paradigm that utilises qualitative methodologies that address understanding the social world based on personal experiences. One of these qualitative approaches is ethnographic research, which has its purpose as to describe and interpret cultural behaviour (Wagner, et al., 2012). Neuman (2011), note that for a qualitative

researcher to understand the social world, context is very vital hence the approach tends to be more case-oriented. Because of this, they tend to be less interested in sample representatives but rather on gathering more cases and events that deepen the understanding of social life (Neuman, 2011).

While quantitative researchers are more concerned with validity and reliability in the measurement to determine the quality of the outcome, these two concepts are applied differently to qualitative researches. Qualitative researchers speak of research validity and reliability; which has to do with research credibility and trustworthiness (Maree, 2007). According to Neuman (2011), in order to obtain reliability, qualitative researchers use different techniques in their observations. They consider different data sources and a number of measurement methods to provide different dimensions to the subject being studied (Neuman, 2011). Creswell (2003) states that the concept of reliability is rarely used by qualitative researchers as it is only used to check consistency of patterns in themes. However, validity on the other hand is regarded as the strength of qualitative research. Unlike in quantitative research where it is vital in measurement, in qualitative research validity is used to determine the accuracy in the findings from the view of all participants (researcher, participants and readers). It therefore has to do more with authenticity of the findings (Creswell, 2003). Neuman (2011) contents validity in qualitative research has to do with providing a fair account of findings from the viewpoint of someone who lives it on a daily basis. In order to obtain the research validity and reliability, qualitative researchers use multiple methods of data collection such as observations, interviews and document analysis (Neuman, 2011).

Qualitative research is therefore characterised by its naturalistic approach, which aims to understand context-specific situations (Creswell, 2003; Maree, 2007; Neuman, 2011 & Wagner, et al., 2012). As a result, data gathering techniques such as interviews and observation are commonly used in this approach. Contrary to the objective approach in quantitative research, qualitative researches are subjective in nature and the researcher is highly involved in the whole research process. Thus, they are regarded as research instruments in the research process. Because of the context-specific nature of qualitative research, non-probability and purposive sampling techniques are used in selecting the population to study. This means participants are carefully nominated because they hold information vital to the study. (Maree, 2007). Neuman (2011) contents qualitative researchers focus less on the sample representativeness but on cases that are relevant to the topic and will

give in-depth understanding of the phenomenon under study, hence their use of non-probability sampling techniques (Neuman, 2011).

The major objective of this research was to investigate governance challenges within the Lesotho health sector. In order to address this objective, this study aims to conduct an in-depth empirical study that describes the reasons leading to this challenge. The aim is to gather and analyse different perspectives and experiences of the health sector staff in different departments. This approach was found to be qualitative in nature, not quantitative. Qualitative research facilitates in-depth study that promotes focus to a particular context and allows for gathering different views of participants (Biggam, 2011). It thus provides the researcher with rich information. It is influenced by the social reality that exist. The social reality provides the researcher with an interest for further study (Wagner, et al., 2012). This provides possible reasons why the health sector fails to provide quality health care to all Basotho. Qualitative research is best suited for the research that is aimed at understanding and explaining social phenomena. In this case the research was aimed at understanding the governance challenges within the health sector and describing the reasons behind the dysfunctional health system thereof. It also aims to achieve the set objectives as indicated earlier. It was influenced by the work environment, whose area of interest is governance challenges in MoH. The unit of analysis for this study was the Ministry of Health.

Contrary to quantitative research that is concerned with providing statistical analysis of findings based on numbers and measurement also referred to as quantification of data (Biggam, 2011), this study does not provide statistical analysis of its findings but a descriptive analysis based on experiences of individuals within the departments. At the end, this research aims to explain possible reasons leading to weak internal system and identifying governance trends. The study also aims to ascertain if the escalation of deficits in governance has anything to do with the weak internal system. Generally, this approach will allow the researcher to establish and understand what the governance challenges are in the Ministry of Health based on the experiences of people within the systems; thereby addressing the primary purpose of this research. In order to address the first objective of this research which was to establish the barriers of effective systems functioning, a qualitative research will help establish how resources are allocated and the degree to which the managers of different units have power in decisions that are made in relation to allocation of resources based on experiences of functional staff members. It aims to provide therefore more than statistical analysis of data but information based on incurred experience.

This research draws on an interpretative school of thought. This school of thought emerged as a criticism to positivism school of thought. It argues against the use of numbers and takes into account that the context in which things happen is embedded in the social reality. It argues for the use of symbolic and verbal presentation of data on the basis of context. Interpretative school of thought is therefore very subjective as it is context-specific in nature and does not aim to generalise (Wagner, Garner, & Kawulich, 2012). This research is therefore context-specific to the Ministry of Health in Lesotho, the results of which are not aimed to be generalised to any other ministry or health sector.

3.3 Research design

A research design is a process of specifying the process of selecting the informants to the study, data collection techniques and how the analysis of data is to be done (Maree, 2007). The research design is based on the researcher's assumptions and influences how data is to be collected in a study. Creswell (2003) points out that research design refers to strategies of enquiry that focus on data collection, analysis and writing but derive out of research disciplines and carry through the entire research process (Creswell, 2003). Different qualitative designs exists and these include conceptual studies, historical research, action research, case study research, ethnography and grounded theory (Creswell, 2003; Maree, 2007; Wagner, et al., 2012).

Central to this study was to investigate the governance challenges within the Ministry of Health in Lesotho. This accounts for a thorough, descriptive design given the explorative nature of this study, the results of which are based on different perspectives of staff in different units on what the factors contributing to the system dysfunction are. Exploratory research may be used to get a better understanding of the concept, it helps the researcher explore the situation where the problem is not clearly defined (Wagner, et al., 2012). For the purpose of this study, explorative research will help the researcher identify the governance challenges by looking at the reasons behind the dysfunctional system within the health sector, focusing on different elements that make up the health system as informed by literature. These include issues related to leadership and governance, resource allocation and HMIS issues amongst others.

3.4 Sampling

A purposive non-probability sampling was used to identify the research subjects. A purposive sampling is referred to as judgement sampling (Wagner, et al., 2012). The aim is to sample

participants with a goal in mind. In purposive sampling, the goal is to sample those participants who will be in a position to provide relevant information to research questions posed. A purposive sampling was ideal as the researcher wanted to find experienced challenges by departmental heads and staff in different units of the sector. Because of its non-probability nature, a purposive sampling does not allow a researcher to generalise to the larger population (Bryman, 2013). The results of this study would therefore not be generalised but would be specific to the Ministry of Health in Lesotho.

3.5 Data collection

Two types of data were used in this study; the primary and secondary data.

According to Leedy and Ormrod (2005), primary data is the most valid and true as it is obtained directly from the source. It is regarded as raw data as it has not been processed in anyway. This data was used for analysis and forms the basis for conclusions drawn in this research. For this study questionnaires comprising of structured open-ended questions were distributed and administered to the Ministry of Health headquarters staff in different units to provide feedback on barriers to effective system functioning. The questionnaire started by providing the background to the study and stipulating the research objectives. It further indicated the participants' confidentiality clause for participating and sought their consent by appending their signatures on the questionnaire. The data collected was then analysed to determine governance challenges within the Ministry.

3.5.1 Questionnaires

In this study, a questionnaires (Appendix A) was used to collect primary data. Questionnaires are other forms of providing qualitative data. They have a high convenience advantage since respondents complete them at their own time. Hence they limit the interviewer's bias that interviews have. Questionnaires also provide a high degree of anonymity to the respondents, thus making them more comfortable to provide the research with the required information. Because of this, they provide the researcher with an opportunity to be objective when analysing data (Biggam, 2011). The questionnaire was designed in a highly structured manner that captures different components of a well-functioning health system. It aimed to identify barriers to effective system functioning in these elements of health system governance and aimed at determining the trends within the Ministry. Section one determined barriers to effective health system functioning. The sub-section included governance and leadership, health information system, health financing and human resources for health.

Section two focused on determining governance trends and included sections such as decision-making powers owned by managers. The questionnaire comprised open-ended questions in order to allow the respondents to provide more information on the questions. These sought to address objective two and three of this research which is to find barriers leading to functional health systems. This section comprised of resource allocation questions, donor resource allocation and decision-making questions. Section two aimed to determine governance trends within the Ministry of Health. An analysis into these will address the primary purpose of this study.

Questionnaires are argued to have a low response rate and the researcher is not able to probe for an in-depth information to the responses provided (Wagner, et al., 2012). In the case of this study, the researcher was able to make a follow-up on the returned questionnaires for in-depth information and increased quality of information provided. A sample size of fifteen [15] respondents were sent questionnaires and only ten [10] were returned. Out of the ten [10] questionnaires, two [2] were administered and follow-up was done on at least four.

Secondary data on the other hand helps the researcher to establish what has been studied and gives the trend of the debates in the researcher's area of study. It helps the researcher identify the knowledge gap. For the purpose of this study two forms of secondary data were important: documentary analysis and literature review.

3.5.2 Documentary Analysis

Document analysis was used to gather the insight of this study on the state of governance within the Ministry of Health. Document analysis is regarded as the review of official reports, statistics that yield important information on the area of study (Wagner, et al., 2012). It therefore helped the researcher to come up with the recommendation for this study.

3.5.3 Literature Review

For this study the reviewed literature was used to come up with chapter two of this report - the literature review. According to Babbie and Mouton (2008), literature review is a thorough critical analysis of existing research done by the researcher on the topic of interest. The aim is to establish the arguments and conclusions that have already been made on the subject so as to identify the gaps and make recommendations for new research. The review for this research was focused on governance; governance and health system functioning and challenges; including how these challenges further impede the health sector. It was also used

to synchronise the findings of this study. However, the findings were reported based on primary data.

3.6 Data Presentation

Data presented in this report was collected using questionnaires and presented in tables, diagrams and in sub-topic descriptive form. The sub-topics covered in this report were developed to cover different health system areas in order to find out what governance challenges prevail under each. Data is therefore presented on general basis of sub-topics captured on the questionnaire. However, where opinions differed in terms of seniority of staff members, these are be presented based on the different levels of staff according to their profiling as presented in chapter four.

3.7 Data Analysis

Data analysis is the way in which data is interpreted. The purpose of analysing data is to make meaning out of the information collected (Wagner, et al., 2012). The analysis therefore gives an interpretation of what has been found in relation and response to the posed research questions.

For primary data, questionnaires were used to solicit information from the participants, a descriptive analysis was therefore used. A descriptive analysis gives a detailed picture of a situation or relationship (Wagner, Garner, & Kawulich, 2012). This study gives a detailed picture of what the governance challenges are by looking at the system components. These components form sub-topics in the presentation and analysis of data. It therefore studies the constraints within these sub-topics as identified and indicate how they relate to one another as inter-connected components of the system. This study hence provides a detailed picture of what the governance challenges are by looking at the system problems, which could lie behind the dysfunctional health system within the Ministry of Health. The collected data was computed with responses to each question under different sub-components of an effective health system. The analysis consisted of review of respondents' feedback under each system component. It therefore provides a descriptive analysis of these components in findings of this study.

The secondary data on the other hand consisted of both the literature review and the document analysis were used. As indicated earlier, this is the review of organisational reports both published and non-published confidential documents. The researcher studied the outcomes of existing literature, reviewed documents and compared to what came out of the

primary data of this study. Based on this analysis the researcher would therefore be able to identify the knowledge gap, make conclusions and address the last objective of this research which is to provide the recommendations on possible strategies the Ministry could adopt to combat the challenges, if any exist.

3.8 Validity and Reliability

Validity and reliability are as important in the qualitative study as they are in the quantitative study. In qualitative research, validity and reliability have to do with truthfulness and credibility of the research findings (Newman, 2006). In order to achieve these objectives, the researcher uses both primary and secondary data.

This research used questionnaires and document analysis to identify the governance challenges within the Ministry of Health. This process accounts for triangulation; a process necessary for increased reliability of the research study. Triangulation is referred to as a method of using different sources of data collection in order to support the researcher's findings (Merriam, 2009).

3.9 Limitations to the study

This study was conducted within the Ministry of Health in Lesotho. The aim was to investigate the Ministry's governance challenges and therefore confined to this purpose. A purposive sampling was used to select the informants and the results would not be generalised to any other ministry. Because of the subjective nature of this qualitative research, the results obtained may be different in other health sectors or ministries depending on their structures, management and cultures.

3.10 Ethical Considerations

The ethics approval was obtained from the Ministry of Health Research and Ethics Committee to conduct this study and collect data from the target group specified in this report (reference ID77-2015) in Appendix B.

Other ethical considerations for this study included developing a consent form for participants to sign before they engaged in this research. The form acknowledged that the participants' rights have been protected and that their participation in the process was absolutely voluntary. (Appendix C).

3.11 Conclusion

Knowledge is gained using different ways and this is referred to as the methodology to be followed in gaining the required knowledge. This could either be from the quantitative or qualitative perspectives. This chapter has presented the methodology that was followed in conducting this study. Firstly it presented the difference between two major research strategies – quantitative and qualitative. It indicated the main differences between the two are in the language and paradigm in which they resonate. It accounted for the use of qualitative research used in this study. A descriptive exploratory design was followed for this study and questionnaires used as a primary data collection method. Furthermore, the researcher discussed other types of data used such as document analysis and literature review and how they were beneficial to this study. Also discussed in the chapter, is the importance of validity and reliability in the research. Hence the researcher indicated the process followed in the study in order to maintain the validity and reliability. This study and the findings thereof are limited to the Ministry of Health in Lesotho and the findings cannot be applied to any other ministry. Finally, this chapter has provided the ethical considerations from the Ministry of Health that had to be taken into account in order to conduct this study.

CHAPTER FOUR: PRESENTATION OF FINDINGS

4.1 Introduction

This chapter reveals the results of the primary data collected through questionnaires. The data was gathered using structured questionnaires. The findings presented here will be structured in a similar manner. These findings are views of the Ministry of Health headquarters mid-level and senior staff. These were the best people to provide better insights on what the experienced governance challenges in the Ministry are. The findings presented in this chapter is the feedback from these respondents through questionnaires. It also takes into account the reviewed Ministry's documents and literature on governance challenges.

The surveyed literature suggested key components to a well-functioning health system. These include leadership and governance, health information system, health financing and human resources for health. A holistic integrated approach of these components is needed for effective governance in health (Kaplan, et al., 2013). The questionnaire was therefore designed in a highly structured manner to capture these components of a well-functioning health system. It aimed to identify barriers to effective system functioning in these elements of health system governance and determining the trends within the Ministry. This gives a descriptive presentation and analysis to this research.

4.2 Respondents biography

This report presents the findings from different respondents from the Ministry of Health headquarters. Questionnaire respondents are full-time employees of the Ministry of Health and have been with the Ministry for a period of two years and above. They are mid-level and senior level staff of the Ministry. Five of the respondents fall under the senior level category. They are part of the decision-making within the Ministry and the implementation of policy decisions. All informants are in possession of a minimum qualification of first degree in their respective disciplines with some holding Master's degrees and others studying towards acquiring their Master's degree on a part time basis. Part of their duties is to see to policy implementations and resource mobilisation including monitoring and evaluation of policy interventions, including proposing for establishment of new positions within the Ministry. Presented below are the general views and experiences of these informants.

4.3 The prevailing situation

As one of the government line ministries, MoH adheres to some of the central policy decisions that govern other ministries. These policy decision regarding allocation of resources

by the Ministries of the Public Service for engagement of public servants and Ministry of Finance for allocation of financial resources. These include governance reform decisions that ended with the implementation of IFMIS for government financial resources. Any issues relating to human resources allocation and governance are guided by policy documents developed by the MPS. In terms of financing and resource allocation, the Ministry is guided by the use of IFMIS and other tools as guided by the Ministry of Finance. Any other operational tools that may be adopted by the Ministry in the end have to ultimately tally with IFMIS for reporting purposes. The Ministry of Health depend heavily on Annual Joint Reviews (AJR) for information sharing with its partners. These reports are also used for resource mobilising. Policy decisions and implementations are guided by the section of planning in consultation with other sections. Through its Monitoring and Evaluation unit, the section also pioneers the monitoring and impact assessment of policy decisions. It provides the statistical data and reports on health issues through the statistics unit. The health planning section also champions the quarterly and annual reviews on health-related matters. The planning section is therefore the hub of health governance issues. Health policy documents and reports used for the documentary analysis in this report have been developed through the guidance of the planning section and other external consultancy where necessary. The majority of them supported financially by the development partners. Health resources are contributed mainly by government and donors. In 2008/09 financial year, donor resources contributed 18% of health resources. These resources are coordinated and accessed through the project accounting unit (PAU). *Figure 1* below provides a summary of the major resource flow in the Ministry of Health. This figure was developed based on the information gathered.

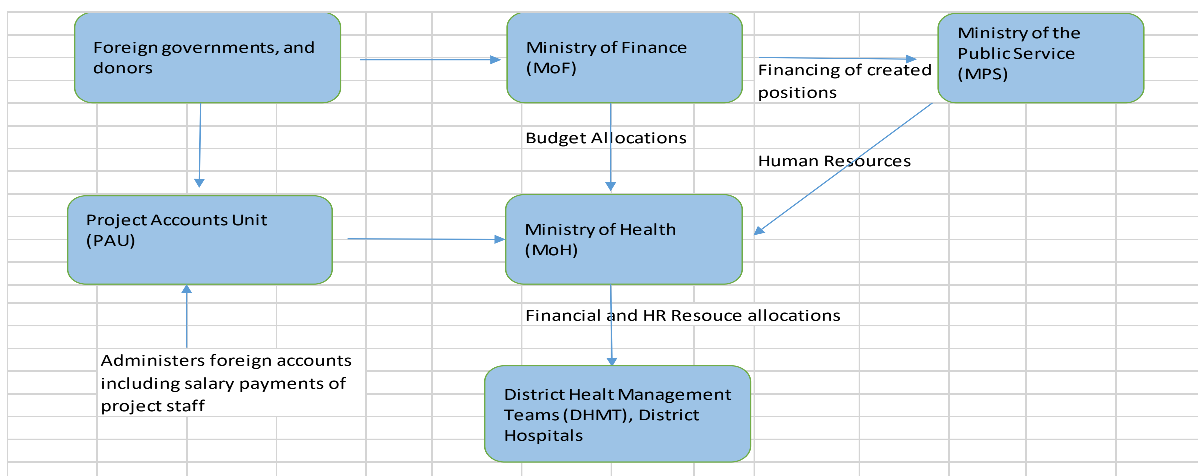

Figure 1: A synopsis of resource flow in the Ministry of Health (caption form the questionnaire informants)

4.4 Barriers to effective system functioning

The main objective of this research is to identify the governance challenges within the MoH. The goal was therefore to study networks, as units or sub-units within the health system as a whole and as processes that inform systems outcomes. There was little demarcation in informants' responses in terms of hierarchy in providing the feedback hence the presentation of findings below is divided into the sub-themes argued to constitute effective health system functioning. Four sub-themes of system functioning were identified. These sub-topics were developed based on the interpretation of literature and delineated in the conceptual framework on what constitutes a well-functioning system. Section two (decision-making) presents findings from managers on the decision-making powers they possess in deciding on priorities and sticking to them, as well as deciding where finances should be directed for implementations of plans. It is important to note that these components are not limited to the above, but have been prioritised per the preference of the researcher.

Figure 2 below illustrates components of a well-functioning health system. The feedback provided here covers all these components as presented in the diagram below. Where necessary, the findings have been classified into two categories of information: the mid-level and senior level staff.

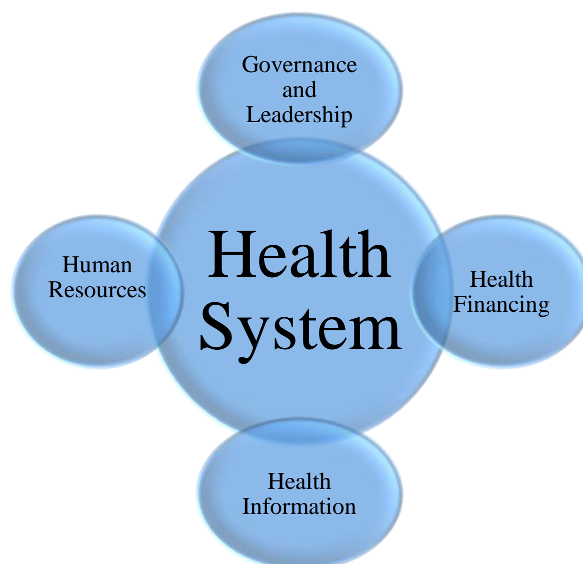

Figure 2: Effective Health System Functioning Components.

Table 1 below gives a summary of the findings of this study, incorporating effective health system functioning components on *Figure 2* above which also formed part of the research questionnaire distributed. Column one indicates the system components that were studied.

Column two, the question or information that the questionnaire aimed to get in relation to the component under study, while column three and four summarise the feedback obtained and the respondents who provided the feedback respectively. The respondents are categorised into levels based on the profiling provided earlier. The table shows an incorporated feedback and where different feedback was obtained. It shows the type of staff that provided a different view. An in depth presentation of all findings are presented in the following sub-sections.

Table 1: Summary of study findings

System Component	Question/focus area	Purpose for the information	Feedback provided	Respondents
Governance & Leadership	What are the governance policy areas	Establish existance of strong leadership through existence of policy	Prevent new HIV/Aids infections (HIV/AIDS Policy); Universal health service coverage; Improved mther to child healt and reduced maternal	All respondents
Human Resources for Health	Availability of the right HRH mix	Establish the existance of the right right skills mix and availability of incentives to encourage the right mix	Central process coordinated through the Ministry of Public Service; IFMIS used for rewarding staff. Similarly graded positions graded the same; Mountain Allowances provided in hard	All respondents
	Availability of incentives			
	Fair rewarding system			
			Establishment of positions depends mainly on availabiity of funds. Limited powers exeercised by managers despite recommendations made.	Senior staff
Health Financing	Availability of Policy	Establish existing mechanisms aimed to increase the financing of health	Health financing Policy 2008	All respondents
	Mechanisms adopted for financing of Health		Government a major health financier through MoH; Resource mapping tool; other supporting tools to be updated for effectiveness	
	Donor Coordination		coordinated through Planning Unit	
Health Management Information System	System Availability	Establish existence of HMIS to inform policy and resource allocation	Electronic (electronic medical record) and paper based system (health information registers) used to source	All respondents
	Utilisation		reliability and insufficient information exist	
Governance Trends	What Strategies have been implemented over the years?	Establish the governance trends and if efforts to escalate deficits do exists	Privatisation, Contracting, Decentralisation, Public Private Partnership, Performance Based Financing	All respondents
Decision Making	who gets to decide on what resources are needed and where they should be directed?	degree on power in deciding how resources should be allocated. Studies have show often managers have little say in resource allocation.	Managers gets to decide priority settings for the units and what resources should be invested.	Mid-level staff
			Limited powers as at times virement of resources happen without consultation	Senior-level staff

4.4.1 Governance and Leadership

The literature shows that it is the quality of the overall governance and leadership that impacts on health system functioning. It identifies governance and leadership as the key principles of health governance (Kaplan, et al., 2013; WHO, 2010) Sound governance and leadership should be able to provide sound policy that shows commitment to policy goals and proper arrangements that channel donor funding appropriately to align it to country priorities. The purpose of this section was therefore to establish the existence of policy and its focus

areas in terms of implementation priorities and institutional arrangements that exist to channel donor funding to the set priorities.

Informants were able to identify at least three policy or strategic documents in the Ministry and what the priorities were. These were namely: National Health Policy, Health strategic plan, HIV/AIDS policy, Health Financing policy, etc. Participants indicated that they regarded some of the health governance priorities as having a strong health system that aims to reduce new HIV/AIDS infections, curb TB and reduce maternal and child mortality. Tools such as the resource mapping, and Sector Wide Approach (SWAp) are used channel donor resources to Ministry priorities, informants indicated. Policy should focus on priority areas such infectious diseases such as HIV/AIDS, TB and maternal and child health receive donor funding and these are in line with identified governance health priorities. However, areas such as health financing and human resources for health were identified as some of the areas that were prone for funding in order to have an effective health system.

Figure 3 below shows the role played by governance and leadership as some of the components of a well-functioning system and how leadership decisions may affect all other components of the system.

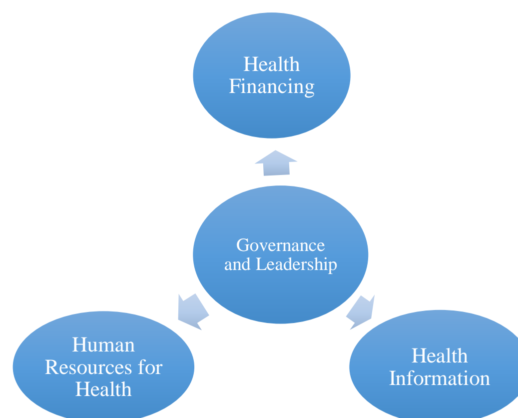

Figure 3: The role of governance and leadership in health system functioning

4.4.2 Health Information System

According to literature, accurate, timely information is important for public health to thrive. It indicates reliable information is imperative in highly limited resource source settings as it helps decision-makers to make informed decisions on areas of dire need (Mwase, et al., 2010). This means the health information informs planning. It also suggests timely, accurate

information also helps policy-makers to develop evidence-informed policies (Kaplan, et al., 2013).

This section had two purposes: primarily it aimed to establish the extent to which information generated is used for the planning and resource allocation purposes. Secondly, the purpose was to establish institutional arrangement that existed to make information accessible to all stakeholders. *Figure 4* below gives a summary of the established information generation and how it flows from the source until it is shared with other stakeholders and used its use to inform policy.

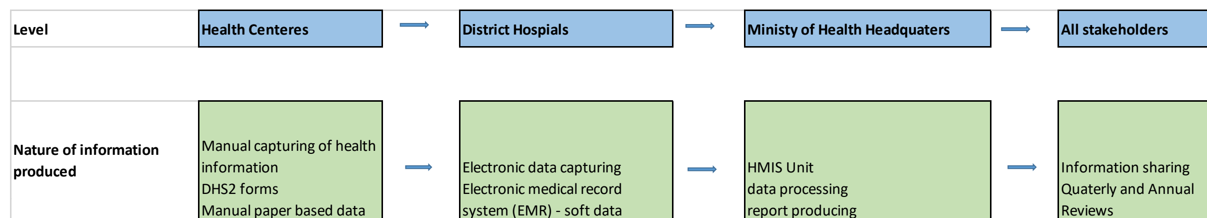

Figure 4: MoH information generation flow

Participants indicated that information is generated at the health centre level and sent to the district level for capturing. From the district hospital, this information is sent to the Ministry of Health headquarters (HMIS unit) for processing. It is then used to produce reports. This is a routine process across the health centres and district hospitals. Health centres collect data on paper based through health registers. This information is then used largely for planning and it gives an indication of areas of focus. Some of the challenges to this informants indicate is lack of data capturers and inaccuracy in filing the forms. In an effort to make information available to all concerned parties, participants mentioned a number of forums on which information is disseminated. For instance, quarterly and annual joint reviews were pointed as the most popular for disseminating information amongst stakeholders, followed by the use of publication of health statistical tables which were identified as common mechanisms for making information available to all parties. However, informants indicated political deployment of ministers and constant changes of leadership as some of the challenges that results in priority shifts in planning and implementation as opposed to empirically produced information based on the processed data.

4.4.3 Health financing

The literature points to health financing as the key policy instrument in overcoming the financial hardships that result in unequal coverage of health services. Health should be well financed to ensure individuals have easily accessible health services. It indicates the

financing should be supported by legislations to ensure increased transparency and efficiency (World Health Organisation, 2010). The purpose of this section was to establish what system exists for sustainable financing of health and whether such mechanisms are supported by legislation. *Figure 5* below provides a preview of health financing mechanisms in the MoH based on the questionnaire informants.

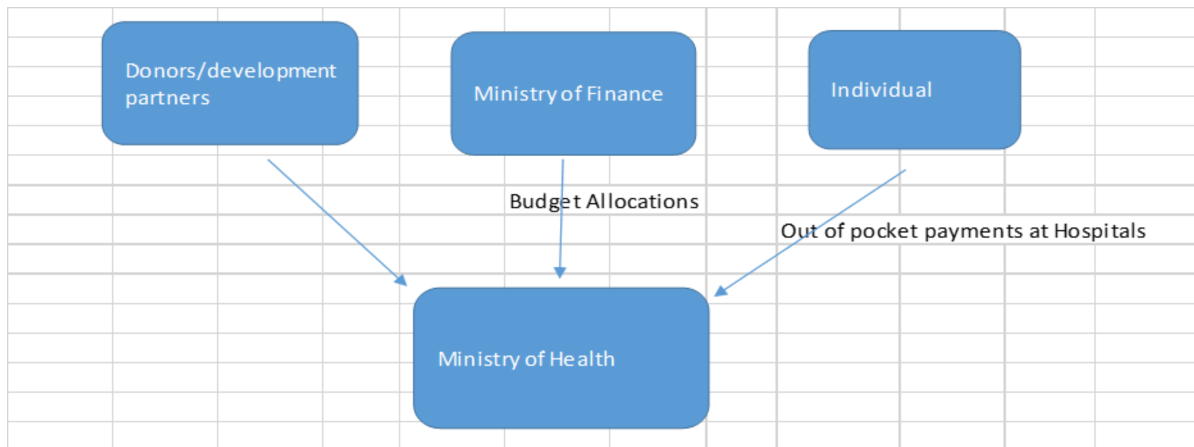

Figure 5: MoH financing preview

Informants indicated two major sources for health financing, government (through the Ministry of Finance) and donor. The government recurrent budget and donor finance. For recurrent budget, a government system called Integrated Financial Management Information System (IFMIS) is used. According to the informants, the system is used for budgeting and allocation of resources through the Ministry of Finance (MoF) and it is one of the systems deployed by government for increased transparency and tracking of expenditure. The other form of financing identified was the user fees charged at hospital level at the rate of M15.00 per patient. For increased financing, participants indicated the use of Lesotho Review proposal to source funds from donors. This gives potential donors progress made on the past focal areas and indicates future plans and areas of focus on health related matters.

4.4.4 Human Resources for Health

The literature suggests health workforce is central to a functional health system. Poor staffing adversely affects the quality of services delivered (Kaplan, et al., 2013; Mwase, et al., WHO, 2010). The Public Service Regulation (PSR) 2008 indicates any public officer engaged may be posted anywhere in the country (Government of Lesotho, 2008). The purpose of his section was to establish existence of institutional arrangement within the MoH that ensures wide deployment of staff with the right mix.

Participants indicated the use of establishment list managed and administered by the Ministry of the Public Service (MPS) for deployment of staff within the Ministry. However, they indicated this does not usually tally with the need. For wide deployment, participants indicated government uses PSR and health professional bodies for deployment of health workforce and that through IFMIS, there are allowances and incentives to the personnel posted in the hard-to-reach areas. In response to the question of whether the payment system used within the Ministry is one that encourages the right kind of incentives and mix, participants indicated that the GoL uses the IFMIS. The system incentifies according to the established positions not on performance, thereby using incremental incentives across the board. They also indicated that the payment system does not therefore reward performance, failing as a result to produce the right kind of skills mix.

4.5 Governance trends in the Ministry of Health

Trends help identify how business has been carried out over the years. The literature suggests, improved health financing mechanism and a well-functioning HMIS should be able to identify areas of need and redirected resources accordingly. The purpose of this section was to identify the governance trends in the Ministry of Health and identify the governance priority areas in health. Finally, the aim was to identify the degree to which line managers contribute to the utilisation and allocation of resources.

Participants indicated that health system strengthening, easy accessible health care, reduced HIV/AIDS infections and reduced infant and mortality rates as some of the governance goals in health. Informants further indicated that since 2000, the sector has been engaged in different governance strategies aimed at enhancing the quality of health care such as decentralisation, PPP, contracting, privatisation and performance based financing. For successful implementation of governance strategies and governance in general informants indicated that it is the role of managers and directors to develop policy and strategies to be implemented. They monitor plans to ensure the set goals are being achieved while also ensuring allocation of resources. Participants indicated that directors and managers are primarily the only group that is charged with the responsibility of leading the priority setting of the sector.

Institutionally, in order to ensure that governance strategies are implemented, participants indicated that there are weekly meetings held by heads of programmes and senior management meetings for reporting on progress made. Strategically, participants indicated

strategic documents such as the National Health Policy 2011-2017, Health Strategic Plan 2011-2017 and Health Management Information System, identify governance as a priority within the sector. Major governance focal areas within these documents, informants indicated, include:

- Setting up measures to enhance governance stewardship amongst senior members in the sector and other staff members.
- Providing quality health care to all Basotho by providing easily accessible health services in all regions.
- Working towards achieving improved disease control in major areas such as TB and HIV/Aids, maternal health, child health, and
- Deepening decentralisation and ensure decentralised health governance and the management of health services.

4.5.1 Decision making – findings from senior staff

This section was focused on experiences of managers within the Ministry on how much decision-making powers they possess as far as resource allocation is concerned, taking into consideration the highly centralised nature of resource allocation mechanisms. The literature indicates that one of the challenges of health systems is the departmental functional relations. It states uncoordinated units result in power issues where diseases are addressed single-handedly. Therefore, it is important to recognise the level of decision-making powers within the system as its sustainability partly relies upon resource allocation decisions (IDRC, 2011). The purpose of this section was therefore to get a glimpse of how and who gets to determine how resources are allocated in the MoH. The mid-level staff think resource allocation powers lie with their senior staff. Below are the findings from the senior level staff on their decision-making powers.

Informants indicated that both human and financial resources are important for smooth operation within the units. They indicated that unit managers and directors are the ones in charge of making decisions on how these resources are allocated within the units. For proper allocation of funds, participants indicated that departmental heads are guided by the operational plans through the process of activity based financing. They indicated this is a more consultative process which includes the Ministry of Finance through the IFMIS system which aims to ensure efficiency and transparency in utilising the government finances. Informants indicated, based on the activities planned, performance also plays a critical role as

finances are cut on those activities whose finances were minimally utilised in the previous year. The process is said to be done and confined within the budget ceilings provided by the Ministry of Finance.

Participants also indicated that there is a resource allocation formula that has to be reviewed for utilisation. The formula is designed in a way that filters factors such as the disease burden and population of the area into account for resource allocation. However, informants indicated the formula is not currently in use, pending its review. On human resource allocation, informants indicated this process is done based on the positions established per department, hospital and health centre. They indicated the dire shortage of human resources is due to the fact that the process of establishing positions is dependent on the availability of funds.

4.6 Examination of records

For the purpose of cross validation of the findings in this study, the researcher reviewed some of the reports and policy documents that guide the Ministry of Health. Mostly utilised are the AJR reports and policy documents.

According to some of these reports, the Ministry of Health leadership aim is to strive for quality of health care services that are accessible and acceptable to every Mosotho. The leadership within the Ministry coordinates policy and strategic plan development and leads the annual priority setting process for each financial year (Ministry of Health, 2015). According to the AJR 2014/15, the utilisation of capital budget and resource mobilisation mechanisms are overseen by the planning unit. In order to mobilise resources, the unit develops project and programme proposals that are then scrutinised by the Public Sector Investment Committee for approval. The Ministry maintains the use of annual financial resources mapping exercise in order to ensure improved partner coordination and accountability to eliminate duplication of efforts and identify resource gaps within the health sector (Ministry of Health, 2015). The 2010/11 to 2014/15 financial reports show, there have been some redirection of funds done by the Ministry of Health and approved by the Ministry of Finance. Where funds were redirected from one activity area to another on the basis of priority changes.

Table 2: *Financing and Resource requirements for the Health sector in Lesotho for the period 2008/09-2010/11 (Maloti).*

Program Areas	Time frame			Total requirements 2009/10-2010/11	Total available budget	Total funding gap
	2008/09	2009/10	2010/11			
Service delivery	362,881,162	1,170,007,486	177,229,786	1,780,265,634	356,901,410	1,424,864,224
Decentralisation	415,817,162	1,216,374,986	221,871,386	1,924,745,134	420,116,510	1,509,128,624
Partnerships	141,244,000	127,597,000	124,126,000	422,967,000	98,967,000	324,000,000
Health sector restructuring and HR plan	1,586,500	1,653,000	715,000	3,954,500	296,500	3,658,000
Infrastructure maintenance and development	133,510,000	335,760,000	1,742,272,000	2,437,284,000	1,028,030,000	1,409,254,000
Research, monitoring and evaluation	6,155,000	14,890,000	5,820,000	26,740,000	660,000	26,080,000
Total	1,061,193,824	2,866,282,472	2,272,034,172	6,595,956,268	1,904,971,420	4,696,984,848

Source: Mwase et.al. 2009

The table above shows the resource requirements for the Ministry of Health in Lesotho for the financial years 2008/2009 to 2010/2011. The Ministry of Health has an estimated total funding gap of M4,696,984,848. In the absence of adequate financing to address the situation above, this gap is expected to increase.

Table 3: *MoH recurrent and budget expenditure for the period 2012/13 to 2014/15*

Financial Year	Recurrent Budget(LSL)	Expenditure(LSL)	Expenditure %
2012/2013	1254	1180	94%
2013/2014	1610	1554	96%
2014/2015	1698	1619	95%

Source: AJR report 2014/15

Figure 3 below depicts the MoH budget expenditure over the past three financial years. It shows fluctuating trends of incurred under-spending of allocated budget by the Ministry of Health for the past three consecutive years. Although there was an increase in utilization of funds in 2013/14 financial year, it still did not meet the ceiling.

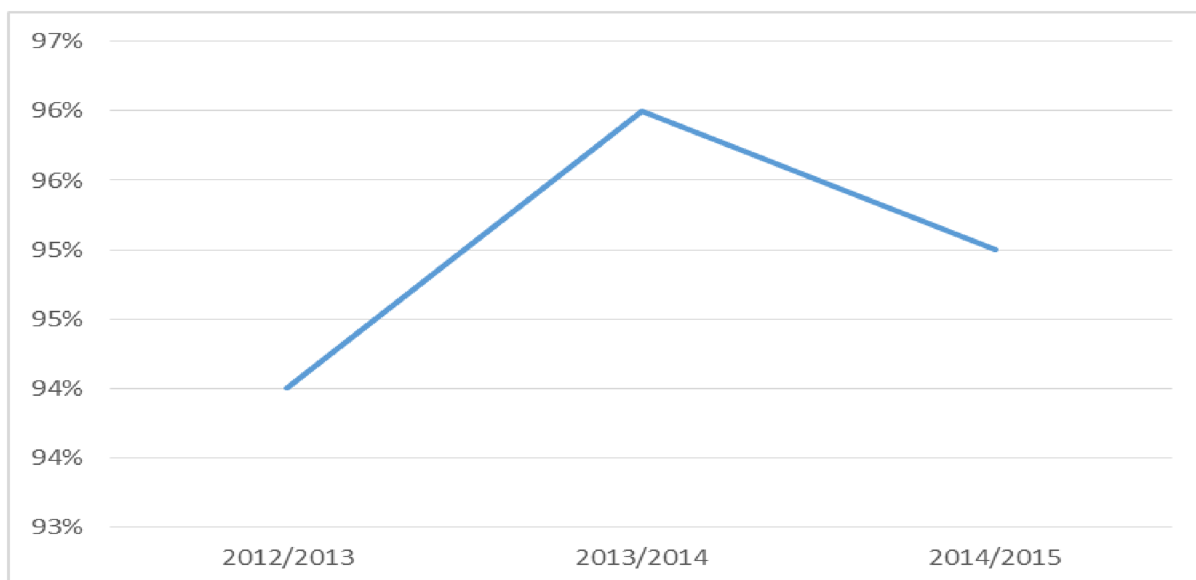

Figure 6: MoH budget expenditure for the past three financial years

This table shows that the Ministry of Health is not able to fully utilize the allocated budget reaching only 96% in 2013/14 financial year. There has been a slight increase in the recurrent budget allocation from 2012/13 to 2014/15 concurrent to the expenditure. However, based on the information that allocation is based on performance, the recurrent budget could be expected to decrease in the financial year 2015/2016. According to the AJR report 2014/15, in an effort to allocate funds efficiently and effectively at district level, the Ministry of Health developed the resource allocation formula in the past years. However the formula was not utilised during the reporting year on the basis that it was developed about seven years ago and has never been executed (Ministry of Health, 2015). *Table 3* below shows the Ministry of Health's resource needs for the years 2009 – 2013.

Table 4: *MoH Resource Needs from 2009 to 2013*

	2009	2010	2011	2012	2013
Resource Needs	91,978,780	99,080,238	106,015,854	113,436,963	121,631,967
Expected Available Resources	60,924,648	52,497,662	55,647,652	53,079,074	26,149,260
Financing gap	31,054,132	46,582,576	50,368,202	60,357,889	95,482,707

Source: Mwase et.al. 2009

Figure 3 below is the MoH resource structure for the years 2009 and 2013. This figure shows how, over the years, the source needs increases, while the expected available resources (the middle layer) are decreasing thereby increasing the financing gap. The Ministry's resource analysis for the same period indicated that there were donors who supported other health programmes outside the MoH programme (Mwase et.al., 2010).

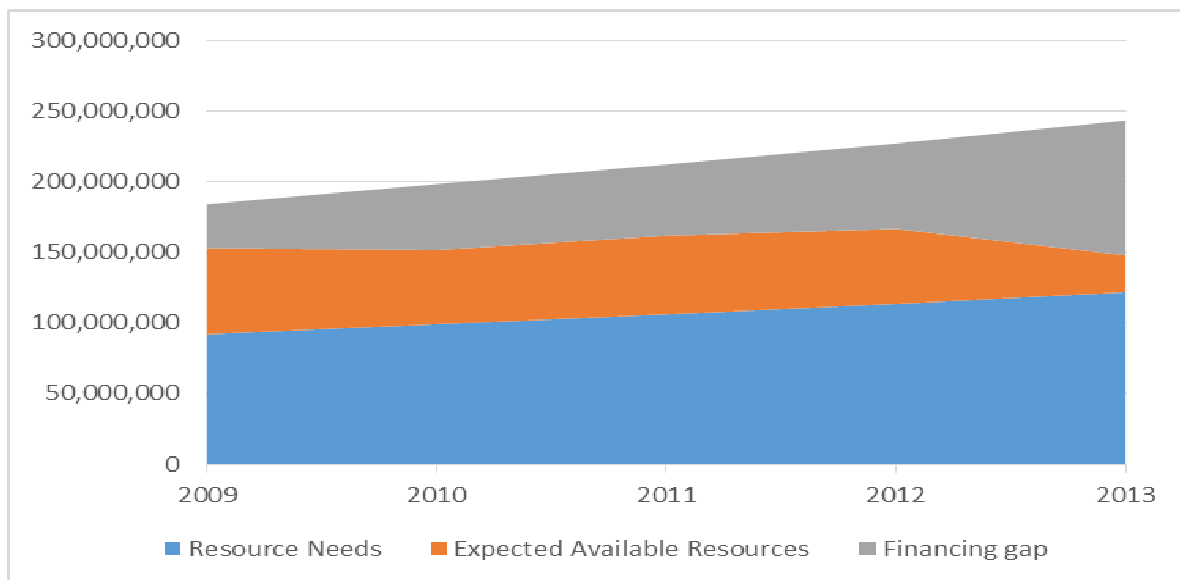

Figure 7: Resourcing performance over a five year period (2009 - 2013)

The Health Management Information System is considered one of the critical building blocks of the health system strengthening as reliable and timely health information helps decision-makers at different levels of the health system (Ministry of Health, 2013). The annual joint review report 2014/2015 indicates, data management has been a challenge over the previous four years where irregular reporting and non-commitment of clinicians in filling the registers accurately and on a regular basis has been experienced. The problem was further exacerbated by the implementation of Emergency Medical Records (EMR) system where most hospitals stopped submitting the routine paper-based outpatient data (Ministry of Health, 2015).

In 2014/2015 financial year, the Ministry was allocated M6 000 000.00 as funding for vacant positions. However, this amount was not utilised as the MPS has not approved any of the positions that were applied to be filled. Further future delays are anticipated based on the newly developed policy in the Ministry of the Public Service that cause all the ministries to apply before filling any vacant positions. Implemented strategies have been taking the form of project implementation of mostly three to five years depending on the proposal and agreements made between interested donors. Resources for such are coordinated through the section established within the Ministry for such projects called PAU.

4.7 Conclusion

Findings from this study indicated the main challenges to effective system in the Ministry of Health in Lesotho. Information gathered through questionnaires seems to confirm what was discovered through documentary analysis. It shows there is a problem of proper coordination of resources within the MoH system; that major governance initiatives are implemented in a

form of projects coordinated through an independent unit. Research has shown a relationship between health system functioning and governance. Therefore findings presented in this study showed health system governance challenges. Constantly changing priorities are some of the challenges faced by the Ministry. Hence adhering to plan is regarded as another challenge. These findings were based on the information gathered through questionnaires and document analysis. The following chapter provides an analysis and discussion of these findings.

CHAPTER FIVE: INTERPRETATION AND ANALYSIS OF FINDINGS

5.1 Introduction

Examining the health system as a network through governance objectives of effectiveness, efficiency, transparency, equity and fairness, gives a framework for assessing possible reasons behind a dysfunctional health system, identifying governance challenges and indicating the governance trends. This chapter therefore provides answers to the primary research questions of this study. The literature has indicated a relationship between governance and health outcomes. As a result, this section provides an interpretation and analysis of findings presented in the previous chapter.

5.2 The problem

Findings from this study indicate there is indeed a problem of escalation of deficits in the Ministry of Health, resulting mainly from lack of proper resources coordination mechanisms. On analysis, the Ministry of Health suffers mostly from inefficient use of health financing resources. Displayed by the incurred underspending of allocated resources over at three consecutive years. It seems to exclude other players in the delivery of health services. As a result of this, there is very minimal coordination of resources from all stakeholders by the Ministry. Therefore the scarcity of resources seems to be the major problem facing the Ministry. Due to lack of coordination and involvement of other stakeholders involved in delivery of health service, there is an influx of resources directed in one area hence more often than not, donor funds are more utilised while government funds are being under-utilised. Consequently, based on the system that is used for allocation of resources by government, which is based on performance from the previous financial year, this results in budget cuts from the government in the following year. The reality of this is not an over financed health system but inefficiency in utilisation of allocated funds.

5.3 Conceptual framework

This study argues the use network theory in governance because of its multi-interaction with all concerned. It views governance as a network initiative and indicates how through the network theory principles, the governance problem indicated above could be overcome. Network governance is argued to be useful where there are limited resources and networks are utilised to share resources between all stakeholders.

This study adopted the sociological definition of network theory of governance that refer to network theory as mechanisms and processes within a structure that interact in order to produce certain outcomes for an individual or a group (Borgatti & Halgin, 2011). This research therefore studied some of the processes within the health system such as leadership and governance, health financing, human resources for health and health information as interactive components of the system in order to determine where the dysfunctionality lies within the health system and shows how network theory could be beneficial in enhancing the system functioning.

The network theory of governance has been argued for its benefit to make public policy efficient and effective due to the involvement of different actors both from public and private entities. Some researchers have argued that networks provide the advantage of mobilising resources from both public and private actors (Börzel, 2011&Parijs, 2013). Similarly, this study argues the use of networks where all actors indicate their committed resources in policy activities. An act which is possible through highly coordinated planning and budgeting mechanism between all actors. Given the problem of escalation of deficit identified, network governance would highly benefit the Ministry in sourcing the limited resources from all actors. However, trust is needed between actors to disclose how much their organisations are to commit and be loyal to the commitment made.

Networks governance has been criticised for its potential to open room for some actors to use power and resources to further their own interests, thereby threatening the political power and responsibility of government (Parijs, 2013). Findings of this study illustrate a collaboration between the Ministry of Health and other health partners in an effort to address one plan. An exercise proven through AJR meetings where the Ministry informs and reports back to the partners on progress made and challenges being encountered in the process. These are pursued through consultative budgeting mechanisms. This study therefore argues that evidence based priority settings and budgeting mechanism employed by government would rather enhance its political power and responsibility in convincing partners to direct resources to those areas identified as areas of dire need. This would minimise some of the network theory of governance discourses as discussed earlier in chapter two.

Evidence has shown that the participation of non-governmental actors in policy development helps the government in policy issues in terms of both quality and implementation; that networks do allow government to mobilise resources between public and private actors

(Börzel, 2011). Evidence form the Ministry of Health documentary analysis, indicates that the Ministry has an influx of funds from donors including WHO, UNICEF, UNFPA, USAID, UNAIDS, PEPFAR, EU, World Bank, CHAI, EGPAF, etc.; that contribute to the Ministry's capital budget. According to the Health Assessment Report (2010), during the period 2008/09 to 2010/11, the majority of these donors funded other health programs and projects outside the framework of Ministry of health budget (Mwase, et al., 2010). This means if well-coordinated, the resource gap identified could be lower than it was then. Although during 2014/2015 financial year, donor resources accounted for 84% of the total Ministry's capital budget (Ministry of Health, 2015), which in terms of coordination proves a positive indication, this would not close down the anticipated resource needs gap considering the further incurred underperformance of the MoH. Over and above this, it shows an overly reliant financing on donors posing a threat of underfinancing in case of donor withdrawal.

Although the 2010/2011 to 2014/2015 recurrent and budget expenditure indicated under spending of allocated budget from the Ministry, the 2008/09 to 2010/11 financial and resource requirements analysis indicated a major resource gap that needs intensive resource mobilisation mechanism from the Ministry. This study therefore argues that the use of strong network collaborations between the Ministry of Health and development partners above and other stakeholders, to support a single framework and minimise the resource gap identified to be crucial. This mechanism can be achieved through highly coordinated networks pioneered by MoH to ensure the support of the same policy framework developed on evidence. Evidence further shows a strong collaboration between stakeholders in terms of reporting, through quarterly and annual joint reviews which the Ministry can benefit from in managing and coordinating these networks for resource mobilisation.

The literature indicates CSO's have a record to deliver health services effectively. The Health Assessment Report (2010) indicates the MoH reports fail to include the CSO's and the community. As a result their contributions are not regarded as necessary for the processes (Mwase, et al., 2010). Despite the recommendation to strengthen ties and recognition of CSO's the 2014/2015 AJR still does not indicate contribution made by the CSO's in service delivery or how resources are shared between those CSO's involved in delivering health services. Hence this study advocates the use networks that involve CSO's and NGO's and other stakeholders for escalation of deficits within the MoH. This would mean including them in the budgetary and planning processes to overcome identified problems alluded to earlier where donors were found to be implementing other programmes outside the MoH

framework. Most of which could be argued to be through the CSOs. With Lesotho having the second highest HIV prevalence in the world (Ministry of Health, 2013), and the history of CSO's in delivering HIV/AIDS programmes, the MoH would really benefit from strengthening ties with the private sector, NGO's, CSO's and all networks in terms of resources and technical expertise to strengthen health system and resource mobilising. This may be the case not just in the area of HIV/AIDS but other programme areas as well. CSO's have been applauded for the role they play in ensuring control over resource allocation and holding health officers at national level accountable (Blas, et al., 2008). This study therefore, argues that a joint network between MoH, Donors, NGO's and CSO's could benefit the Ministry in escalation of deficits.

5.4 MoH Health system functioning

There are at least four elements of a functional health system. These are: leadership and governance, HRH, health financing and HMIS (World Health Organisation, 2010). Although the health system is not limited to the afore-mentioned elements but mainly because they form part of the network processes of the health system functioning. As a result they do form the basis for research into dysfunctional health system. Evidence shows governance with equity as the key factor that can strengthen health system functioning. At the heart of equity is primary health care – first contact of the individual. In the context of Lesotho this is at the health centre level. Closely linked to the issue of equity is that of health finance where resources are equally distributed. (IDRC, 2011).

Leadership and Governance

According to the World Health Report of 2000, the government's responsibility for ownership of health system includes providing the vision and policy direction of health (World Health Organisation, 2000). Informants indicated the existence of defined policies with clear priorities within the Ministry. Information gathered and literature reviewed shows existence of measures to put such policies into plan with clear priorities. Although this shows an existence of a committed leadership, there seems to be limited or no clear indication on policy on how financing of health is to be sourced. There were only two health financing mechanism identified within MoH; government and donor funding.

Informants indicated an existence of institutional arrangement such as the resource mapping tool aimed at aligning donor funding to government priorities. This strategy indicates a coordinated mechanism where governments and donors support one plan. However, this

means in the case of donor withdrawal government would be the sole financier of health. This carries risks of under financing considering the budget cuts that occur from time to time. In the long run it means increased disease burden due to limited financial resources to address the diseases.

Although findings indicates strong commitment leadership in providing strategic direction, regular redirection of funds to other areas and lack of mechanisms for financing the plans other than government and donor funding indicates lack of commitment of plan and stewardship from the leadership. In the case where the leadership owned the policy and showed strong leadership towards execution of the health policy, the MoH would not experience cases where donors are implementing other programmes outside the Ministry's framework. From the researcher's understanding this means efforts to sell the plan to donors for financing are either non-existent or lack basis for execution and it becomes difficult to convince other partners for support. The ability to provide strong policy direction can be achieved with policy that is based on reliable information. Successful frameworks have been said to outline responsibilities of all actors and resources that will be available. In the same way that policy framework regulates or enables action towards addressing health equity is another way in which government can exert leadership (Blas, et al., 2008), so can stewardship be achieved through the ability to have a well-resourced plan for execution of policy; a strategy which the Ministry of Health can deeply benefit from.

Human resources for Health

The human resources for health is central to achieving efficiency within the system. It is important to have a system that encourages the right kind of numbers, skills mix and incentives and encourages deployment according to the needs (World Health Organisation, 2010). Information gathered and the document analysis indicate that the Ministry is able to provide incentives in order to have the right numbers especially in areas identified as hard to reach. The PSR (2008) indicates any public officer engaged may be posted anywhere in the country (Government of Lesotho, 2008). Informants indicated the use of IFMIS for rewards.

The system allows rewards and pays per established positions whereby similar positions are similarly graded. This includes providing incentives to those areas identified as hard to reach. Similar graded positions are rewarded on the same scale. This indicates high equity and fairness in the payment system. However, in terms of encouraging the right skills mix this grading mechanism may prove to be lacking as certain skills within the same cadre may

require more expertise and similar graded pay. Likewise, this may create a challenge in terms of efficiency as the system does not reward officers in accordance with performance.

On analysis of records, since 2010/11 financial year to date, the Ministry of Health has never been able to fill all vacant positions despite the human resources for health shortage that has consecutively been reported over the years. This could be due to poor performance of staff or long processes that have to be satisfied before vacant positions can be filled. On implementation of the new developed policy that requires line ministries to source authority from the MPS, this problem is expected to worsen as it adds to the already existing red-tape suffered for the positions to be filled. This means increased shortages for the HRH. It also means the Ministry runs the risk of having a compromised quality of health care due to existing human resources burnout and overworked staff. Mechanisms to expedite the recruitment processes would need to be looked into in the near future especially in the case where positions are funded and finances are not the problem.

The Human Resources for Health system runs completely independent to the HMIS. The lack of integration between the two therefore leaves a bleak picture of how human resources affect the system functioning in other areas. Although records indicate delays in human resources recruitment and shortages of human resources, these are not matched with the amount of work to be carried out within the system. Moreover, this carries the risk of over or under staffed health system that does not match the system human resource needs. It further displays sings of the risk of lack of accountability and efficiency from programme managers on account of human resources shortages and blame shifting as a result of independently run components within a system.

Health Financing

Health financing is regarded as a policy instrument to overcoming financial barriers to health and enhancing improved access to health care (World Health Organisation, 2010).Empirical evidence shows a relationship between health financing and health outcomes where increased spending on health results in improved health outcomes (Kim & Lane, 2013). Similarly, Fryatt, Mills & Nordstrom (2010) indicate an underfunded and weak health system as a constraint to attaining health millennium development goals (Fryatt, et al., 2010). Novignon (2013) notes that Sub-Sahara African countries spend far less than what has been regarded as the government spending on health which is 15% of national government budget (Novignon,

2013). This target was set as the minimum government spending on health with the aim to improve health outcomes.

Informants and document analysis showed two financing mechanisms used in MoH. Government and donor funding. Despite larger funding allocation by government to health, informants indicated at times allocated funds are not fully utilised within the Ministry. This was also found to be the case during the document analysis, which showed incurred constant budget cuts from government funding over the years due to under-utilisation of allocated funds in the previous years. This raises a concern for accountability and efficiency as governance principles in utilising the allocated resources. According to the Lesotho PHC Revitalisation plan 2011-2017, government funding on health is estimated at 14%. This figure is 1% lower than the recommended minimum percentage of the Abuja Declaration agreement on government financing on health (Ministry of Health, 2011). Likewise, given the recurring recorded underspending, the utilisation may prove even far lower percentages on actual spending on health. Although the degree of government spending on health and health outcomes was not part of the finding of this study, the literature indicates increased government spending on health results in improved health outcomes. Based on these studies and findings of this study, whereby allocated funds are not fully utilised, this may be regarded as some of the possible reasons behind the dysfunctional health system in the Ministry of Health in Lesotho.

Notable, is that there is an efficiency in utilisation of resources. The reported and recorded under-utilisation of financial resources paints a picture of an over-resourced health sector. However, evidence indicate a dire need for more resources and this prompts the need for leadership enquiry into the reasons behind frequently incurred underspending while outcomes are still reported to be unsatisfactory and shortages still reported. The resource gap versus available expected resources for the years 2009 – 2013 and the incurred underspending over the years with budget cuts means increased resource gap that accumulates over the years, arguably affecting the delivery of services. However, further research to determine the relationship between government financial allocations on health, Ministry spending and health outcomes is needed to determine if the current state of health is due to financing problem. With government as the main source of health finance, the Ministry needs to explore other innovative ways of financing health besides relying on government and donors; and utilising funds allocated for health activities. This includes the ability to predict future investment by the donors based on the bilateral agreements for the purpose of planning.

Despite, the recurring underspending over the years and donors implementing other programmes outside the MoH framework, the Health financing policy provides a steady progress for the Ministry of Health to move towards resource coordination. However, increased mechanisms to move towards exploring other methods for financing of health other than government and donors are needed to avoid the case of having government as the sole financier in case of donor withdrawal. Having government as the main source of health expenditure may prove sustainable in terms of financing of health system but fails in terms of adequacy as government funding depends on other fluctuating source of income such as revenues which are influenced by other political and macro-economic performances (Mwase, et al., 2010). This poses a threat of further budget cuts and decreased financing for the Ministry of Health. In general, this paints an insufficient health financing, reliant on donor funding and government with very little coming from out-of-pocket financing. High inefficiency in utilising resources is experienced within the Ministry of Health.

Heath Management Information System

Health management information is one of the super-structures to health system strengthening good governance. It provides information on health challenges. Existence of timely and easily accessible information on health issues is crucial to the planning and financing of health (World Health Organisation, 2010). The health information therefore provides trends on health issues. A well-managed HMIS requires an existence of a national monitoring system that ensures the information is timely, accurate and reliable.

According to the Lesotho PHC Revitalisation Plan 2011-2017, progress has been made in attaining reliable and high quality data. However, concerns over its accuracy and inadequacy still exist (Ministry of Health, 2011). This was further confirmed by respondents in this study. If data produced cannot entirely be relied upon, this mean further research would still need to be done for policy and this would cost the Ministry more money. Informants indicated an existence of data collection mechanism. However, this is a manual process at health centre level and captured electronically at hospital level. The timely existence of this information would therefore depend on availability of human resources for data-capturing at hospital level. This process brings about efficiency issue and raises concerns on how policy developed based on it quickly addresses the current problems. This would then mean even in times of disease outbreaks the Ministry may not be able to rapidly respond to such cases, due to the time taken for information to be processed.

Similarly, studies have shown that focus on singular health information can result in parallel systems where diseases are addressed independently (IDRC, 2011) indicating the need to have HMIS linked to financing and planning. The documents indicate an existence of a Monitoring and Evaluation (M&E) section within the Ministry however, it was not indicated by the informants how the HMIS unit links and coordinates with M&E for enhanced efficiency. The Ministry of Health cannot afford to have a weak information system with identified challenges as this information is basis for informed resource allocation mechanisms. In a similar manner that CSO's have been said to affect resource allocation, they have been alluded to support generation of information (Blas, et al., 2008) due to the fact that they work closely with the society, where information is based. This may prove to be beneficial to enhance health information.

If the Ministry of Health wants to focus on addressing the real health issues in communities, it cannot afford to have challenges of inaccurate data as this information is imperative for policy development and resource allocation purposes. Problems such as inaccurate and inadequate data pose the risk of having over-concentration of resources in some areas while others are left under-resourced. It is therefore relevant that data collected is accurate and timely delivered. However, timely processing of data is much dependant on availability of human resources as one of the challenges raised by informants also discussed earlier. This means that capturing of information may be delayed due to lack of enough human resources as one of the challenges identified by informants. Therefore delays in allocation of resources in areas of dire need may results in disease burden with limited resources to address them. Prioritising the HMIS unit would be ideal for informed decision-making and monitoring of progress made on policy and resource decisions. Building a reliable Health Management Information System may not be an easy task in terms of resources, hence collaborative network efforts between all stakeholders may help overcome some of the challenges identified. In the same way, drawing from the same information source can help address the real challenges that affect the society even in the case where the framework is not one although this may not be advisable in terms of network principles and can result in some areas being over resourced.

5.3 Governance Challenges

Based on the discussion and analysis above at least three major challenges have been identified.

Firstly, although the Ministry has a clear strategic direction in terms of policy and plan, achieving easily accessible health care would remain a challenge given the high dependency of health financing mainly on government and donor funding. Secondly, there is inefficiency in utilisation of allocated financial resources given the recorded budget cuts over the years due to under-spending. Thirdly, given the processes and time taken for the health information to be processed (paper capturing then from paper to electronic) this may create delays in terms of developing policies that respond to health challenges in time. Consequently, given that financial resources are allocated based on performance which, in this case is utilisation of allocated resources, this means there is poor performance in the Ministry of Health given the recorded underspending of allocated financial resources.

5.4 The MoH Governance Trends

This study examined institutional arrangements instigated by the MoH in order to achieve good governance – if focused on the normative trends to achieve effectiveness, efficiency transparency, access, equity and fairness. The analysis and discussion is based on findings of this research and previous studies conducted.

An analysis into the governance trends within the MoH indicates great commitment within the sector in making arrangement to achieve good governance. Over the years since 2000 to date, information gathered indicates the Ministry of Health has been engaged in different strategies such as decentralisation of health services to the local councils, contracting of health services, PPP, privatisation and performance-based financing. The Lesotho's Queen 'Mamohato Memorial Hospital built under the PPP initiative is another example of one of the strategies undertaken by the MoH in an effort to address the universal and equitable health coverage in Lesotho. Although some of the processes are still at their infancy stages and ongoing, this shows commitment from the leadership to achieve good governance.

The LHSA conducted in 2010 (Mwase, et al., 2010), found the only one contracting mechanism existed was between MoH and CHAL, and this was to increase access to health services. This was governed by an MOU between MoH and CHAL where MoH funded CHAL for its inputs while CHAL delivered the health services to the population within its catchment area. It was also indicated that MoH also conduct other contracting mechanisms

although non-systematic. These exist with private hospitals where the MoH supplies private hospitals with medication (such as ARVs) for easy access to those infected. Although still at the infancy stage and progress could not be recorded, the MoH has currently implemented the performance based financing mechanism. This is anticipated to improve the quality, access and utilisation of health care services.

Based on the findings, access to healthcare remains a major concern to the MoH. Despite reports that five years prior to 2010 access to health had improved, statistics in the levels of maternal mortality, HIV/AIDS and TB were still very poor (Mwase, et al., 2010). This brings concerns as to whether it is access to health care that is a problem or lack of health education at grassroots level on why, what and when to access health services. Moreover, the trend shows implementation of strategies that exacerbate the resource burden on government without any other mechanism on how resources would be sourced. For instance the PPP initiative between government and QMMH which has been criticised for increased cost on government due to incurred referrals made by the clinics and district hospitals (Government of Lesotho, 2015). This means therefore that the health financing mechanisms run parallel to policy strategies being implemented thus, placing increased resource strains on government as the major resource provider on health. With the implementation of the PBF, resource utilisation is anticipated to improve and the result-based human resource performance to be encouraged.

In view of the trends followed, it is not clear how the Ministry of Health aims to escalate its deficits. This therefore justifies the decrease in resource flows over the years as discussed earlier. Strategies being implemented also need resources directed towards them and draws from the same limited pool of resources thereby increasing the resources need burden. Project implementation should be used to enhance resource flow rather than drawing from the same resources allocated for the Ministry. Notable is that these are implemented as projects supported mainly by the donors. Programmes implemented through projects often lack stewardship from government during the handing over phase and often fail after being taken over by government. Despite progress made during the project implementation phase, often regression is experienced when the government takes over. This could be due to lack of stewardship or lack of enough resources to run the programmes. Moreover, at the end of the project this further increases the resource needs gap from government as it has to carry over some of the programmes from the project for continuity in provision of services. It further poses similar threats alluded to earlier in case of donor or project withdrawal by the donors.

Decision making – analysis from senior-level staff

The literature reveals that one of the governance challenges is the degree of power in decision-making in the implementation of plans and financing owned by managers in health (IDRC, 2011). Informants indicates that managers and directors within the sector are the ones who decide where resources should be allocated. Similarly, managers confirmed having taken active participation in deciding which areas resources should be directed. But they also indicated the process is too long and often excludes managers during the final stage which, at times, leads to major budget cuts in areas of dire need. When asked about the criteria used for resource allocation, informants indicated that the resource allocation formulae that allocates funds based on factors such as population, geographic location of the area from the centre and disease burden is not in use as it needs to be updated. Rather other tools, such as activity-based planning based on previous year performance are used.

Contrary to popular beliefs studies reveal that often managers in health settings do not make decisions on how and where resources should be allocated, which leads to diseases being addressed single-handedly (IDRC, 2011). This was not found to be the case in MoH but concerted efforts were made between MoF, MoH and development partners through participative budgeting, and information sharing during quarterly and annual reviews. However, pending the updated resource allocation formulae, the MoH run the risk of misdirection of funds. In the same way, processes in HMIS indicate that resources may be misallocated based on the time information is processed to inform decision. Performance may not necessarily translate into addressing the need, other administrative activities that do not address the actual disease burden may perform better and this means more funds would be directed on these activities. Consequently, basing the decision on performance shows a governance focus area weakness. Hence the need to have a reliable HMIS that gives timely information on disease burden and other areas of focus for resource allocation.

5.5 Conclusion

This study viewed health system as a network from which different parts of the system inform one other in order to have a well-functioning system. There is an inter-connection between parts of the system to form a functional system. Although governance forms part of this network within the functioning of health system, it mainly functions as the base for the whole structure. Therefore, examining the health system through the governance lens, has unearthed problems with the base and not the structure. Hence the results of this study

suggest there is a problem of escalations of deficits in governance in the Ministry of Health which, given the discussion above, are mainly caused by lack of proper coordination of resources directed to health and by lack of other ways of financing health. Moreover, even when programmes area implemented, government is acting as a sole provider of health services with disregard of civil society organisations. Also, delays in information processing within the system cause delays in addressing the systems problems until such problems have intensified and an influx of resources is needed to address them.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter presents conclusions and recommendations of this study. Conclusions drawn here are based on the study findings and discussions presented. It also provides recommendations on lessons learned from the case of the Ministry of Health in Lesotho, with special focus on strategies that could be implemented to overcome identified problems from in this study. Finally it provides recommendations for further research based on the limitations identified during this study.

6.2 Conclusions

The conclusions drawn here are based on the findings from this study.

6.2.1 Purpose statement

The purpose of this study was to investigate the governance challenges within the Ministry of Health in Lesotho. It aimed to provide the reasons behind the dysfunctional health system and provide governance trends within the Ministry.

Governance is perceived to be the cornerstone behind every government's wellbeing. Consequently, it continues to be associated with the development of any society. It is therefore used synonymously with government. World-wide governments have made it their priority to get governance right for the purpose of development. Failure to develop is regarded as a governance failure and as a result, rated low on good governance interventions. Good governance is an evaluative measure of governance providing the principles against which governance is measured to determine progress. Although there is no agreed upon definition for the concept, it is largely regarded as a framework that provides for government processes and decision-making.

According to the literature, in health, governance deficits are evident in dysfunctional health system that result in poor health outcomes. According to WHO (2010), a well-functioning health system is one that responds to the ill-health of the nation, provides equitable access to healthcare to the people and protects the people against the cost of ill-health amongst others (World Health Organisation, 2010). Central to achieving this, is governments' strong leadership and governance that respond to these challenges. Globally, governance challenges range from non-communicable to communicable diseases, to which the answer is a strong governance at national level (Frenk & Moon, 2013).

A qualitative enquiry was conducted in order to investigate governance challenges within the Ministry of Health in Lesotho. The study focused on components of health system strengthening and were studied through the health system governance lens. A purposive sampling targeting those members within the system that have direct experience on reasons behind the dysfunctional health system was used. A descriptive analysis, through the governance lens, was done using sub-topics and components of a well-functioning health system. A descriptive analysis was used to analyse and interpret the data collected through the governance lens. Clear evidence of constraints to scale up resources is exhibited and this is due to inefficient utilisation of existing ones. This means there is indeed the problem of escalation of deficits in the Ministry of Health in Lesotho. Governance trends within the Ministry were identified. Although positive in trends that shows commitment to achieve good governance, these proved to be some of the contributing factors to the primary concern that led to the carrying out of this research as they add to resource burden on government in the long run due to lack of other innovative financing mechanisms that tally with trends. Below are the conclusions drawn from the findings of this study.

6.2.2 Reasons for dysfunctional health system in MoH

The literature indicated that some of the reasons which create a dysfunctional health system is that of failure to adhere to governance priority areas; the processes and mechanism used to determine where and how resources are allocated; lack of evidence-based planning and resource allocation mechanisms deployed by national governments; ineffective health reform policies; corruption; inefficient and uncoordinated donor investment; under and inappropriately resourced health sector; departmental and functional relationships amongst units within the system; power issues of unsupportive and uncoordinated units that work in silos and fragmented health system where diseases are addressed singlehandedly rather than being addressed as a whole and within a system.

The conclusion drawn from the analysis of this study, based on the primary data collected and documentary analysis. The examined health system is not entirely dysfunctional but its basis which in this case is governance and leadership has challenges that need to be addressed in order to have a well-functioning health system. From the study, clear governance goals have been set and plans are linked. There are clear mechanisms to coordinate donor investments and the information from the health centres is crucial to planning and policy. It was found managers and directors to be the main decision-makers on allocation of resources. However, the study discovered some irregularities in the allocation of resource mechanisms and health

financing, where tools utilised for resource allocation based on population and disease burden were not fully utilised. Irregularities identified in other components can be addressed by a strong committed leadership which seems to be affected by constant replacement of ministers and directors. The literature further indicated increased financing results in improved health outcomes. Habitual underspending incurred by the Ministry of Health which results in budget cuts is regarded as one of the reasons behind the dysfunctional health systems in the Ministry of Health in Lesotho.

An analysis of the examined units of the health system showed positive networking connections to constitute a functional system and positive efforts towards achieving good governance, particularly findings that indicate the need to address an element of efficiency in good governance. Although the information generated is said to be used to inform planning and resource allocation, the tools used are mostly based on performance. However, performance does not indicate where the need is since such allocation is not based on factors such as the disease burden, population and geographic location (remoteness of the area) which are factors that indicate the need. Hence, governance focus area during implementation is a concern.

6.2.3 The governance challenges

Analysed literature indicated that governance challenges in the health systems are evident in addressing disease burden. This poor state of heath is noticeable through the issue of fragmented health systems, which are a governance issue. From the study, some bottlenecks in governance do exists in MoH and the following challenges were identified.

- Although the Ministry has a clear strategic direction in terms of policy and plan, achieving easily accessible healthcare still remains a challenge given the high dependency of health financing mainly on government and donor funding.
- Given the processes and time taken for the health information to be processed (data capturing from paper, then from paper to electronic media). This could create delays in terms of developing policies that respond to health challenges in time. Moreover, given challenges of accuracy in collected data, this means data produced may not entirely be relied upon.
- According to the IFMIS, resources are allocated to the Ministries based on previous year financial performance. Given this as a premise to move from, it is not surprising that r the Ministry of Health has been experiencing budget cuts over the years,

because the Ministry more often than not, demonstrates under-utilisation of allocated financial resources. It could therefore be argued that poor performance of health systems exhibits inefficiency in governance.

- There is no coordination or liaison between the Ministry of Health and other health service providers except for CHAL and this leaves the Ministry highly strained in terms of resources; both human and material.

6.2.4 MoH governance trends

Examining trends in an organisation is the best way to learn what has been happening over the years. From the trends, one is able to learn strengths and weaknesses of an organisation based on identified norms.

The document analysis and informants indicated the Ministry has been implementing strategies that show commitment in achieving good governance. Some of these are followed by clear policies and plans for implementation. From 2000 to date, the MoH has been engaged in strategies such as decentralisation, privatisation, PPP, contracting and performance-based pay. In light of the above-identified trends, one would conclude there is indeed a sign of concerted efforts and commitment by MoH for improved quality and increased access to healthcare. The analysis into the type of agreements and effectiveness of these mechanisms was beyond the scope of this study.

6.3 Recommendations

6.3.1 Problem statement

Findings from this study indicate there is indeed a problem of escalation of deficits in the Ministry of Health in Lesotho. The study shows how little the coordination of the resources exists within the Ministry of Health in Lesotho. This follows logically on the analysis of the findings and conclusions drawn above. Below are the lessons learned from the study and recommendations based on the analysis.

- There is need for collaborative efforts between all stakeholders in resource mobilisation to avoid situations where resources are all directed to one area. This can be achieved through participative planning and evidence-based priority setting mechanism that shows areas of dire need. A strategy that could be employed by other ministries where resources are limited and for increased efficiency in delivering services.

- Given the challenges of data collection and timely delivery of the said data to inform policy, strong collaborative efforts between the Ministries of Finance, Communication, Science and Technology and Health are needed to move from paper based work to technological advancement.
- There is a need to have an updated resource allocation formulae that takes into account the population and disease burden needs so that allocation of resources and performance can be tallied to burden for improved equity and efficiency thereof.
- In view of the high commitment to quality, access and efficiency demonstrated by the trends, further studies in the success of such mechanisms in achieving their primary purpose is crucial.
- A strong collaboration between the Ministries of Finance, Energy, Communications and Health is needed to address service delivery issues and to help in mitigating migration from paper-based to electronic data capturing in health centres.

6.3.2 Possible strategies for implementation

The study did not go into details on effectiveness of implemented strategies. Based on the discussion carried out in this paper, positive mechanisms are being instituted to enhance quality and improve access. The following recommendations are made:

- The Ministry of Health needs to implement a monitoring and evaluation strategy with very clear indicators on how to evaluate their effectiveness in achieving the intended goals and document lessons learnt. Information from this mechanism should be used to inform policy and decisions on future strategies for implementation.
- Mechanisms that strongly engage with Civil Society Organisations in providing health services are needed.
- A strong health education strategy targeting the population to be tallied with any other mechanisms to be considered for improved governance.

6.3.3Recommendations for further studies

- Further research/study is needed to determine where the bottlenecks in governance really lie within the Lesotho MoH.
- What is the relationship between government financial allocations on health, Ministry spending and health outcomes?
- How best can the MoH use information to inform governance of the health system functioning?

- An analysis into implemented governance strategies and the role of government beyond the contracting is needed to determine the success of these strategies in achieving their primary goal.

6.4 Conclusion

Evidence shows there is a problem of escalation of deficits in the Ministry of Health in Lesotho. The problem is caused mainly by lack of institutional arrangements to obtain resources committed by all stakeholders. Despite available resource mapping mechanisms, there is no evidence of collaborative planning efforts between all stakeholders especially CSO's which have a successful record in providing health services. Efforts to enhance resource flow with the aim of gathering the nature of resources to be committed in different policy areas to be implemented seem very minimal. Therefore available resource allocation mechanisms prove to be meaningless and result in a dysfunctional health system that is under-resourced and unable to address health problems effectively. The Ministry's governance trends seem to be carried out in project form and this leaves the Ministry with further resource gaps during the handing over phase of the project. This research provides possible strategies that could be deployed to procure/increase the limited resources and/or to maximise the efficiency and effectiveness of the existing limited ones. This would result in a more effective health system functioning.

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APPENDICES

Appendix A: Questionnaire

Instruction: Answer all questions under each section. You are allowed to provide as much information as you can. Extra space is provided at the back for more information.

SECTION A: DEMOGRAPHICS

Respondents
Position/Title ____

Duration in position ____

Department/Unit: ____

Work Physical
Address: ____

Telephone
Numbers (work): ____________________ Mobile: ____________________

SECTION B: DETERMINING BARRIERS TO EFFECTIVE SYSTEM FUCTIONING

Governance and leadership

1. What would you regard as the country's health priorities:
   a) ____
   b) ____
   c) ____

2. What mechanisms and institutional arrangements exists to channel donor funding and align it to the country priorities?
   a) ____
   b) ____

c) ____

3. Which of the areas mentioned in (1) above receive donor funding?

   a) ____
   b) ____
   c) ____

4. Are there any other areas which you would regard eligible for funding?

   a) ____
   b) ____
   c) ____

5. What mechanisms are there to ensure accountability in the sector?

   a) ____
   b) ____
   c) ____

Health Information System

6. What arrangements exist to make information accessible to all stakeholders (civil society organisation, health professionals, donors etc.)?

   a) ____
   b) ____
   c) ____

7. How does the Ministry access the health information?

   a) ____
   ____
   b) ____
   ____
   c) ____
   ____

8. To what extend is this information used for planning and resource allocation?

a) ______________________________

____

b) ______________________________

____

c) ______________________________

Health financing

9. What mechanisms are there to raise funds for health?
   a) ______________________________
   b) ______________________________
   c) ______________________________

10. What system is used for financing of health?
    a) ______________________________
    b) ______________________________
    c) ______________________________

11. Is this supported by the legislation/financial audit/operational rules for efficient use of funds? How?
    a) ______________________________
    b) ______________________________
    c) ______________________________

Human Resources for Health

12. What regulatory mechanisms/systems are used to ensure system wide deployment and distribution in accordance with needs?
    a) ______________________________
    b) ______________________________
    c) ______________________________

13. What payment systems in the Ministry?
    a) ______________________________

    ____

b) ____

____

____

14. Does the payment system produce the right kind of incentives?

a) ____

____

b) ____

____

c) ____

____

SECTION C: DETERMINING GOVERNANCE TRENDS

15. What are the strategic goals in health?

a) ____

____

____

b) ____

____

____

16. What forms of governance is the Ministry implementing (Privatisation, Public Private Partnership (PPP), Decentralisation etc.). Give example of each. (**in your answer indicate when each was implemented and which ones are ongoing**)

a) ____

____

____

b) ____

____

c) ____

____

17. What role do Directors/Managers play in the success of these strategies and in governance in general?

    a) ____

    ____

    b) ____

    ____

    c) ____

    ____

18. What institutional arrangements are there to ensure above mentioned strategies are implemented?

    a) ____

    b) ____

    c) ____

19. What strategic documents within the sector identify governance as a priority? Mention at least three and their year.

    a) ____

    ____

    b) ____

    ____

    c) ____

    ____

20. What are the priority areas for these documents?

    a) ____

    ____

    b) ____

    ____

    c) ____

    ____

Decision making

21. What resources does your department make use of?

a) ____

____

b) ____

____

22. Who is in charge of making decision on how these resources are allocated?

a) ____

____

____

b) ____

____

____

c) ____

____

____

23. What tools are available to inform your decisions on resource allocation?

a) ____

____

____

b) ____

____

____

24. What decision space do Health Managers have?

a) ____

____

b) ____

____

25. What affects this?

a) ____

____

b) ____

____

Thank you very much for your participation!

Kindly provided additional information on any of the questions below. Indicate the question number to which additional information is being provided.

Appendix B: Ministry of Health research ethics letter (Institutional Approval)

Appendix C: Consent form

Background and Consent Form

As a participant in this questionnaire, you are being asked to help the researcher to establish the governance challenges in the Ministry of Health. This research is conducted in partial fulfilment of the researcher's degree with Wits University. The main objectives are:

1. To establish barriers that lead to effective system functioning in the Ministry of Health.
2. To establish the governance trends within the Sector.

In order to ensure that you are informed your participation in this study. You are asked to read this consent form. You are asked to confirm your consent by signing yourself at the end of this consent form. Kindly ask the researcher to explain anything you do not understand in this questionnaire.

Participants' part:

If you agree to participate in this study, you are asked to answer all questions in this questionnaire. This will take approximately 20-30 minutes.

If you decide not to participate:

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

Confidentiality:

Participation is under complete anonymity. The participants name will not be tied to or any responses they provide in this questionnaire. You do not have to put your name on the questionnaire.

Benefits:

There are no benefits either financial or personal to participating in this study. However, your participation may provide insights into the best strategies the Ministry can employ.

Risks:

There are no known risks in participating in this study. However, if you feel uncomfortable during the filling of this questionnaire, you may refuse to respond to such a question or stop participating.

Contact Person for Questions:

If you have any questions or problems about the questionnaires you may contact Ms Mosa Theko at +266 587 11986 or m_theko@hotmail.com

Participant's signature ________________________ Date ___________________