

## **Institutional commitment and HIV/AIDS: Lessons from the first 3 years of the Lesotho–Boston University Collaboration**

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### **Abstract**

In mid-2003, Boston University made a decade long institutional commitment to collaborate with the Government of Lesotho as it grappled with the human resource implications of the HIV/AIDS epidemic. The collaboration is a work in progress. We explore the rationale for the University's commitment, detail the development of the relationship between the Government and the University, review the principles that guide the collaboration, report on the activities, results, and challenges to date, and conclude with a look toward the future. We stress the importance of six principles: trust, mutual respect, shared interests, a long time horizon, sustainability, and a country-driven agenda. Although technical or programme content is important, long-term results of value are difficult to achieve if these principles are not honoured.

**Keywords:** *HIV/AIDS, university collaboration, developing countries, Lesotho*

### **Lesotho in brief**

Lesotho is a stable, multiparty, democracy with about 2,000,000 people, approximately the size of Belgium, and entirely surrounded by South Africa. The majority of the population lives in the lowlands relatively close to the South African border. Most of the country's land mass is mountainous and the altitude in the lowlands is rarely less than 5,000 feet. Lesotho's selection as one of 16 first-round countries by the US Millennium Challenge Corporation testifies to its good governance, low corruption, and a Government characterized by openness

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and transparency. The physical infrastructure at the district hospital and health centre levels is surprisingly good, particularly when compared to other similar low-income countries. Good, paved trunk roads and excellent cellular telephone communication link the country. Political problems, though not absent, are less overwhelming than in many other countries as Lesotho is culturally homogenous. Sesotho and English are the official languages with all instruction in English beginning in grade four at age 10.

Lesotho's health system is a mix of government, mission, and private services. Government services include one national referral hospital, one mental hospital, one very small leprosarium, nine district hospitals, and 72 health centres, all operated by the Ministry of Health & Social Welfare (MOHSW), as well as a military hospital operated by the Ministry of Defence. An additional seven hospitals and 73 health centres are run by various church groups under the auspices of the Christian Health Association of Lesotho (CHAL). In addition, there are physicians and nurses in private practice, who are mainly Lesotho nationals or long-term residents of Lesotho, working on a fee-for-service basis. Tertiary care is by referral to nearby Bloemfontein in South Africa.<sup>1</sup> The physician to population ratio varies but tends to be about one physician for every 15,000–25,000 people. Lesotho has a long and very positive history of using double qualified nurses and nurse clinicians to deliver the majority of primary health care in health centres.<sup>2</sup> Lesotho trains its own nurses and allied health professionals but physicians are trained abroad, most predominantly in South Africa (Bicknell et al. 2002).

With the onset of HIV/AIDS, life expectancy has dropped to about 36 years. The most recent data on HIV seroprevalence reveals that, for 30 to 39 year old women and men, the rate is about 40% and the prevalence for all adults (ages 15–49) is about 24% (Bureau of Statistics [Lesotho] 2004). It is noteworthy that, in 2002, few people were hospitalized for clinical AIDS but, by early 2005, hospitalizations for complications of AIDS were common (Bicknell et al. 2002). Thus, the epidemic was, and still is, in its early stages, and the full impact will not be felt for at least a few more years. This has profound implications for every sector. Deaths of key and critically needed workers will increase, and the ability of Government and the private sector to respond will be more difficult as fewer people are asked to do more. All of the problems that the Government faces in managing programmes, and developing and implementing sound policies, will be compounded by the deaths from AIDS, and the enormous financial implications of the need to treat an estimated 250,000 to 300,000 children and adults out of a population of approximately 2,000,000 (Bicknell 2005a). In brief, Lesotho is a country with a very severe HIV/AIDS problem, but whose size, culture, government structure, and physical infrastructure strongly suggest that those problems can be surmounted. Were these factors lacking, the Boston University (BU) commitment would have been difficult to justify.

## **Partnerships and collaborations**

Partnerships and collaborations in development assistance have been extant for many years. Church health services are a case in point. Ullah et al. (2006), in a wide-ranging review, conclude that there is no single ideal model for collaboration. Public-private partnerships work when there is mutual respect and trust, recognition of mutual strengths and weaknesses, the regulatory and legal environment is favourable, mechanisms for effective management exist, and there is transparency, accountability, and continued commitment of partners with ongoing involvement of stakeholders. Many universities in the USA and abroad are involved in health and development work with countries around the world. For US universities, such collaborations are often supported by USAID, frequently through its Higher Education for Development programme, an association of over 2,800 colleges and universities in the USA (Higher Education for Development 2006). A Google search demonstrates higher educational institutions commonly participate in contract work with bilateral and multilateral donors (Google 2006). A noteworthy example of cooperation without US Government support is the Baylor College of Medicine International Pediatric AIDS Initiative, with programmes in a number of countries, including Lesotho (Baylor International Pediatric AIDS Initiative 2006).

The Lesotho-BU Collaboration<sup>3</sup> is unique in that the commitment: (1) is University-wide, (2) was made with the intent of drawing on all relevant resources of the University, (3) was initiated by a substantial infusion of University funds with full knowledge they would likely not be recouped, (4) was made before any donors had been approached for funding, and (5) is driven by Lesotho's assessment of its own needs relative to BU's areas of relevant strength in the search for donor funds. The last point is critical. It is common to have donor funds in hand and then seek to fit country activities within the framework predetermined by the donor. The BU approach is exactly the opposite. First, an open-ended and non-predetermined, 10-day, collaborative and very interactive, assessment of Lesotho's needs and BU's strengths was done. From this, and from a growing knowledge of needs gained through work on the ground, donor funding is sought to fit within an overall strategy. This has worked remarkably well in six of seven donor-funded activities. The one case that has been more challenging violated the principle of country first, donor follows.

## **The origin and rationale for the Boston University commitment**

The BU commitment to service, engagement on pressing social problems, history of substantial work in Lesotho since 1990 (Bicknell 1990, Puglisi and Bicknell 1990, Bicknell et al. 1993, 2002), and a number of graduates from Lesotho, led the University in 2003 to commit to a long-term, decade or longer, collaboration with the Government for the purposes of preserving and enhancing human capital. BU has always had a strong social mission and commitment to community and world service. In the nineteenth century, the University had

programmes and graduates in 40 countries. Now the University has students from 140 countries with worldwide programmes of service, research, and education. Examples of the University's commitment to service include the Chelsea Schools Project. BU took responsibility for operating the school system in one of Massachusetts' poorest communities, one with very sub-standard public schools. The University has been successfully operating the Chelsea schools for 18 years.<sup>4</sup> In the health arena, BU took the lead in initiating a problem-based, community-oriented, medical school at Suez Canal University in Egypt: a successful, decade-long, activity (Bicknell 1984).

Boston University consulted in Lesotho several times since 1990. In late 2002, a senior BU faculty member learned that 44% of women attending antenatal, sentinel site clinics in the capital city of Maseru were HIV positive.<sup>5</sup> A discussion with the Minister of Health & Social Welfare indicated interest in working with BU. This led to the mid-2003 commitment by the University President with the strong support of the University Provost. The idea was presented to the Provost informally and orally, rather than following the usual channels of communication and programme development within the University. When the Provost reacted favourably, a draft memo for consideration by the Provost and his team was written, and after a second meeting with the Provost, the unedited draft memo was forwarded to the President with a strong endorsement from the Provost. The President gave his approval within 48 hours (Berkey 2003).<sup>6</sup> There were several key factors supporting this commitment. Boston University had a strong institutional track record in Lesotho, and individuals in Lesotho and Boston knew each other, and had a sense of trust and mutual respect.<sup>7</sup> In addition, everything about Lesotho suggested a collaboration could work, and Lesotho's needs were relevant to Boston University's interests. The institutional commitment, though, really stemmed from pre-existing relationships between a senior faculty member at Boston University and senior officials in the University.<sup>8</sup>

Prior to making a commitment, the University leadership wanted to know: (1) Why Lesotho? (2) Could the idea of a University commitment to a nation work? (3) Was anything similar being done elsewhere in the world? The answers were straightforward. The HIV prevalence rate meant there was acute need, and the life of a nation was at stake. Lesotho was big enough to test the concept of institutional commitment, and not so big as to be beyond what BU could manage (Berkey 2003). To the best of our knowledge, similar broad, long-term, and rather open-ended commitments were not being made by other universities to other nations. Once the University commitment was secured, the Minister of Health and Social Welfare was approached, and the assumptions underlying the University commitment were laid out in a letter dated July 6, 2003, from the BU Project Director, Dr. William Bicknell, to Lesotho's Minister of Health and Social Welfare. Specifically:

Some combination of natural selection, the natural history of epidemics, new technologies for prevention and treatment, the growing use of existing antiretrovirals as their cost continues to fall, along with changes in sexual behaviour, will result in the HIV/AIDS epidemic in Lesotho coming under control in 10 to 15 years. Control, in this case, means adult prevalence rates dropping,

from as high as 40% down to 10%, 5%, and possibly lower. However, the consequences of the epidemic, when it is effectively controlled, are going to be grim. School teachers, accountants, mechanics, hotel workers, nurses, doctors, bus drivers, police, and university faculty, to name but a few, will all be in short supply. Running the existing infrastructure will become more and more difficult, and the capacity to educate and train the work force will be more and more degraded. Normal attrition, plus growing deaths from AIDS, are likely to seriously weaken not only Lesotho today, but also its capacity to educate and train future workers of every type. Therefore, the ultimate goal must be more than merely controlling the epidemic. A viable national workforce, sufficient to assure continued socio-economic growth and development, is essential (Phooko 2003).

The Lesotho–BU Collaboration is intended to contribute to meeting the needs of a nation by focusing on human capital, with the national workforce better equipped to directly address the challenges of a country facing one of the world's most severe HIV/AIDS epidemics. As the epidemic recedes, that workforce needs to be sufficient to assure continued socio-economic growth and development. In the words of the BU Provost, the key to success will be to remain true to the strategic goal of a functioning nation after AIDS (Berkey 2003). Now that the University had made a commitment, and the principles underlying that commitment had been established, the BU team had two questions for Lesotho: (1) Did the collaboration make sense? (2) Where should we begin?

### **The response of the Government of Lesotho**

The Minister of Health and Social Welfare agreed to a working visit of a two-person BU team to explore the viability of the idea, and an intense 10-day mutual exploration and needs assessment took place in August of 2003. BU had no proposal, approach, or plan when the commitment was made. The BU team met with 68 individuals in and outside of Government, including representatives from: the Ministries of Health & Social Welfare, Finance and Development Planning, Agriculture, Labour, Education, Youth Gender and Sports, the Minister of Health & Social Welfare, as well as the Deputy Prime Minister/Minister of Education and Training. Other meetings included: UNDP, the US Ambassador, Irish Aid, Christian Health Association of Lesotho, Maluti Adventist Hospital, staff and students at the Lesotho College of Education, Lerotholi Technical Institute, the National Health Training College, physicians in private practice, and Sechaba Consultants. This intensive, open-ended, multi-sectoral consultation for input and guidance was only possible because of three complimentary factors:

- The Minister of Health & Social Welfare provided extensive support, including airport pick-up, assigning a staff member to assist the BU team, and being personally available for consultation, guidance, direction, and feedback.
- The BU team leader had substantial prior knowledge of the country and the players.
- Former graduates provided assistance with regard to both substantive input and facilitating contacts with key players.

This 2003 visit resulted in the report *HIV/AIDS—The long view: Initial impressions and a way forward* (O'Donnell and Bicknell 2003) with the following conclusions:

- The commitment makes sense and was worth pursuing.
- The clinical impact of the HIV/AIDS epidemic was just beginning.
- Preserve existing people through education, counselling, and antiretroviral care. Give priority to persons in the work force, with first priority given to teachers and health workers.
- Improve efficiency so fewer people can do more. Address problems by translating plans into action that make a difference in service delivery.
- Strengthen educational capacity.
- Everything cannot be done at once. Therefore, begin with carefully selected projects.

The report suggested that initial projects should contribute to improving efficiency in the use of human resources, and increasing sustainable capacity to educate and train key personnel. Specific areas suggested as desirable for initial projects included:

#### Education

- Healthy teachers\*
- Strengthening secondary school counselling
- Educational technology and capacity building

#### Health

- Strengthening MOHSW strategic planning
- Autonomous institutions, AIDS, and the MOHSW\*\*
- District hospitals, Family Medicine, and QE II\*\*<sup>9</sup>
- Clinical officers: extending physician effectiveness

#### Public sector efficiency and effectiveness

- Decreasing the hiring gap<sup>10</sup>
- Education for effective management\*

A single asterisk (\*) indicates an area where there has been substantial programme development and implementation activity. A double asterisk (\*\*) indicates an area where activities are underway, but are still at an early stage. The paper was explicit that activities will be collaboratively developed, and BU will only take on activities that are supported by relevant authorities in the Government of Lesotho. BU had no intention of duplicating existing efforts, or providing support where others are better qualified. Programmatically, BU will focus on improving efficiency, strengthening educational and training capacity, and assuring long-term sustainability. All BU supported activities will be planned with recurrent costs affordable, from realistic projections of public and private sector funds likely to be available.

These principles have proved to be relevant, practical, and useful, and continue to guide our work.

### **Activities and results**

The activities of the collaboration can be divided into two broad categories, those supported by external donor funds and those supported by the University. Our donor-funded activities have included: developing management capacity through Problem Solving for Better Health (PSBH); addressing needs of the education workforce through a partnership with the Lesotho College of Education; enhancing collaboration of services through a local survey to inform plans for operation of the new referral hospital; identifying strategies to improve the quality and accessibility of affordable and sustainable primary care through exchanges of health professionals; building HIV/AIDS capacity at the community level by training community health workers; and strengthening district health services through workplace improvement and workforce development. Boston University-supported activities have relied heavily on volunteerism, but also include contributions to technology, research, and policy in Lesotho.

#### *Donor-funded activities*

With support from the Dreyfus Health Foundation, BU introduced the PSBH methodology to Lesotho to develop problem-solving and management skills. Successful in 37 countries around the world, this 2–3 day workshop requires participants to develop a detailed work plan to address a specific problem that they can solve using available resources in 6–8 months. PSBH is about doing more with less, improving efficiency, and helping individuals understand they can make a difference by taking the initiative to identify and solve problems on their own. More than 250 individuals from the health sector, government ministries, schools, NGOs, FBOs, CBOs, the private sector, as well as community leaders, have been trained. Of those, about 175 have been successfully completed. The programme has been extremely well received and will soon be institutionalized as a national resource at the Lesotho College of Education, with anticipated funding from the Dreyfus Health Foundation directly to the Lesotho College of Education.

At the request of the Deputy Prime Minister/Minister of Education, to focus on keeping teachers healthy, Boston University formed a partnership with the nation's only teacher training college, Lesotho College of Education (LCE), with support from USAID. This grant supported some assessment and strengthening of HIV/AIDS content in the curriculum for teachers in training. Most importantly, it provided funds for the planning of a clinic designed to operate without recourse to donor funds. The clinic was opened on March 10, 2005, by the Deputy Prime Minister, the Minister of Health & Social Welfare and the US Ambassador.<sup>11</sup> Housed in a renovated double rondavel on the college compound,<sup>12</sup> the clinic serves faculty, students, staff, and their spouses and children

(a population of about 4,000) with a full range of good primary care services, including counselling and testing for HIV and, when indicated, treatment for AIDS. From the moment the clinic opened, all personnel were supported by national, not donor, revenues. A sliding scale of user fees supplements the clinic budget, laboratory services are provided at no charge by the nearby National Laboratory, and ARVs are provided by the Government.<sup>13</sup> A valuable by-product of planning for this clinic was making the first contact with the Clinton Foundation on behalf of the Minister of Health & Social Welfare, and working with relevant players in Lesotho and with the Global Fund to allow Lesotho to use awarded, but not released, funds to purchase ARVs for the entire country. Connecting with the Clinton Foundation and freeing up of Global Fund money would certainly have happened without BU involvement. However, the need to assure funding for ARVs for the clinic accelerated these processes.

A grant from the US Department of State for Africa Workforce Development provided funds for exchange visits and workshops on subjects ranging from the human resources needed to manage the HIV/AIDS epidemic, through the role and potential for Family Medicine training in Lesotho, to a discussion of primary care, effective district hospitals, and health centres and, most recently, the principles underlying the protection of human subjects, and the application of these principles (Bicknell 2005b). This grant provided funds for exchange visits between Lesotho and Boston, allowing us to make the collaboration far more real, as well as catalysing the interest of physicians and others to volunteer for work in Lesotho. Of equal importance, it allowed BU, working with the MOHSW, to lay the groundwork for a programme to strengthen the management of district hospitals in decentralizing the health care environment, and to improve clinical services through initiating continuing medical education for physicians in practice, and through starting a Family Medicine residency programme in cooperation with the Department of Family Medicine at the University of the Free State in Bloemfontein, South Africa. Planning for this 5-year programme is now actively underway, with support from the W.K. Kellogg Foundation. Management improvement and continuing education will begin in January 2007, and the Family Medicine residency programme is scheduled to begin in January 2008.

A small award from the International Finance Corporation, to assist in planning for the new national referral hospital, builds on BU's earlier work (Bicknell et al. 2002). This complements the work with district hospitals, mentioned above, as the new national hospital faces challenges similar to those facing district hospitals. Although the specifics of the approach to each will vary, the objectives of more autonomy and flexibility at the level of the hospital, and improved quality of care, are very similar. Finally, with funding from USAID, BU is leading implementation of the national Know Your Status campaign in the Berea district in partnership with the Berea District Health Management Team. The programme includes conducting training on HIV/AIDS testing and care at the community level to all active Community Health Workers in the Berea



district, providing technical assistance on developing systems for their management and supervision, and organizing referral services and processes available outside of standard health facilities.

### *University-funded activities*

Volunteer physicians, initially from Family Medicine and now also from Paediatrics as well as Internal Medicine, are making regular and frequent rotations to Maluti Adventist Hospital and are integrated into their clinical programmes. Twenty-four physicians and five fourth-year medical students have volunteered their time. These clinical visits are all supported by the individuals and/or their parent departments. Eleven carefully supervised Public Health students have played key roles in implementing the Dreyfus Health Foundation programme, and have assisted with aspects of the clinic development programme at the Lesotho College of Education. These activities are funded by the students, with very modest support from grant funds. We expect Public Health students to continue to play a significant role in the implementation of future activities.

Senior faculty from the Department of Family Medicine and the School of Management have visited and worked in Lesotho and are key players. The Associate Provost for International Programmes visited with a view toward adding Lesotho as a semester-abroad experience. Two adjunct faculty appointments have been granted and both recipients have visited Boston. Visits both to and from Lesotho since 2004 have further cemented the collaboration. The Minister of Finance and Development Planning attended a dinner meeting in honour of several former African Heads of State, and met with the Provost and University President, as well as Deans of the Schools of Management, Medicine, and Public Health, and gave a very well attended public lecture. The Director of Maluti Adventist Hospital, the Deputy Director\*\* and the Dean of Students\* of the College of Education, have visited, as has the Manager of the Senkatana-Bristol Myers Squibb (BMS) HIV/AIDS Clinic. On the occasion of the first US showing of the Prince Harry documentary about his experiences in Lesotho, the Lesotho Ambassador to the USA, accompanied by her son and the current Medical Director of the Baylor Pediatric AIDS Center of Excellence, visited Boston Medical Center. Our Basotho programme administrator\* recently completed an orientation visit, and a planner from the MOHSW\*, a physician staff member of the HIV/AIDS Directorate\*, and three nurses\*, have just completed a working visit.<sup>14</sup>

BU recognizes the potential of technology in improving access to information and training in Lesotho. The University provided 12 email accounts for persons or institutions in Lesotho affiliated with our collaboration. These provide full access to all the electronic library resources of the University for all fields and disciplines. Use is limited by the cost and slow speed of dial-up Internet connections in Lesotho. This constraint should slowly be resolved as connectivity improves; furthermore, the collaboration hopes to expand access and develop capabilities for virtual distance learning.

On request, BU has reviewed research proposals for the MOHSW with regard to the protection of human subjects. We have now begun explorations to further develop the Ministry of Health and Social Welfare's research programme. BU has assessed the need through 2010 for ARVs, compared need to the funds projected to be available, and commented on the issues this raises for the nation. BU also developed a working paper on health insurance, as the country considers options for insuring civil servants. These are examples of BU's work to assist with policy analysis and development.

From mid-2003 until mid-2006, University funds have accounted for about 40%, or over US\$400,000, of programme expenditures, and donor funds for about 60%. The University figure excludes funds for travel and most subsistence in Lesotho, which is provided by individual volunteers and their departments. We have learned that sustainability and figuring out the best approach within existing resources can work, and work well. The excellent results from PSBH, and the integrated primary care HIV/AIDS clinic at LCE, have demonstrated this. In every area of the Lesotho-BU Collaboration, from policy analysis through programme development, we will continue to search for the very best approach within the framework of human and financial resources realistically likely to be available.

### **Challenges and lessons learned**

Every programme has its challenges. Forming agreements, maintaining communication, negotiating relationships, balancing priorities, building a strong team, and allowing for flexibility in planning, have all been essential to overcoming these challenges. Collaborations often start with a Memorandum of Understanding. There has been no Memorandum of Understanding (MOU) and, until very recently, there has not been a need for one. The time spent in developing a MOU in the early years of a collaboration has a real opportunity cost and may prematurely prescribe a framework and set of principles which can inhibit rather than enable. For BU to begin working, and for the collaboration to begin to implement substantial programmes, there was no need for a MOU, and neither the Lesotho or BU sides discussed this until 2006. In the fourth year, with the growth and maturation of the collaboration, a MOU is being developed, as it is now needed.

Operating without a MOU requires constant communication. Open and full discussion with all interested parties, as expected, has proven to be essential. Equally essential is the willingness to question premises and consider non-traditional approaches. Support from key Government Ministers in Health & Social Welfare, Finance and Development Planning and Education, has been and continues to be essential. For the benefits of ministerial level support to be realized, the BU team must maintain good working relationships with line managers and planners in central ministries and operating units, such as district hospitals and LCE. In a multi-faceted collaboration of this type, there are bound to be misunderstandings and difficulties. Avoiding misunderstandings requires a

continuing effort. It has been essential that senior representatives from BU spend substantial amounts of time in Lesotho. Each year, the director typically makes four 1-month trips, and the deputy three or four of similar length, mostly non-overlapping. The importance of assuring the University fields a first-class team is unquestioned. When misunderstandings do occur, as they will, trust and respect are the foundations that support a forward-looking, solution-oriented resolution.

In 2003, donor interest and the expatriate presence in Lesotho were far less. Since then there has been a welcome increase in donor interest. This interest created a new set of problems for Government. Coordinating and satisfying donors and a growing number of implementing organizations, without losing sight of national priorities, is not an easy task. The collaboration's first step is policy and programme direction, then to look for funding, to fit within a mutually agreed to vision. This approach works, and is subtly but substantially different from many donor-driven agendas, where the funding agency comes with priorities and constraints, and the country, if it is to access donor funds, is required to fit within the donor agenda.<sup>15</sup> For successful long-term collaboration, the country's priorities must come first.

Donors often support more than one activity. However, the recipient of donor funds, particularly if it is an organization from outside the country, usually focuses on a single, very specific programme, such as counselling and testing, laboratory quality improvement, technical assistance to a particular office or programme within the MOHSW, or service delivery at a specific place to a specific population. The Lesotho-BU Collaboration differs from this model. The collaboration programmes are being funded by a variety of donors, including the University itself. The collaboration comprises a number of specific, complementary, but different activities united by a common conceptual framework. The collaboration's approach can lead to misunderstandings by other international organizations. This is minimized by putting a premium on communication with all health development partners working in Lesotho.

Developing a core team, capable of implementing activities and expanding the work of the collaboration, has required the commitment of the University as a whole, as opposed to a single school or department. To date, the Schools of Medicine, Public Health, and Management have taken lead roles, and the potential for participation of other schools is very real. It has been important to make sure that participating schools and departments are relevant to the needs of the country.

Finally, it is even clearer now than it was at the beginning, that a mutual long-term commitment is essential. Even when all parties are in agreement, everything takes longer than anticipated. Patience and flexibility in planning and implementing are even more important in the context of a long-term commitment.

### **Key elements for successful collaboration**

There are several key factors that have contributed to the success of Boston University's collaboration with Lesotho. They include a clear long-term goal,

country-driven activities, a long-time horizon, a focus on sustainability, excellence and relevance, as well as trust, respect, and openness.

*A clear long-term goal.* In partnership with the Government of Lesotho and the Lesotho private sector, BU commits to work with Lesotho, to educate and train key elements of the Lesotho workforce sufficient to assure a functional country, with enough trained personnel to allow the country, as a whole, to function, as the AIDS epidemic comes under control (Phooko 2003).

*Country-driven activities.* Specific activities are developed collaboratively. This is easy to say but far more difficult to accomplish. What makes sense from the perspective of a country, and what donor funds will support, are not easily aligned. Well-intended donor-driven projects that simply do not work over the long-term are common in many countries. Minimizing this pitfall by maximizing country partnership has been a top priority.

*A long-time horizon.* If there is one principle that should guide development assistance, it is the need for a long-time horizon. Improvement in the face of very scarce resources requires time. Identification of problems is far easier than their solution. Time allows for the development of trust and mutual understanding. Time allows for the attitudinal changes by all parties, invariably necessary as change is implemented. Further, most organizations, whether funders, universities, or firms, are reasonably and appropriately focused on the crisis of the moment—containing HIV/AIDS. They have just not been able to consider what will happen in the later stages of the epidemic. Finally, this large and multi-sectoral concept does not follow the usual programme development approaches and typically more categorical and shorter-term priorities, of the development community.

*A focus on sustainability, excellence and relevance.* The collaboration recognizes that human and financial resources are limited. In every situation, we seek to find the best way to tackle a particular problem, and assure that any solution or approach proposed and implemented will fall within a realistic projection of the human and financial resources, likely to be available to the nation. Relevance speaks to making choices. There are many possible activities, but the collaboration must choose which ones are of most importance to the nation, and where BU has particular strengths.

*Trust, respect, and openness.* Any long-term relationship, such as the Lesotho–BU Collaboration, will have moments of difficulty and stress. To surmount difficulties, and to meaningfully identify and work on issues that have the potential to make a long-term difference, requires that the key players have a relationship characterized by mutual respect and trust, and that they can speak frankly to each other. They need to be confident that the truth, however difficult

and transiently painful, will ultimately strengthen the relationship and result in a stronger collaboration with better programmes and services.

### **Looking ahead**

Programmatically, the Lesotho–BU Collaboration plans to focus its energies on five strategic areas:

*Strengthening the immediate response to HIV/AIDS.* A programme with funding from USAID/Pact, to strengthen the capacity of community health workers to respond to the growing need for home and community care of patients with AIDS, has just begun. As the epidemic wanes, the need for community health workers will remain. Thus, an investment in community health worker training has the dual benefits of an immediate strengthening of the national response to HIV/AIDS while also contributing to strengthening a key cadre essential for sustainable primary care.

*Strengthening clinical and managerial effectiveness of Government district hospitals and their associated health centres.* District hospitals and their associated health centres are the backbone of primary care and first line secondary care in Lesotho. The physical infrastructure for the districts is quite good. The problems are in management and clinical capacity. How can resources be best managed in the context of decentralization? What do physicians at the district level need to know, and what will it take to attract and retain more physicians and nurses at the district level? These questions are being refined in detail, and will be addressed over the next 5 years in two demonstration districts, with the intent of expansion to other districts as new or modified practices are seen to work. Key elements will be strengthening problem solving and management at the level of the district. However, there is little doubt that, for the districts to function optimally, there will need to be some changes in central Government policies and procedures. This will be difficult and time consuming, but there is every reason to believe that essential complementary changes at the district and central levels can be affected. Hospitals will work better and job satisfaction will rise. There is a parallel need to develop a training programme, in US terms a residency programme, for family physicians that, over a period of several years, trains younger clinicians, at the beginning of their careers, to deliver a wider range of in-patient services, while also strengthening their public health and management skills, so the district physician is a true primary care generalist. The starting date for the residency programme is January 2008.

*Sustaining and strengthening volunteerism.* Volunteerism, the willingness of health professionals in Boston to commit to a meaningful role in Lesotho, has worked. A BU–Lesotho Interest Group was started in Boston after one of the senior Family Medicine clinicians returned from Lesotho. The group meets monthly and is seeking to develop more volunteer interest while also coordinating activities of

volunteers. This spirit of caring, interest, and commitment is intangible, but of vital importance. This needs to be sustained and strengthened. The benefits are many. So long as the structure is good, as is the case at Maluti and soon, we hope, elsewhere, the volunteer can make an immediate contribution to clinical care, and a successful experience leads to more volunteers and more resources. For example, a laptop computer, loaded with clinical support material, was donated to Maluti Hospital by the Boston Medical Center Department of Paediatrics, after some of their residents returned from Lesotho.

*Learning from our experiences.* Critical self-examination of what has been done is a continuing need. What went well? Where could we improve? How are needs changing? These are just some of the questions that we need to continually ask, answer, and feedback into our collaboration.

*Building collaborations.* BU will be vigilant in looking for opportunities to involve other schools and departments in the collaboration. However, for the next few years, clinical strengthening with Family Medicine taking the lead, management strengthening with the assistance of the School of Management, along with continuing involvement of the School of Public Health, are the likely major players from BU. On the Lesotho side, the Ministry of Health and Social Welfare, the Ministry of Education, and the Ministry of Finance and Development Planning, will remain very central, along with CHAL and, particularly, Maluti Adventist Hospital. With the advent of a residency training programme in Family Medicine, the Department of Family Medicine at the University of the Free State in Bloemfontein, is an important new participant. Finally, as BU expands its scope of work, opportunities for collaboration with local and international partners will continuously be explored.

## Conclusion

With 3 years of experience, it is fair to conclude the Lesotho–BU Collaboration is working. The value of the commitment of a great University has been demonstrated; for a collaboration to be real it must be a two-way street, and that is the case. Lesotho responded to the University's interest in an open and flexible way. The University has been successful in augmenting its own, necessarily limited, funds with donor funds. Together we have demonstrated that extraordinary progress can be made in a short period of time. However, although some progress can be made rapidly, we also recognize that root problems that adversely affect service delivery and sustainable services of good quality will take years to overcome. Finally, our experience and progress to date suggests there is every reason to believe that the tougher problems can be overcome, with the wonderful result of better and sustainable services, more accessible, to more people, more of the time.

## Notes

<sup>1</sup> Bloemfontein is 140 km of good roads from Lesotho's capital city, Maseru.

<sup>2</sup> Most of Lesotho's nurses complete 1 year of training in midwifery after receiving their diploma in general nursing. As these nurses staff most health centres, the access to skilled pre-, intra- and post-partum health services is quite good. Nurse clinicians receive additional training and are comparable in their skill set and knowledge to US nurse practitioners.

<sup>3</sup> Recently renamed the Lesotho-Boston Health Alliance.

<sup>4</sup> To learn more about the Chelsea School Project, visit: Inaugural symposia in honor of President Robert A. Brown, April 28, 2006, <http://www.bu.edu/inauguration/multimedia/>

<sup>5</sup> More recent data from the 2004 Demographic and Health Survey suggest male seroprevalence peaks at 41.3% between ages 30 and 34, and women between 35 and 39 at 43.3%. The adult combined male and female prevalence, between ages 15 and 49, is 24%. The HIV+ rate at antenatal care sentinel sites, from the 2005 HIV/AIDS Directorate Sentinel Survey, was 27%.

<sup>6</sup> This paper uses the title President as synonymous with Chancellor and, at the time within BU, that was the case.

<sup>7</sup> Not only had BU done considerable technical work in Lesotho, a number of Basotho students had studied at BU, most in Public Health. One of these students has served as a Principal Secretary in the Ministry of Health and has also been Lesotho's Ambassador to the US. He has provided very useful insights and assistance since our first work in 1990.

<sup>8</sup> Prior to 2000, Dr. Bicknell served as Associate Vice-President for International Health, founded and directed the University-wide Center for International Health and the Department of International Health in the School of Public Health.

<sup>9</sup> QE II is the national referral hospital named after Queen Elizabeth II.

<sup>10</sup> This is the time between when health professionals graduate from their professional training and are actually employed by and working for the MOHSW. Since 2003, substantial progress has been made in this area, unrelated to any work done by BU.

<sup>11</sup> It is very important to acknowledge the importance and effectiveness of the support from the US Ambassadors in Lesotho. From our earliest exploration in August of 2003 to the present, they have provided guidance and support. This is the case with regard to US Government resources that have been central to several key initiatives, specifically: (1) the LCE clinic, (2) a grant to support Africa Workforce Development that set the stage for our current work with district hospital strengthening, and led to (3) our current USAID/Pact support for strengthening the capacity of Community Health Workers to respond to HIV/AIDS in village settings.

<sup>12</sup> Rondavel is the name for the traditional round, thatch-roofed, one-room home, seen throughout the countryside of Lesotho.

<sup>13</sup> Funds for ARVs come from both Government and the Global Fund. To the extent the entire nation is dependant upon donor funds for ARVs, so too is the LCE clinic.

<sup>14</sup> Visitors marked by an asterisk (\*) have been funded by the Africa Workforce Development from the US State Department, and those marked with (\*\*) were funded by a grant from USAID in support of the clinic at the LCE.

<sup>15</sup> Irish Aid is a notable exception in this regard.

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