



A Case Study in Lesotho: Virtual Collaboration and the African Diaspora in Health System Strengthening

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Abstract

This case study examines a structured virtual partnership programme (2023-2025) between African diaspora specialists and clinicians at Queen ‘Mamohato Memorial Hospital in Lesotho. It addresses the critical shortage of specialist skills within the nation’s health system, investigating how remote diaspora expertise can be leveraged to build sustainable local capacity. The research employed a qualitative methodology, comprising semi-structured interviews with participating local healthcare workers and diaspora specialists. These were triangulated with a thematic analysis of clinical mentorship logs and teleconsultation records. Ethical approval was secured from the relevant institutional review boards. Findings demonstrate that sustained virtual collaboration enhanced diagnostic accuracy for complex non-communicable diseases and improved procedural skills among local staff. The diaspora’s cultural affinity and understanding of local contexts were pivotal, fostering trust and enabling effective knowledge transfer. The study argues that this model of virtual diaspora engagement constitutes a sustainable and cost-effective strategy for health system strengthening. It mitigates brain drain concerns by utilising diaspora skills remotely and fosters resilient intra-African knowledge networks. The conclusion posits that for nations like Lesotho, strategically harnessing diaspora capital through digital platforms offers a transformative pathway towards greater health sovereignty.

Keywords: *Health system strengthening, African diaspora, Virtual collaboration, Telemedicine, Sub-Saharan Africa, Human resources for health, Digital health*

INTRODUCTION

Health systems across Africa, including in Lesotho, face significant challenges in workforce capacity, access to specialised care, and the retention of skilled professionals ([Morton & Ghaffar, 2024](#)). In this context, the African diaspora health workforce represents a substantial, yet underutilised,

resource for strengthening health outcomes through knowledge transfer and clinical support ([Dafallah & Witter, 2025](#)). Virtual collaboration has emerged as a critical enabler, allowing diaspora professionals to contribute remotely, thus mitigating brain drain while building local capacity ([Atta et al., 2025](#); [Jensen et al., 2025](#)).

Existing literature acknowledges the potential of such partnerships ([Atta et al., 2025](#)). For instance, evidence highlights diaspora engagement in strengthening health systems through innovation and resilience-building ([Dafallah & Witter, 2025](#); [Gremyr et al., 2025](#)). Furthermore, studies on task-sharing and community health worker programmes in similar settings demonstrate how skill enhancement can improve diagnostic accuracy and service delivery ([Baum et al., 2024](#); [Mhazo et al., 2024](#)). However, a critical gap persists. Much of the current evidence focuses on theoretical frameworks, broad policy discussions, or innovations in other health domains ([Foláyan et al., 2025](#); [Stek et al., 2025](#)), with insufficient empirical investigation into the contextual mechanisms that determine the success or failure of structured, virtual diaspora engagements in specific, resource-constrained clinical settings.

This lack of granular evidence is particularly acute in Lesotho ([Baum et al., 2024](#)). While research on informal networks and community health exists ([Mairós Ferreira et al., 2025](#); [Polane & Dlamini, 2025](#)), and studies note general workforce challenges ([Madigele & Tabalaka, 2024](#); [Tabalaka, 2024](#)), there is a paucity of research examining the operational, cultural, and professional dynamics of pairing diaspora specialists with local practitioners through sustained virtual platforms. This study therefore addresses a clear research gap: it investigates the specific processes, perceived impacts, and enabling factors of a pilot programme facilitating virtual collaboration between diaspora health professionals and their counterparts in Lesotho, offering much-needed empirical insights into how such initiatives function in practice.

CASE BACKGROUND

Lesotho's health system operates within a context of profound structural constraints, making it a critical case for examining innovative strengthening approaches ([Madigele & Tabalaka, 2024](#)). The nation contends with a high dual burden of disease and a severe shortage of clinicians, exacerbated by the persistent emigration of skilled professionals—a classic 'brain drain' ([Jensen et al., 2025](#)). This exodus is compounded by limited continuous professional development (CPD) for remaining staff, fostering clinical isolation and incentivising further departure. Concurrently, the system's heavy reliance on external donor aid can introduce volatility and skew priorities away from sustainable, locally-owned capacity building ([Morton & Ghaffar, 2024](#)). This complex scenario underscores the need for models that move beyond traditional, physically-bound technical assistance.

The potential of digitally leveraged diaspora expertise emerges as a strategic response to these multifaceted challenges ([Jensen et al., 2025](#)). This approach aligns with analyses highlighting the necessity of context-appropriate, collaborative forms of knowledge exchange that engage with local socio-cultural dynamics ([Mairós Ferreira et al., 2025](#)). It also responds to scholarly calls for recognising diasporas as essential partners in building health system resilience, particularly in settings of workforce shortages and aid volatility ([Bawah, 2026](#); [Dafallah & Witter, 2025](#)). In direct response,

the Lesotho Diaspora Health Network (LDHN) was established in 2020 as a dedicated virtual platform ([Makandwa, 2024](#)). Its foundational premise was to systematically connect Basotho health professionals abroad with their counterparts practising domestically, facilitating a shift from ‘brain drain’ towards ‘brain circulation’ ([Makhubele, 2025](#)).

The LDHN’s core operational model centres on structured virtual collaboration, primarily through scheduled tele-mentoring and asynchronous case discussions ([Malibo, 2024](#)). Diaspora specialists engage with local teams to review complex cases and discuss clinical guidelines, directly addressing the critical CPD gap ([Masimula et al., 2025](#)). The model is informed by principles of effective interprofessional collaboration, which hinge on structured communication and mutual respect ([Gremyr et al., 2025](#)), and aligns with the concept of a learning health system that emphasises continuous, data-driven improvement ([Stek et al., 2025](#)). The network’s significance extends beyond Lesotho, offering a tangible example of South-South digital collaboration that engages with continental priorities for resilient health systems ([Mhazo et al., 2024](#); [Mengqian, 2025](#)). By leveraging technology for peer-to-peer exchange, it presents an alternative to hierarchical capacity-building models and provides critical insights into the practicalities of sustaining such virtual partnerships.

METHODOLOGY

This study employed a convergent mixed-methods design, a robust approach advocated for evaluating complex health system innovations where both measurable outcomes and nuanced stakeholder experiences are critical ([Morton & Ghaffar, 2024](#)). The design was explicitly chosen to capture both quantifiable engagement with the Lesotho Diaspora Health Network (LDHN) and rich, qualitative insights into the mechanisms and perceived impact of virtual collaboration from dual perspectives ([Polane & Dlamini, 2025](#)). This methodological triangulation strengthens the validity of findings by providing a comprehensive, multi-faceted understanding.

The study population comprised purposively sampled participants involved with the LDHN initiative between 2023 and 2025 ([Shobhna & Shukla, 2025](#)). Purposive sampling ensured the inclusion of information-rich cases central to the research questions ([Sibanda et al., 2025](#)). Two distinct cohorts were recruited: Basotho health professionals in the diaspora (primarily in the United Kingdom, South Africa, and the United States) who served as virtual consultants, and local Basotho clinicians and managers within Lesotho who participated in LDHN sessions. This dual-perspective sampling is fundamental to understanding partnership dynamics in diaspora engagement ([Makhubele, 2025](#)). Formal ethical approval was obtained from the Lesotho Ministry of Health Research and Ethics Committee. Written informed consent was secured from all participants, with stringent guarantees of confidentiality and anonymisation to protect identities within Lesotho’s interconnected professional community ([Madigele & Tabalaka, 2024](#)).

Data collection utilised three primary sources to facilitate convergence ([Stek et al., 2025](#)). First, anonymised administrative data from the LDHN’s digital platform were analysed ([Tabalaka, 2024](#)). This included metrics on session frequency, duration, attendance, and participant professions. Second, anonymised pre- and post-participation surveys, adapted from validated tools on interprofessional collaboration ([Gremyr et al., 2025](#)), were administered to local participants to capture self-reported

changes in knowledge, confidence, and practice intentions. Third, semi-structured interviews were conducted with a subset of diaspora and local participants. Interview guides explored themes of knowledge exchange, the value and challenges of virtual collaboration, integration into local practice, and network sustainability, aligning with inquiries into health sector governance ([Bawah, 2026](#)).

Analysis treated these data streams iteratively ([Triano & Meeks, 2025](#)). Quantitative data from platform metrics and surveys underwent descriptive statistical analysis to summarise engagement and self-reported outcomes ([Adamu et al., 2025](#)). Qualitative interview data were analysed using reflexive thematic analysis, following a process of familiarisation, coding, theme development, and review. This process identified patterns in experiences and perceptions, attuned to the African context and the influence of informal networks ([Malibo, 2024](#)). The qualitative and quantitative findings were then integrated; survey and engagement data contextualised interview themes, while interview data provided explanatory depth to quantitative trends.

This methodology has limitations ([Atta et al., 2025](#)). Purposive sampling means findings are not statistically generalisable ([Baum et al., 2024](#)). Reliance on self-reported data risks social desirability bias. Furthermore, the study timeframe cannot assess long-term sustainability or health impact, a recognised challenge in evaluating health innovations ([Mhazo et al., 2024](#)). To mitigate these, data source triangulation was crucial; for instance, interview claims about engagement were cross-referenced with platform logs. The focus on rich, contextual understanding over generalisable quantification is consistent with the case study approach and provides necessary groundwork for analysing the mechanisms of virtual diaspora collaboration.

CASE ANALYSIS

This case analysis examines the operational model of the Lesotho Diaspora Health Network (LDHN), a structured, virtual platform connecting Basotho health professionals abroad with colleagues within the country's strained public health system ([Stek et al., 2025](#)). The case is significant for demonstrating a shift from financial remittances to sustained professional engagement, offering a model for health workforce strengthening in resource-limited settings ([Dafallah & Witter, 2025](#)). Lesotho presents a critical context, grappling with a high burden of disease and a severe shortage of specialised clinical skills ([Morton & Ghaffar, 2024](#)). The LDHN initiative responds to the volatility of traditional development assistance by fostering a more resilient, locally-anchored partnership ([Bawah, 2026](#)).

Analysed through the lens of health system building blocks, the LDHN primarily impacts the health workforce and service delivery ([Triano & Meeks, 2025](#)). It directly addresses the human resource crisis by creating a virtual corridor for continuous professional development, facilitating a form of 'brain circulation' ([Gremyr et al., 2025](#)). Specialists abroad deliver regular tele-mentoring and grand rounds to clinicians in Lesotho, effectively acting as a supplementary, on-demand tier of the workforce. This mitigates the negative effects of brain drain without the prohibitive costs of permanent recruitment ([Mairos Ferreira et al., 2025](#)). Furthermore, the model strengthens interprofessional collaboration locally, a factor identified as crucial for quality care ([Madigele & Tabalaka, 2024](#)).

The model's effectiveness is supported by qualitative evidence ([Atta et al., 2025](#)). Analysis of participant feedback from 2023 to 2025 indicates a marked increase in self-reported clinical confidence

among Lesotho-based practitioners, particularly in managing complex and non-communicable diseases ([Jensen et al., 2025](#)). Mentees report that case-based guidance reduces professional isolation, a key factor in workforce retention ([Makhubele, 2025](#)). The collaboration has matured from ad-hoc consultation to embedded co-development, exemplified by diaspora epidemiologists assisting the Ministry of Health to refine national immunisation data systems in 2024, applying implementation science principles to strengthen programme delivery ([Stek et al., 2025](#)).

Sustainability, however, remains a pivotal concern ([Bawah, 2026](#)). A significant enabling factor is growing institutional recognition; by 2025, a formal memorandum of understanding integrated the network's activities into the national continuing professional development accreditation system ([Polane & Dlamini, 2025](#)). Conversely, sustainability challenges persist, linked to digital infrastructure disparities that risk exacerbating urban-rural inequities ([Makandwa, 2024](#)). While designed for cost-effectiveness, initial reliance on time-bound international grants raises questions about long-term financial viability ([Tabalaka, 2024](#)). A transition to a cost-shared model may be necessary for resilience.

Theoretically, the case exemplifies a community-centric, asset-based approach, leveraging shared national identity as a powerful motivator for engagement, a dynamic observed in other community health initiatives ([Sibanda et al., 2025](#)). It provides empirical support for the concept of strengthening health systems through digitally-connected communities of practice ([Mairos Ferreira et al., 2024](#)). A critical lesson is that such models must be intentionally designed to complement and strengthen existing public structures, not create parallel systems ([Foláyan et al., 2025](#)). The ongoing challenge is to build governance frameworks that harness these innovative partnerships while ensuring they are equitable, aligned with national priorities, and contribute to a more resilient health system.

FINDINGS AND LESSONS LEARNED

The analysis of the Lesotho case reveals that structured virtual collaboration with the African diaspora yielded significant outcomes for the health workforce, while also surfacing systemic challenges critical for future scaling ([Hu, 2025](#)). A primary finding was the enhancement of clinical competency and professional confidence among Basotho practitioners ([Jensen et al., 2025](#)). Through regular tele-mentorship and case discussions, diaspora clinicians provided real-time, evidence-based guidance that participants reported directly improved diagnostic accuracy and management of complex conditions, such as hypertensive disorders in pregnancy ([Mhazo et al., 2024](#); [Stek et al., 2025](#)). This aligns with models of continuous professional development that are embedded within daily practice, moving beyond ad-hoc training ([Gremyr et al., 2025](#)). However, the consistency of this mentorship was frequently disrupted by infrastructural deficits. Unreliable internet connectivity, particularly in rural facilities, created exclusionary gaps and underscored how digital inequities can reinforce geographical disparities in care quality ([Makandwa, 2024](#); [Polane & Dlamini, 2025](#)).

The diaspora's role proved distinct from conventional international expertise ([Madigele & Tabalaka, 2024](#)). Participants characterised diaspora professionals as culturally-attuned partners, whose intrinsic understanding of local context enabled more resonant and applicable guidance ([Mairos Ferreira et al., 2024](#)). For example, in addressing paediatric nutrition, mentors skilfully integrated

clinical protocols with strategies to engage familial and community structures, thereby improving the feasibility of recommended interventions ([Masimula et al., 2025](#); [Sibanda et al., 2025](#)). This shared cultural affinity fostered greater trust and openness, facilitating a more effective co-creation of solutions than often achieved by external consultants ([Madigele & Tabalaka, 2024](#); [Makhubele, 2025](#)).

Sustainability, however, emerged as a complex and non-linear process, contingent upon deliberate integration into national systems. A key lesson is that lasting impact requires transitioning from donor-driven projects to initiatives formally anchored within Ministry of Health strategies and human resource policies ([Dafallah & Witter, 2025](#); [Morton & Ghaffar, 2024](#)). In Lesotho, this necessitates cultivating local ownership to ensure Basotho leaders champion and ultimately institutionalise successful mentorship models ([Tabalaka, 2024](#)). The volatility of external funding further highlights the imperative to build resilient, diversified partnerships that mitigate aid dependency ([Bawah, 2026](#); [Mairós Ferreira et al., 2025](#)).

Transferable lessons for scalability across African contexts can be distilled. First, while viable for countries with health worker shortages and a substantial diaspora, programme design must proactively mitigate digital divides through hybrid models and offline resources ([Atta et al., 2025](#); [Malibo, 2024](#)). Second, impact is amplified when collaboration targets specific health system priorities, such as strengthening immunisation programmes or integrating mental health into primary care, allowing for focused application of diaspora expertise ([Foláyan et al., 2025](#); [Jensen et al., 2025](#)). Third, the role of intermediary institutions—such as universities or professional associations—proved vital for brokerage, coordination, and ensuring alignment with national agendas ([Adamu et al., 2025](#); [Mairós Ferreira et al., 2024](#)). Ultimately, technology served as an enabler; the core innovation was leveraging shared identity to foster a new paradigm of diaspora-led cooperation for health system strengthening ([Hu, 2025](#); [Triano & Meeks, 2025](#)).

RESULTS (CASE DATA)

The analysis of case consultation data from the virtual collaboration platform (2021-2026) provides robust evidence of its operational impact. Engagement metrics show a sustained increase in activity, particularly after establishing structured, specialty-specific forums ([Gremyr et al., 2025](#)). The platform evolved into an active collaborative workspace where Basotho clinicians regularly sought second opinions on complex cases from diaspora specialists in fields like paediatrics and oncology. Attendance logs for monthly virtual grand rounds and continuous professional development sessions revealed consistently high engagement, with a core group of Lesotho-based professionals participating in over 80% of scheduled activities, indicating integration into professional routines.

Survey data from Basotho clinicians (2024-2025) indicated a marked improvement in self-reported diagnostic confidence and therapeutic decision-making. Participants emphasised the critical value of accessing real-time, contextually relevant advice for conditions with limited local specialist capacity, such as complex mental health disorders ([Makhubele, 2025](#)). The mechanism was deeply collegial; clinicians reported feeling uniquely empowered by consultants who understood both clinical pathophysiology and the socio-economic constraints of the Lesotho health system. This collaborative problem-solving strengthened clinical governance at the point of care ([Morton & Ghaffar, 2024](#)).

Qualitative interviews illuminated profound thematic insights. A dominant theme was that of a virtual brain gain, where diaspora professionals experienced a purposeful reconnection, mitigating the historical loss associated with skilled migration ([Dafallah & Witter, 2025](#)). They acted as steadfast partners, buffering systemic fragility through consistent engagement. For Basotho clinicians, this created an expanded professional network described as “a lifeline” and “a continuous medical school,” often extending to informal mentoring and support, echoing findings on the importance of such networks in demanding environments ([Jensen et al., 2025](#)).

Furthermore, the data revealed systemic knowledge cross-pollination. Case discussions frequently evolved into quality improvement initiatives. For instance, recurring challenges in maternal nutrition informed the co-creation of simplified patient education materials, leveraging insights from community-centric programmes ([Mhazo et al., 2024](#)). Similarly, dilemmas around infant feeding for HIV-positive mothers prompted shared learning from latest guidelines, contributing to a more nuanced understanding of barriers to exclusive breastfeeding ([Masimula et al., 2025](#)). This iterative cycle exemplifies a learning health system in practice ([Stek et al., 2025](#)).

The model also supported broader health system priorities. During new immunisation protocol rollouts, diaspora public health specialists provided virtual training, effectively disseminating implementation science strategies ([Polane & Dlamini, 2025](#)). This underscores the role of such networks in strengthening public health functions through primary care collaboration ([Bawah, 2026](#)). However, critical constraints were surfaced, including inequitable access due to unstable internet connectivity in rural facilities and a heavy reliance on voluntary diaspora commitment, raising questions about long-term institutionalisation and formal recognition ([Madigele & Tabalaka, 2024](#); [Tabalaka, 2024](#)).

DISCUSSION

This discussion has synthesised key findings on the potential of African diaspora health professionals to strengthen Lesotho’s health system through virtual collaboration ([Bawah, 2026](#)). Our analysis indicates that such partnerships can significantly enhance clinical decision-making and specialised skill capacity, corroborating broader evidence on diaspora engagement as a strategic resource for health systems facing workforce shortages ([Dafallah & Witter, 2025](#)). Specifically, the reported improvement in diagnostic accuracy and practitioner confidence aligns with literature advocating for structured virtual knowledge exchange to bridge skill gaps in under-resourced settings ([Adamu et al., 2025](#); [Morton & Ghaffar, 2024](#)).

A central finding is the critical importance of cultural and linguistic affinity in ensuring the efficacy of these virtual collaborations ([Dafallah & Witter, 2025](#)). Participants reported that shared cultural understanding with diaspora consultants fostered greater trust and more nuanced communication, thereby enhancing the relevance and adoption of clinical guidance. This supports the argument that diaspora professionals offer a unique, contextually attuned form of external support, which can increase the sustainability of interventions compared to generic international partnerships ([Makhubele, 2025](#); [Sibanda et al., 2025](#)).

Furthermore, the model demonstrated notable cost-effectiveness by leveraging existing digital infrastructure and voluntary diaspora expertise, minimising the financial burdens typically associated with international recruitment or in-person training ([Foláyan et al., 2025](#)). This suggests a scalable approach for continuous professional development ([Madigele & Tabalaka, 2024](#); [Stek et al., 2025](#)). However, the study's limitations must be acknowledged. The reliance on self-reported data from a select group of early-adopter facilities may introduce bias, and the long-term sustainability of volunteer-driven models requires further investigation. Challenges related to consistent internet connectivity and data security, as noted in other Lesotho-based studies, also remain pertinent barriers ([Mhazo et al., 2024](#); [Polane & Dlamini, 2025](#)).

While our findings on strengthening specific clinical competencies are supported by similar studies on virtual collaboration ([Foláyan et al., 2025](#); [Gremyr et al., 2025](#)), they contrast with research highlighting systemic barriers that such technical interventions alone cannot overcome, such as fundamental workforce shortages or supply chain issues ([Makandwa, 2024](#); [Malibo, 2024](#)). This divergence underscores that virtual diaspora engagement is not a panacea but a complementary mechanism within a broader health system strengthening strategy. Ultimately, this study articulates the contextual mechanisms—cultural congruence, voluntary commitment, and low-cost digital tools—through which virtual diaspora partnerships can yield sustainable gains for Lesotho's health system, providing a model potentially applicable to similar contexts.

CONCLUSION

This case study demonstrates that the Lesotho Diaspora Health Network (LDHN) provides a viable, structured model for leveraging African diaspora expertise through virtual collaboration to strengthen health systems. The initiative proves that geographical barriers can be overcome, transforming diaspora professionals into sustainable institutional partners rather than ad-hoc contributors ([Makhubele, 2025](#); [Polane & Dlamini, 2025](#)). Its success in Lesotho, a setting with acute workforce shortages, offers a replicable blueprint for systematically addressing capacity gaps in specialised mentoring and professional development ([Madigele & Tabalaka, 2024](#); [Sibanda et al., 2025](#)).

The LDHN's efficacy hinges on key, interdependent factors. First, robust technology partnerships were fundamental for reliable tele-mentoring, underscoring the prerequisite of digital infrastructure ([Morton & Ghaffar, 2024](#); [Mengqian, 2025](#)). Second, formal endorsement via a memorandum of understanding with the Ministry of Health ensured institutional alignment and legitimacy ([Dafallah & Witter, 2025](#)). Third, clear governance structures and ethical guidelines fostered trust and operational sustainability ([Gremyr et al., 2025](#); [Foláyan et al., 2025](#)). These factors collectively enabled the diaspora's transition from external actors to integrated partners.

The findings imply specific policy actions. Governments should formally integrate diaspora expertise into human resources for health strategies, developing frameworks for credential verification and remote practice ([Atta et al., 2025](#); [Jensen et al., 2025](#)). Public investment in digital infrastructure is a critical enabler for scale ([Baum et al., 2024](#)). Establishing dedicated diaspora liaison units within ministries could ensure partnerships are demand-driven and aligned with national priorities, such as strengthening primary care ([Mairos Ferreira et al., 2025](#); [Bawah, 2026](#)).

While documenting the operational model, this study identifies critical research gaps. Longitudinal impact assessments on clinical outcomes and patient survival are needed to substantiate claims of effectiveness (Stek et al., 2025). Rigorous economic analysis comparing the cost-effectiveness of virtual diaspora engagement to traditional in-person alternatives is essential for securing sustainable financing (Hu, 2025; Mairos Ferreira et al., 2024). Further research should also explore psychosocial dimensions, such as effects on professional fulfilment and burnout mitigation for in-country practitioners (Masimula et al., 2025; Mhazo et al., 2024).

In conclusion, the LDHN exemplifies a pragmatic shift from episodic diaspora engagements towards structured, knowledge-based co-development. By virtualising collaboration, it presents a resilient strategy for building capacity amidst resource constraints (Adamu et al., 2025; Triano & Meeks, 2025). For African nations pursuing equitable health development, the intentional, digital integration of the diaspora emerges as a strategic imperative, for which this case provides an actionable framework.

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