A Rapid Assessment of Strategic Information Systems for Lesotho's HIV/AIDS Programme

June 2005

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A project of:

- National AIDS Secretariat/National AIDS Commission Lesotho
- Ministry of Health and Social Welfare Lesotho
- United States Agency for International Development/Regional HIV/AIDS Program Southern Africa
- MEASURE Evaluation
- Centers for Disease Control and Prevention

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Maseru, Lesotho
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'In support of evidence-based decision making'

Acknowledgements

This report is a result of ongoing collaborative effort among numerous individuals and organisations supporting the effort to coordinate and harmonize HIV/AIDS programme monitoring and evaluation efforts in Lesotho. Of special note is the contribution of an individual who has since passed, 'M'e Ntilo Matela who, as a person living openly with HIV/AIDS, saw efforts such as this one as a window of hope for all those infected and affected by the epidemic. She participated in this exercise eagerly and saw its importance in enhancing the national response as a whole.

May her soul rest in eternal peace.

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Contents

List of acronyms

AIDS	Acquired Immunodeficiency Syndrome
API	AIDS Programme Effort Index
ART	Anti-retroviral therapy
ARV	Anti-retroviral drugs
BCC	Behaviour Change Communication
BoS	Bureau of Statistics
CBO	Community Based Organisation
CDC	Centers for Disease Control and Prevention
CHAI	Clinton HIV/AIDS Initiative
CHAL	Christian Health Association of Lesotho
DATF	District AIDS Task Forces
DCI	Development Corporation of Ireland
DFID	Department for International Development, United Kingdom
DOTS	Directly Observed Therapy – Short Course
EU	European Union
GoL	Government of Lesotho
HAHPCO	HIV/AIDS Health Products Coordinating Services
HBC	Home-based care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPSU	Health Planning and Statistics Unit
HSA	Health Service Area
HBC	Home Based Care
IDSR	Integrated Disease Surveillance and Response
LAPCA	Lesotho AIDS Programmes Coordinating Authority

LCN	Lesotho Congress of NGOs
LDHS	Lesotho Demographic and Health Survey
M&E	Monitoring and Evaluation
MIS	Management Information System
MoHSW	Ministry of Health and Social Welfare
NAC	National AIDS Council
NAS	National AIDS Secretariat
NGO	Non-governmental organization
OVC	Orphans and vulnerable children
PCP	*Pneumocystis carinii* Pneumonia
PSI	Population Services International
PMTCT	Prevention of mother-to-child transmission
RHAP-SA	Regional HIV/AIDS Programme – Southern Africa
SADC	Southern Africa Development Community
SI	Strategic information
SISA	Strategic Information Systems Assessment
STI	Sexually transmitted infection
TB	Tuberculosis
ToR	Terms of Reference
TWG	Technical Work Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organization

I. Executive summary

Overview

Successful strategies for Lesotho's National HIV/AIDS programme expansion will be based in part upon the availability and use of high quality and timely information. Yet, in this War against HIV/AIDS, the prevailing situation indicates a paucity of useful, accurate information on all nearly aspects of infection, its spread, the impact and the scale and pattern of our programmatic response. (Partnership of the Government of Lesotho and the Expanded Theme Group on HIV/AIDS, 2004).

The Lesotho Strategic Information Systems Assessment (SISA) was intended to produce a common understanding among HIV/AIDS stakeholders regarding existing strategic information mandate, data availability, data collection and use activities, and plans going forward cutting across most areas of strategic information collection and use.

Methods

The Assessment included three main activities: identification of key informants and guidance on available documentation by the technical working group; interviews with key informants and other data and document collection by the Assessment Team; and synthesis, validation, and targeted dissemination of findings.

Key informants were chosen based upon technical experience and skills in the nine component data system areas for which they were interviewed: National M&E Capacity and Coordination; Policy; Population-based surveys; Facility-based surveys; HIV and AIDS Surveillance; Routine facility-based HIV/AIDS service statistics, ART client monitoring and management, Community-based programme monitoring, and National database.

Data collection for the Assessment was conducted by a two–person team over a 4 week period (March-April, 2005). For each of the nine component areas a series of questions, divided by subcomponents, was developed and applied as a guide for interviews and data collection. These interviews allowed the interviewer to focus on the individual as a provider of fact and opinion. Following the interview, to reduce the potential for interviewer bias, the interviewer and research assistant reconciled their individual notes. In addition to the interviewing process, a simultaneous document acquisition and review process took place, which led to the formation of the National AIDS Secretariat M&E Document Centre.

This report was based on information drawn from the interviews, documents obtained, and through discussions during the subsequent validation workshop held in May 2005.

Findings

As LAPCA transitions into NAS, the NAS will, by virtue of its autonomy, legal authority, and hiring authority, be empowered to function as "the" national body responsible for coordinating the implementation and M&E of HIV/AIDS programmes. NAS will generate and house the national HIV/AIDS M&E plan and accompanying systems. Further, the priority for NAS is to develop an HIV/AIDS national policy and to update the national HIV/AIDS strategic plan.

According to the 2003 MoHSW Strategic Plan, the STI/HIV/AIDS Directorate (then still referred to as the National AIDS Prevention and Control Programme) is responsible for activities to measure and monitor national HIV prevalence and incidence, national AIDS cases, and AIDS-specific morbidities and mortalities. Helath Planning and Statistics Unit plays a key role in the implementation of these activities through the provision of relevant expertise. An HIV/ AIDS specific national M&E operation plan will be the domain of NAC/NAS, but will need to be closely coordinated with the MoHSW plan.

The BoS coordinates national population-based surveys and assists other ministries and organizations in designing sampling methodology, questionnaires, and providing technical assistance for surveys. The most recently completed Behavioural Surveillance Survey (BSS) occurred in 2002. The Lesotho Demographic and Health Survey (DHS)was conducted in 2004; the results, including general population-based estimates of HIV prevalence will be available during 2005.

Health facility-based surveys are typically conducted to capture information on service availability and quality of care. To-date, capacity limitations within the MOHSW have meant that these surveys have not been fully implemented.

Surveillance is the routine tracking of disease, disease outcomes (death, disability, quality of life) and, less commonly, risk behaviour (sexual, unsafe injection, etc.). The principle routine HIV/AIDS surveillance activity conducted in Lesotho is the HIV Sentinel Surveillance Survey, implemented every 2 years and based on data obtained from pregnant women attending selected antenatal clinics. The 2005 HIV sentinel surveillance round is due for completion in July 2005.

Based on interviews conducted in the assessment, the collection, coordination, and management of health service data was found to constitute a significant ongoing challenge for the health sector. These routine systems are highly underresourced. As well, a disproportionate amount of time and effort is spent on the actual collection of data, with little focus on the use of data to produce information that will benefit decision making and general programme development and management.

Treating HIV-infected clients with ART is highly complex, given the lifelong requirement for ART, the need for best practices to support treatment efficacy, and the rapid evolution of scientific evidence. The Clinton HIV/AIDS Foundation is examining the Lesotho medical system to improve primary health care and ART delivery and is developing a pharmacy-based monitoring and data capture system. Tse'pong Clinic (OHA), which provides ART to over 1,000 clients, reports significant resource constraints which limits the programme in collecting, managing, and using data.

Two broad types of databases have proven helpful in the job of national programme partner coordination and reporting to national and international stakeholders – programmatic database and national indicator database. At the moment, neither of these types of databases exists although both are part of the National M&E workplan now being developed by the national M&E workgroup. Regarding the indicator database, NAS plans to push for a single system, accessible to all stakeholders, and housing the indicators that are collected with the uniform tools.

Key initial findings identified existing bottlenecks and limitations with data systems, capacity, data quality and management, data ownership, secondary analyses, and ethics.

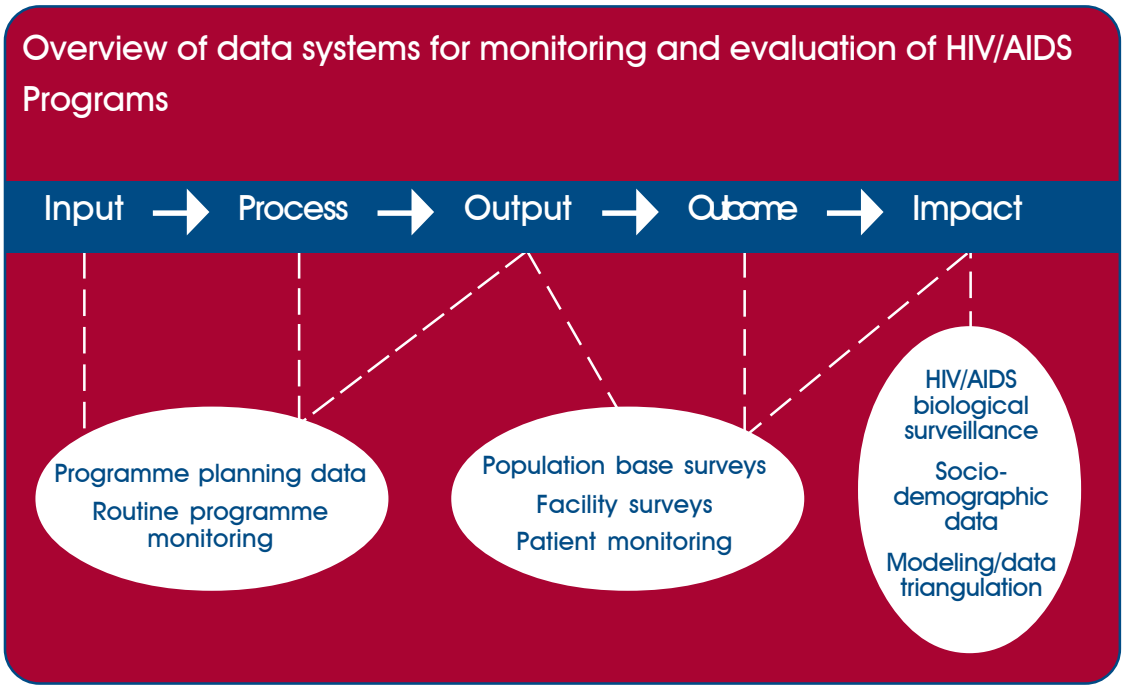
II. Introduction and rationale for the SI systems assessment

A. Introduction

Successful strategies for Lesotho's National HIV/AIDS programme expansion will be built in large part upon the availability and use of high quality and timely information. Strategic information to guide policies and to monitor and evaluate programmes is thus foundational. These informational "pillars" come in many forms and are derived ultimately from data systems that have various technical, institutional, and human capacity dimensions.

The following diagram describes an illustrative and very basic framework for understanding and communicating the types of data (or indicators) needed on one hand, and data systems required to support National indicator measurement on the other. Programmes are managed and monitored through collection and use of routine data at the following levels: (1) financial, material, and human resource outlays (**inputs**), (2) **processes** occurring at various levels in the programme (e.g. trainings, delivery of service), (3) counts and quality of services provided (**outputs**). Programme **outcomes** and **impact** are measured through collection of behavioural, biological and social data via various types of surveys and surveillance activities.

Figure 1: Data systems for monitoring and evaluation



B. Objectives

The Lesotho Strategic Information Systems Assessment (SISA) was intended to produce a common understanding among HIV/AIDS stakeholders regarding existing strategic information mandate (institutional and technical), data availability, data collection and use activities, and plans going forward cutting across most areas of strategic information collection and use:

The specific objectives of SISA:

1. An authoritative and consensus document that:

- Establishes what core national indicators are covered by each of the following monitoring and evaluation (M&E) system components:
  - National M&E capacity and coordination
  - HIV/AIDS Policy Assessment (added after initial design)
  - Population-based Surveys
  - Facility-based Surveys
  - Surveillance
  - Routine aggregate service statistics
  - ART Client-level data
  - National HIV/AIDS Database
  - Community Programme Activity Monitoring
  - Targeted Evaluation/Essential Research (added after initial design)
- Describes the current status of each of the system components,
- Describes the location and mandate in each of the system component areas with regard to data collection, processing, analysis, and use. (i.e., currently responsible organization),
- Documents current plans for system development (if any).

2. Establish a baseline from which to track strategic information (SI) system development and an accountability framework for the national monitoring and evaluation (M&E) work plan: the "M&E of M&E".

3. Establish an ongoing institutional activity within the newly formed National AIDS Secretariat (NAS) that informs strategic planning for SI systems development. In sum, the assessment was intended to provide a common framework for planning of SI systems and national M&E activities. In this way, a coordinated "one M&E" approach to building of capacity for "information products" is greatly facilitated.

The need for a National SI systems assessment was initially discussed during late 2004 amongst key national agencies; Ministry of Health and Social Welfare (MoHSW), Bureau of Statistics (BoS), and the National AIDS Secretariat (NAS); UN agencies; and representatives of the donor and non-governmental organization (NGO) community. In early 2005, the commitment to conduct the assessment was made.

This was a baseline activity intended to result in a detailed description of the SI systems currently in place in Lesotho and to form the basis for development of the NAS' M&E plan. While comprehensive in data type coverage, the assessment was not expected to yield exhaustive results describing specific data elements or whether specific indicators will be measured by current or planned SI activities. Notably not included in the assessment is prioritization of data needs. This type of exercise and discussion requires evaluation of feasibility and cost information, which often involves a wider, less technical stakeholder group.

III. Methods

Once the need for the SI systems assessment was articulated, a draft assessment tool was developed and circulated amongst key HIV/AIDS data stakeholders in Lesotho including MoHSW, NAS/The Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM); BoS; Joint United Nations Programme on HIV/AIDS (UNAIDS)- Lesotho and Regional; United Nations Development Programme (UNDP); World Health Organization (WHO); United Nations Children's Fund (UNICEF); United States Government (USG): Centres for Disease Control and Prevention (CDC) and the Untied States Agency for International Development (USAID); MEASURE Evaluation, and Population Services International (PSI). The assessment tool was adapted to the Lesotho context.

The SI Systems Assessment was planned to include three main activities:

- Identification of key informants and guidance documentation by the **Technical Working Group** (TWG),
- Interviews with key informants and other data and document collection by the **Assessment Team**, and
- Synthesis, validation, and targeted dissemination of findings.

A. Technical Working Group

The success of the exercise was dependent in large part on the contribution and participation of key SI stakeholders. Towards that end, members of the TWG were identified and invited to contribute in the adaptation of the assessment tool and identification of key informants. The TWG met several times prior to the implementation of the assessment, which resulted in the final SISA instrument. A list of key informants was constructed; although many of the persons eventually interviewed were identified through "snowball" approach once the assessment was underway. The two SISA coordinators, one from the Health Planning and Statistics Unit (HPSU)/ MoHSW and one from the National AIDS Commission's (NAC) NAS, identified most of the initial key informants.

Key informants were chosen based upon having technical experience and skills in the component data system areas for which they were interviewed.

B. Assessment Team and Operations

The assessment was conducted by a two–person team over a 4 week period; a team leader who did most of the direct interviewing, organized documents and compiled interview results; and a research assistant who provided reliability checks and general administrative support.

For each of the nine component assessments a series of questions, divided by subcomponents, was developed and applied as a guide for interviews and data collection. Each interview was attended by the participant(s), the interviewer, and the research assistant. Both the implementor and research assistant took comprehensive notes. These interviews allowed the interviewer to focus on the individual as a provider of fact and opinion (Prairie Research Associates, 2001). Although open-ended, the interviewer approached each interview with the goal of obtaining specific pieces of pertinent information. Exploratory interviews require *sequencing*, that is, the interviews began with broad questions followed by probing for more detailed information, as required.

Following the interview, the interviewer and research assistant reviewed their individual notes, which were then reconciled by the interviewer. If multiple participants were interviewed for a single component (e.g., Population-based Surveys or routine aggregate service statistics) the notes were compiled to produce a synthesis of the component area and were reviewed by the interviewer and research assistant.

C. Document Archive

In addition to the interviewing process, a simultaneous document acquisition and review process took place. This process led to the formation of the NAS M&E Document Centre. This centre acted as the repository for documents collected during the exercise and is structured so that it can easily incorporate additional resources as they are identified and made available.

D. Assessment Timeline

Implementation, exploratory interviews, and document acquisition began 07 March 2005 and were completed on 01 April 2005, with review and follow-up activities through April 2005. This report is to be finalized by a technical workgroup by the end of May 2005.

E. Identification of Findings and Recommendations

Initial findings were identified and outlined by the assessment team. These findings were then presented to a technical workshop held in Maseru on 11 May 2005. The technical workshop reviewed the findings and identified additional ones, which were then defined as "findings" and incorporated into this report. All recommendations were identified during the technical workshop and subsequently incorporated into the report.

IV. Findings

A. National capacity and coordination

Illustrative national indicators – National capacity and coordination:

1. Existence of national monitoring and evaluation capacity for HIV/AIDS care and support programmes
2. Percentage of health facilities with record-keeping systems for monitoring HIV/AIDS care and support

Source: WHO, 2004a

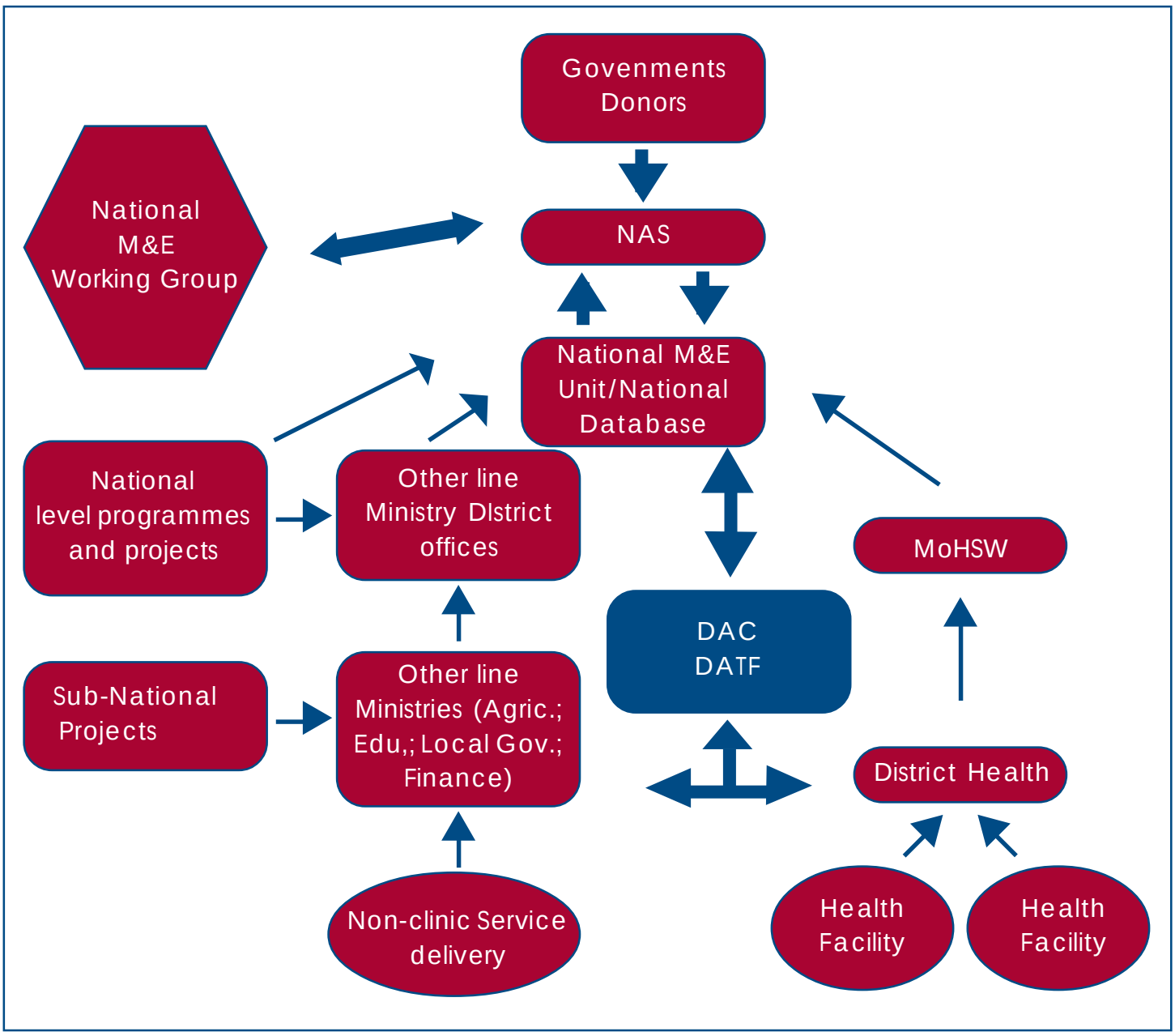
In 2003 three policy guidelines were developed by the MoHSW: (1) the National Information, Communication and Technology Policy Guidelines, (2) the Monitoring and Evaluation Policy Guidelines and (3) the health management information system HMIS Policy Guidelines. In the following year Strategic Plans were developed for the Information and Communication Technologies (ICT) Guidelines and the M&E Guidelines. Health Planning and Statistics Unit (HPSU) of the MoHSW has been struggling to implement the guidelines due to the lack of financial resources. However, as of May 2005, funds have been assured for the implementation of both guidelines by the World Bank and the Development Cooperation, Ireland-Lesotho (DCI). MoHSW intends to have the District Health Management Teams to be the vehicles to implement the strategic plans.

According to the 2003 MoHSW Strategic Plan, the STI/HIV/AIDS Directorate (the Directorate) (referred to in the Strategic Plan as the National AIDS Prevention and Control Programme) is responsible for activities to measure and monitor national HIV prevalence and incidence, national AIDS cases, and AIDS-specific morbidities and mortalities. The Directorate currently collects and analyzes data. HPSU plays a key role in the implementation of these activities through the provision of relevant expertise.

The MoHSW M&E operation plan currently in use by MoHSW is not HIV/AIDS specific, but rather covers all health related programme areas. An HIV/AIDS specific national M&E operation plan will be the domain of NAC/NAS, but needs to be coordinated with the MoHSW plan. Currently, the MoHSW's plan to respond to HIV/AIDS covers three programmatic areas: care and support; prevention; and social mitigation. The MoHSW's M&E plan was developed with input from the following organizations:

- Christian Health Association of Lesotho (CHAL)
- World Bank
- DCI
- UNICEF
- European Union (EU)
- WHO

Figure 2: Proposed overview of the data flow system in Lesotho



The M&E plan is reviewed at the end of each subsequent year to determine if monitoring and evaluation activities are on target. There is minimal change from year to year in terms of indicators or targets.

Of the three members of the MoHSW M&E staff, one, an Economic Planner, has been functioning as the M&E focal point for HIV/AIDS issues. This has been a functional responsibility because the individual has not been trained in M&E.

1. Lesotho AIDS Programme Coordinating Authority

Lesotho AIDS Programme Coordinating Authority (LAPCA) is mandated to oversee and coordinate all HIV/AIDS programmes and projects in the country and to act as a coordinating body. LAPCA specifically was mandated to coordinate, monitor and evaluate the national response to HIV/AIDS. Each ministry must pledge 2% of its budget and have an AIDS focal point (either an individual or an AIDS unit) that is held accountable. However, LAPCA does not have the authority to hold any ministry or organization liable for not complying with agreed upon practices or activities. In general, coordination encompasses the following activities:

- Report review
- Recommendations – resource mobilization
- Facilitation – technical assistance to develop policy
- Funds distribution (World Bank, GFATM, etc.)

LAPCA has up to now been channelling funds to organisations implementing HIV/AIDS activities in Lesotho through a sub-granting mechanism. In the future, as LAPCA transitions into NAS, this aspect will be executed more effectively with support from the World Bank. The World Bank has committed a total of US$5 million, for a period of two years, to support the implementation of HIV/AIDS programme activities using GFATM resources.

LAPCA facilitated the establishment of District AIDS Task Forces (DATF) in each district to coordinate district level HIV/AIDS programmes. Each DATF is comprised of representatives from respective line ministries (Heads of Departments), non-governmental organisations (NGOs) (both local and international), and is headed by a District Secretary from the Local Government Ministry. Currently, DATFs do not have terms of reference, guidelines, and resources and therefore remain a centralized group of government officials.

A functional district entity is an important prerequisite for effective data management and strategic information flows.

2. The National AIDS Secretariat

The NAS, once formalized, will be the national body responsible for coordinating the implementation and M&E of HIV/AIDS programmes. NAS will generate and house the national HIV/AIDS M&E plan and accompanying systems. MoHSW, on the other hand, envisions HIV/AIDS M&E response mainstreamed into the national M&E process that would include a database to link NAS & the MoHSW.

As LAPCA transitions into NAS, the NAS will, by virtue of its autonomy, legal authority, and hiring authority, be empowered to function as "the" national body responsible for coordinating the implementation and M&E of HIV/AIDS programmes. NAS will generate and house the national HIV/AIDS M&E plan and accompanying systems.

Further, the priority for NAS is to develop an HIV/AIDS national policy and to update the national HIV/AIDS strategic plan. It will be important to incorporate and agree on policy level indicators in the proposed national policy for future use.

NAS envisions the establishment of an M&E unit that will be made up of five to six professionals, including an M&E Technical Advisor, a National M&E Counterpart, Researcher, Assistant Researcher, Communications Officer and Data Entry Officer. To date, only the Technical Advisor is in place and the process of recruiting a counterpart is underway. These two positions are fully supported by the GFATM funding to Lesotho for the next three years. Additional resources will need to be tapped to cover costs of the remainder of staff once agreed.

One of the short-term goals for the NAS M&E unit is to set up the National Technical Working Group on M&E (MEWG). The inaugural meeting of the MEWG was held 31st May 2005. The focus of the MEWG is to provide guidance on coordination, advice to the implementers of HIV/AIDS strategies and facilitate the production and dissemination of strategic information. The MEWG will specifically aim at providing technical and managerial guidance on aspects of monitoring and evaluation at all levels of Programming in Lesotho. Furthermore, relevant policy structures of the government of Lesotho (GoL) will be informed based on the input and feedback from the regular reviews of the national response, which will also form a basis for a forum for broader discussions regarding monitoring and evaluation in general. At the very least the MEWG will be expected to establish national M&E needs through the tracking and review of:

- Outputs of the efforts/support of the multi-lateral, bi-lateral organisations and others;
- Performance of the donor support system (including multi-lateral, bi-lateral, and other);
- Assessment of the national responses (including GoL, NGO/community based organisations (CBO) [international and local]); and
- Assessment of impact

Table 1: M&E Operational Plan April 2005 – March 2006 for Lesotho

Code	Output / Target	Time Frame 2005									2006		
1	Completed SI Assessment 31/05/2005												
	ACTIVITIES / RESPONSIBLE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Finalise the SI Assessment / NAS/USAID/CDC	x											
	Call meeting of Technical Working Group / NAS/USAID/CDC	x	x										
	Conduct Validation workshop with key stakeholders / NAS/USAID/CDC		x										
	Disseminate findings widely / NAS/USAID/CDC		x										
	Conduct follow-up SIA (detailed) / NAS/USAID/CDC										x	x	x
	Set up and maintain functional resource centre / NAS/USAID/CDC	x	x	x	x	x	x	x	x	x	x	x	x
2	M&E Mapping / 30/6/2005	2005									2006		
	ACTIVITIES / RESPONSIBLE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Integrate outputs from strategic information assessment / UNAIDS & partners	x	x										
	Consultations with stakeholders on M&E / UNAIDS & partners		x										
	Produce the M&E map / UNAIDS & partners			x									
	Presentation to the M&E working group and other stakeholders / UNAIDS & partners			x									
3	Proper M&E staffing at NAS / 31/7/2005	2005									2006		
	ACTIVITIES / RESPONSIBLE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Develop & agree on proposed composition & structure of NAS M&E unit / NAS	x	x										
	Discuss the proposed composition and structure / NAS		x										
	Recruitment of M&E unit personnel at NAS / NAS		x	x	x								
4	Workshop on estimations / 31/07/2005	2005									2006		
	ACTIVITIES / RESPONSIBLE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Define workshop outline / MoHSW - HPSU	x											
	Apply/Request for TA and funding / MoHSW - HPSU	x	x										
	Prepare and run workshop / MoHSW - HPSU			x	x								
	Documentation and follow-up / MoHSW - HPSU				x	x							

Code	Output	Target	Time Frame											
5	Data on behaviour, attitude and practice, sero prevalence among general population and specific groups collected analysed and disseminated	31/05/2005	2005									2006		
	ACTIVITIES	RESPONSIBLE	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	Finalize HIV Sentinel survey	MOHSW	x	x	x	x	x	x	x					
	Start AIDS Sentinel surveillance (revision of 2004 protocol) in 3 hospitals	MOHSW						x	x	x	x			
	Dissemination and printing for report	MOHSW												
	HFS (write protocol)	MOHSW						x	x	x	x	x	x	x
	Integrate data from Integrated Disease Surveillaince & Response (IDSR) report	MOHSW/WHO												
6	National core indicators agreed and system to collect data in place	31/01/2006	2005									2006		
	ACTIVITIES	RESPONSIBLE	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	2 meetings of M&E WG to define core indicators	M&E WG					x	x						
	2 meetings of M&E WG to discuss system to collect treatment, care & prevention data	NAS							x	x				
	Implement system	NAS									x	x	x	x
7	M&E plan linked to the new NSP	31/01/2006	2005									2006		
	ACTIVITIES	RESPONSIBLE	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	Present current M&E plan to M&E Working Group for comments/endorsement	NAS et al		x	x									
	Publicise and distribute to wider stakeholders for comments/endorsement	NAS et al				x	x	x	x	x	x	x	x	x
	Publicise and disseminate aspects of M&E with stakeholders (all levels)*	NAS et al				x	x	x	x	x	x	x	x	x
	Agree on core indicators for the country	NAS et al			x	x	x							
	3 day retreat for all GFATM implementers & key stakeholders	NAS						x						
8	Workshop on estimations	31/01/2006	2005									2006		
	ACTIVITIES	RESPONSIBLE	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	Develop manual	NAS						x	x					
	Dissemination and circulation for comments and endorsement	NAS							x	x	x			
	Review manual	NAS										x	x	
	Print and disseminate final version	NAS												x

Table 1: M&E Operational Plan April 2005 – March 2006 for Lesotho

Code	Output	Target	Time Frame											
9	**Unified electronic database system**	31/01/2006	2005									2006		
	ACTIVITIES	RESPONSIBLE	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	Analyse characteristics and current use of existing databases within HIS and others	NAS/UNAIDS		x	x									
	Present CRIS to NAS	NAS/UNAIDS		x										
	Elaborate a system to integrate all databases	NAS/UNAIDS			x	x								
	Publicise and validate among key stakeholders and others	NAS					x	x						
	Develop and print paper formats	NAS/MoHSW et al							x					
	Purchase of equipment	NAS/MoHSW et al							x					
	Develop the software	NAS/MoHSW et al							x	x				
	Development of accompanying manuals	NAS/MoHSW et al								x				
	Training of all relevant staff	NAS/MoHSW/UNAIDS								x	x	x		
	Implement pilot phase	NAS/MoHSW et al										x	x	x
10	**Evaluation study TBD**	31/01/2006	2005										2006	
	ACTIVITIES	RESPONSIBLE	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	Identify priority areas for evaluation study	NAS et al					x	x						
	Discuss and agree with key stakeholders on priorities	NAS et al							x	x				
	Mobilise resources to conduct evaluaton study(s)	NAS et al						x	x	x	x			
	Conduct evaluation study(s)	NAS et al								x	x	x	x	
	Dissemination of findings	NAS et al												x
11	Improved understanding of M&E among stakeholders	31/01/2006	2005										2006	
	ACTIVITIES	RESPONSIBLE	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
	Conduct assessment (on needs) and develop advocacy strategy	NAS							x					
	Develop advocacy materials and messages	NAS								x	x			
	Circulate for comments/endorsement	NAS										x	x	
	Conduct advocacy activities	NAS								x	x	x	x	x

Code	Output	Target	Time Frame											
12	Data on behaviour, attitude and practice, sero prevalence among general population and specific groups collected analysed and disseminated	31/05/2005	2005									2006		
	ACTIVITIES	RESPONSIBLE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Finalize DHS+ (started in 2004)	MOHSW	x	x	x	x	x	x	x	x	x			
	Data entry DHS+	MOHSW	x	x	x									
	workshop	MOHSW				x								
	dissemination of DHS+ results	MOHSW					x	x	x	x	x			
	Expand on 2002 BSS	MOHSW				x	x	x	x	x	x	x	x	x
13	Functioning M&E Working group	31/01/2006	2005									2006		
	ACTIVITIES	RESPONSIBLE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Finalise the TORs of the M&E Working Group	NAS & other partners	x											
	Call the M&E Working Group meetings	NAS		x	x	x	x	x	x	x	x	x	x	x
	Facilitate and document meetings	NAS		x	x	x	x	x	x	x	x	x	x	x
	Evaluate first year of work	NAS												x
14	Defined staffing M&E needs at district level	31/01/2006	2005									2006		
	ACTIVITIES	RESPONSIBLE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Consultations with key stakeholders on District level M&E	NAS et al				x	x	x					x	x
	Rapid assessment on essential inputs for functional District M&E	NAS et al					x		x					
	Implement the district level M&E system	NAS et al							x	x	x	x	x	x
15	Selected actors - Gov't & NGOs trained on M&E	31/01/2006	2005									2006		
	ACTIVITIES	RESPONSIBLE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Training workshop	NAS et al					x		x		x		x	
	MEASURE/HEARD short course	USG						x			x			x
	Develop basic training material and related booklets on M&E	NAS et al					x	x	x					
16	UNGASS report	1/01/2006	2005									2006		
	ACTIVITIES	RESPONSIBLE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	Identify data sources	UNAIDS		x										
	Promote additional surveys and/or studies	M&E WG/NAS			x	x	x	x	x	x	x			
	Enter data into CRIS	NAS et al						x	x	x	x	x		
	Produce report	NAS et al								x	x	x	x	

3. National AIDS Secretariat Document Centre

In addition to this report, the assessment also resulted in the formation of the NAS resource centre. The resource centre is a valuable means to disseminate HIV/AIDS relevant essential research, targeted evaluations, information on national policy, national indicators, and national, district, and community level programme information and evaluations. In addition, the research centre has the potential to evolve into a forum through which best practices, studies, and a collaborative approach to evaluation planning can be disseminated. Over 120 archived documents are now available and the archival system has been structured so that it can easily absorb future documents.

4. The UN Expanded Theme Group

The UN Expanded Theme Group on HIV/AIDS (the Theme Group) meets on a monthly basis bringing together key stakeholders in Lesotho to exchange information on programmes and act as an open forum on HIV/AIDS. Participants in the Theme Group represent the GoL, foreign donor governments, NGOs, and the UN system (See Appendix (3): UN Expanded Theme Group Participants).

B. HIV/AIDS Policy Assessment

Illustrative national indicators – National Policy:

1. Amount of national funds spent by governments on HIV/AIDS
2. National Composite Policy Index:
   - Political Support
   - Policy Formulation
   - Organizational Structure
   - Programme Resources
   - Evaluation, monitoring and research
   - Legal and regulatory environment
   - Human rights
   - Prevention programmes
   - Care programmes
   - Service availability
   - United Nations role

Source: UNAIDS, 2002; UNAIDS, USAID and the Policy Project (n.d.)

SISA did not identify any activities to monitor development of national HIV and AIDS policy. However, there are several indicators that have been developed at a global level that attempt to capture key dimensions of HIV/AIDS policy. The AIDS Programme Effort Index (API) was developed by the United Nations General Assembly Special Session on HIV/AIDS. The API is intended to measure the amount of effort made by national programmes to confront the AIDS epidemic and is useful for highlight areas of strength and weakness in national responses and for identifying progress.

The following sections look at the specific national data systems that support measurement of National HIV and AIDS Programme performance indicators.

C. National Data Systems: Population-based surveys

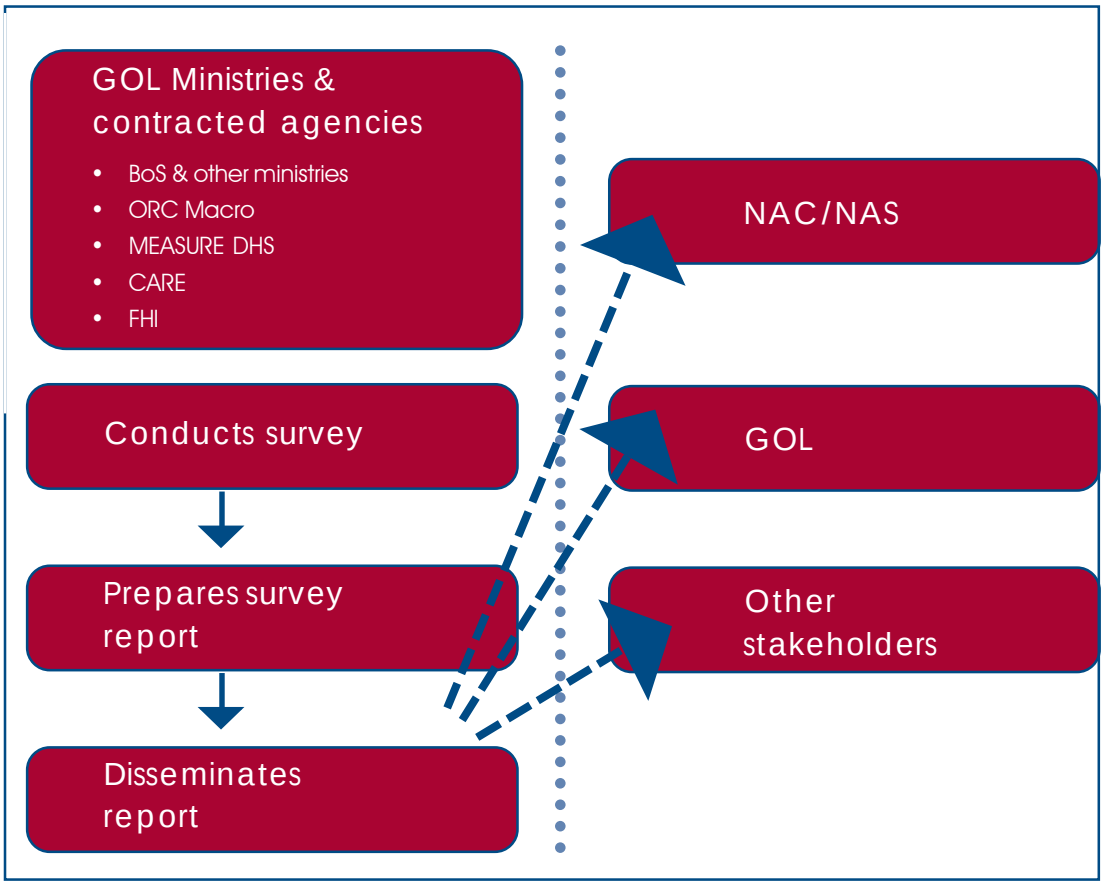
Illustrative national indicators – Population-based surveys:

1. Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission. (UNGASS **Target: 90% by 2005/ 95% by 2010**)
2. Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner
3. Median age at first sex
4. Percentage of population who know methods of preventing mother-to-child transmission of HIV
5. Ratio of current school attendance among orphans to that among non-*orphans aged 0-14*

Source: UNAIDS, 2002a; UNAIDS, 2002b

Population-based surveys are a type of data collection method wherein data are systematically obtained from a representative sample of the population. Such surveys can be conducted at a national or sub-national level. Government programmes designed to have national coverage can be evaluated in terms of their effect on the general population. District level or pilot projects can be evaluated at a sub-national level (Bertrand and Escudero, 2002).

Figure 3: Data source flow chart, population-based surveys



Source: Ministry of Finance and Development Planning, 2004

The Bureau of Statistics (BoS) conducts national population-based surveys and assists other ministries and organizations in designing sampling methodology, questionnaires, and providing technical assistance to field staff during data collection. Additional BoS activities include: training fieldworkers from its permanent interviewer staff; data entry/management; and data tabulation and report writing. BoS also engages in other on-going, routine activities, including hospital and health centre data from MoHSW; Department of Prisons data; and *Vital Events Statistics*, which are to be produced in collaboration with the Ministry of Local Government.

The Information Technology Division of BoS houses survey data files and is also responsible for disseminating data. Generally dissemination of research findings at the national level is initiated in Maseru and then spreads out to the rural areas. Workshops are typically held at district level. Hard copy (paper) reports, CDs, and diskettes are also produced and available (for a cost).

Data are available for secondary analyses and may be obtained after a request has been submitted to the Demographic, Labor, & Social Statistics Division of BoS. The individual or organization requesting data must have a BoS approved research question. Data are distributed for one variable per person per the life of that person. It is important to note that an inactive ethics board does exist in Lesotho. There is an unstaffed Research Office in MoHSW and a management information system (MIS) unit housed in the Directorate's office, leaving BoS with the responsibility to protect the privacy of survey and research participants and therefore is protective of its data.

BoS serves as the national data collectors and research coordinator. GoL requests data for policy development from BoS. Therefore, all surveys being conducted in Lesotho are to be first approved by BoS. However, this assessment indicates that surveys do proceed without BoS coordination, support, or knowledge. To remedy the situation, BoS wants to develop a national plan for collection and use of population-based survey data.

BoS is committed to developing a national research agenda. As part of this research agenda other ministries will be informed of the role of BoS and the need for cooperation to produce usable statistics.

The following are recently conducted population-based surveys relevant to HIV/AIDS M&E:

- 2004 Demographic and Health Survey was conducted by BoS last year in collaboration with MoHSW, with technical assistance from MEASURE DHS+/ORC MACRO. Some preliminary findings are expected in June 2005, although serological data on HIV prevalence will probably come out at a later time.
- The 2002 BSS
- The 2002 Lesotho Reproductive Health Survey and was funded by UNFPA.
- The 2002 Lesotho Core Welfare Indicators Questionnaire (CWIQ survey) included a KABP HIV/AIDS module. This study was conducted by the BOS and funded by the World Bank. It was conducted from April to May 2002.
- The Multiple Indicator Cluster Survey (MICS) of 2000 was funded by UNICEF.

D. National Data Systems: Facility-based surveys

Illustrative national indicators – Facility-based:

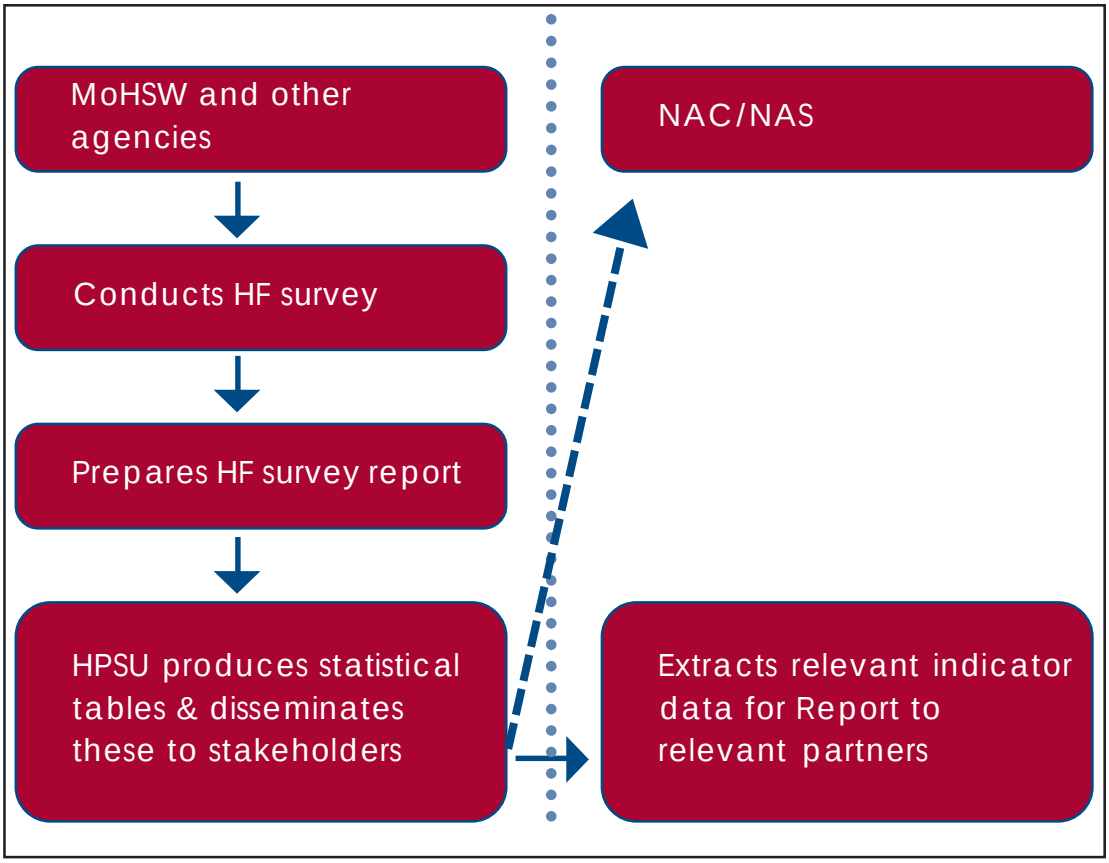
1. The (a) number and (b) percentage of health facilities providing HIV/AIDS care appropriate for level of facility
2. Percentage of health facilities that have the capacity and conditions to provide basic HIV counselling and testing and to manage HIV/AIDS clinical services
3. Percentage of health facilities that have the capacity and conditions to provide advanced HIV/AIDS clinical and psychosocial support services, including providing and monitoring antiretroviral combination therapy
4. Percentage of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines
5. Percentage of health facilities with record-keeping systems for monitoring HIV/AIDS care and support

Source: UNAIDS, 2002a; UNAIDS 2002b; WHO, 2004a

Health facility-based surveys are conducted to capture information on service availability and quality of care. Such surveys can be conducted at a national or sub-national level and typically involve a sample of facilities. The focus of these surveys lies in measurement of the service delivery environment; inventories, provider interviews and record/register reviews form the core methodology of facility surveys.

The rationale for evaluating availability and quality is two-fold. First, evaluation of these topics serves to focus programme managers' attention on the need to improve service delivery. Second, this type of evaluation measures programme objectives from the service environment perspective, which complements the population-based perspective (Bertrand and Escudero, 2002a).

Figure 4: Proposed data source flow chart, health-facility based surveys



Source: Ministry of Finance and Development Planning, 2004

In 2002 the Ministry of Health and Social Welfare commissioned a Health Centre Rationalisation Study (Medical Care Development International & Sechaba Consultants, May 2002) to evaluate the then current distribution of health centers in Lesotho to determine spatial distribution, coverage, accessibility, quality of infrastructure, equipment and supplies, the range and volume of services produced, demand, and human resources supply and workload. This survey was never conducted.

The specific objectives of the study were to:

- Define primary health care facilities (health centers and clinics);
- Assess accessibility of all health centers and clinics (GOL &NGOs) to their clients;
- Assess the adequacy and status of the infrastructure;
- Assess the extent to which each health center and clinic is utilized (acceptability and workload);
- Assess the level of current technology and the competence of the current staff
- Assess the management structures, community involvement and management of information;
- Assess affordability of services provided;
- Appraise the current operations of all GOL and CHAL health centers and clinics in order to specify feasible and acceptable strategies for right sizing and rationalization/redeployment of facilities and human resources

E. National Data Systems: HIV and AIDS Surveillance Data

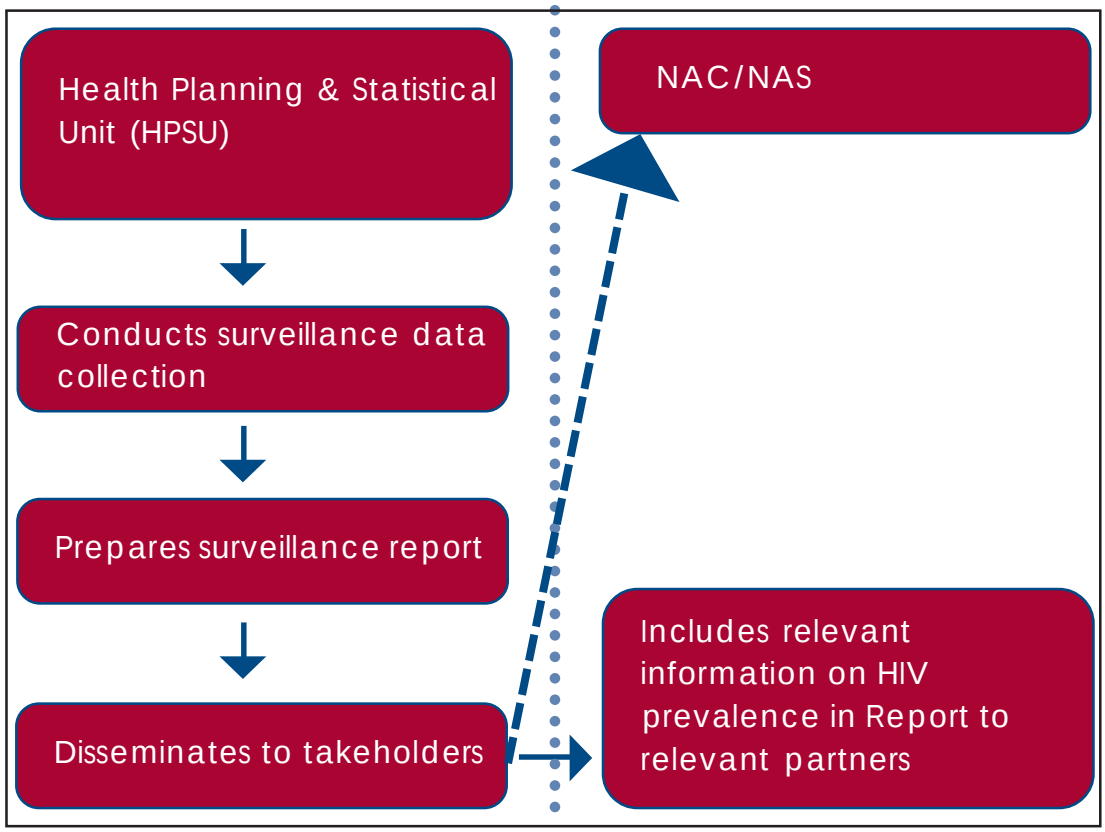
Illustrative national indicators – HIV and AIDS Surveillance Data:

1. Percentage of young people aged 15-24 who are HIV-infected (**Target: 25% reduction in most affected countries by 2005; 25% reduction, globally, by 2010**)
2. HIV and syphilis prevalence among (a) all antenatal women; (b) women aged 15-19; and (c) women aged 20-24
3. Percentage of blood units screened

Source: UNAIDS, 2002a; UNAIDS, 2002b; Bertrand and Escudero, 2002b

Surveillance is the routine tracking of disease, disease outcomes (death, disability, quality of life) and, less commonly, risk behaviour (sexual, unsafe injection, etc.). Emphasis is placed on establishing trends and thus stability of the surveillance system and measures over time. Surveillance helps describe an epidemic and its spread, and can contribute to predicting future trends. In the case of HIV, surveillance systems typically track impact in terms of HIV and sometimes STI prevalence, and effects in terms of sexual risk behaviour. It is typically conducted at both the district-level (sentinel sites) and aggregated at central level to produce a picture of level, trends and patterns of HIV prevalence in the country (UNAIDS, 2000).

Figure 5: Proposed data source flow chart, HIV and AIDS surveillance



Source: Ministry of Finance and Development Planning, 2004

The principle routine HIV/AIDS surveillance activity conducted in Lesotho is the HIV Sentinel Surveillance Survey. This survey is ante-natal clinic (ANC) based and receives funding and technical assistance from DCI and WHO and is mandated to be conducted every other year. In the 2005 round, now being conducted, financial support is provided by the GFATM and DCI. Additional financial and technical support is being provided by the US Centers for Disease Control and Prevention (CDC). HPSU/ MoHSW unit oversees its implementation and data analysis. HPSU is also responsible for field staff training; data entry and management; and, with assistance from WHO and CDC, data tabulation, data analysis, and report writing. In 2003 UNAIDS/WHO/ Futures Group International provided the Estimation and Projection Package (UNAIDS, n.d.) and Spectrum Package (The Policy Project and UNAIDS, 2005) for analyzing the sentinel surveillance data. For the 2003 survey a report was produced within one month after fieldwork was completed. The data are housed with the Epidemiology Unit of HPSU. Actual ownership of the data remains unclear. Key in-country stakeholders are required to request data for secondary analysis from either MoHSW or BoS.

The sentinel surveillance survey is conducted in ANCs, using a paper-based data capture system. These clinics are typically hospital-based, but some are also housed in satellite clinics or filter clinics. In Lesotho, facility-based record keeping is paper-based. This leads to two paper-based recording keeping systems being maintained per patient during the sentinel surveillance period.

Implementation of plans to make use of other serologic HIV data from testing service sites [prevention of mother to child transmission of HIV (PMTCT), voluntary testing and counselling (VCT), tuberculosis (TB)] is underway. However, there are barriers to its success. There is no national body to which data should be submitted and there remains a lack of a common database or data warehouse.

Another new source of HIV surveillance data comes from the 2004/2005 Lesotho DHS+. The LDHS will collect blood samples from adult women and men and, for the first time produce general population-based estimates of HIV prevalence. The MoHSW is interested in establishing an analysis activity to compare ANC-based and general population-based HIV estimates, which will enrich discussion regarding national strategic planning, such as the use of both ANC and DHS data to estimate national prevalence rates. Serological findings from the LDHS, which was funded by DCI and World Bank, are expected to be available by end 2005.

AIDS-related mortality is not yet measured and monitored through national level activities. The LDHS identified three leading causes of death, which were chest pain, pneumonia, and tuberculosis based on death reported in the last year. In addition to population-based surveys, birth and death records are the responsibility of the BoS, which is to develop a Vital Statistics National Register. Stigma and ethical aspects of clinical management make directly collecting information on AIDS-related mortalities difficult and limits the ability of the Vital Statistics National Register to directly capture AIDS-related mortality.

F. Routine National HIV/AIDS facility-based services statistics

The collection, coordination, and management of health service data constitutes a challenge for the health sector. Data collection and management is characterised by the existence of a large variety of data collection instruments, most of which have been introduced with the on-going arrival of new programmes and projects. There is significant duplication and repetition of data collection efforts. Review and rationalisation of the tools used in the collection and management of data has been limited. A disproportionate amount of time and effort is spent on the actual collection of data, with little focus on the use of data to produce information that will benefit decision making and general programme development and management.

Currently, nationwide HIV/AIDS service data collection, coordination, and management is supposed to be conducted by the Statistics Unit in HPSU/MoHSW. Data entry clerks enter data from paper forms into two databases: Access and Foxplus. If data do not appear, then follow-up via telephone is initiated. Counts are run on numbers in hospital, numbers with a certain diagnosis, and numbers who improved, worsened, remained stable, or died. AIDS Sentinel Surveillance, which was due to be implemented in 2004 at three hospitals, is planned to comprehensively address HIV/AIDS service based data collection. The protocol was compiled in 2004. However, implementation was delayed due. The Southern African Development Community (SADC) M&E Framework is to capture gaps in the MoHSW HIV/AIDS data capturing system, but has not yet been completed.

Counts of services delivered can only be obtained by a health facility-based register system that captures such data. The client is required to bring the *Bukana* with them at all times when undergoing medical (or health) review. The *Bukana* is a client-level data collection device and is primarily used for client management and is limited to tracking complaints, diagnoses, and treatments.

Changes to the *Bukana* system have been suggested that would require a unique patient ID to be linked to a database which can be accessed by the health care provider. This is addressed in the MOHSW ICT policy document that was compiled simultaneously as the HIMS policy document in 2003.

1. Voluntary counselling and testing services

Illustrative national indicators – volunta counselling and testing services:

1. Percent of population requesting an HIV test, receiving a test, and receiving test results
2. Percentage of the general population aged 15-49 years receiving HIV test results and post-test counselling in the past 12 months
3. Voluntary counselling and testing centres with minimum conditions to provide quality services

Source: WHO, 2004a; Bertrand and Escudero, 2002b

Having knowledge on the broad reach of VCT services over time and knowing the percentage of the population who have been tested and received results will go a long way towards determining whether those services achieve their threefold aims of providing an entry point for care and support, promoting safe behaviour, and breaking the vicious circle of silence and stigma (Bertrand and Escudero, 2002).

National VCT guidelines were compiled in 2004 and have been instrumental in attempts to ensure a standardized approach to VCT. This was important because the various VCT centres in operation do not conform to one method of providing VCT services.

There are currently seventeen sites in Lesotho providing VCT services. In addition, PSI operates three VCT sites in collaboration with MoHSW and plans to open two additional sites by June 2005. Each of the PSI sites also operates a successful mobile component. The Directorate is responsible for the overall design and implementation of the national VCT-MIS. The PSI VCT-MIS is viewed as a national standard by VCT providers, including the MoHSW.

2. Prevention of mother to child transmission of HIV services

Illustrative national indicators – PMTCT services:

1. Percentage of HIV-infected pregnant women receiving a complete course of antiretroviral prophylaxis to reduce the risk of MTCT
2. Percentage of pregnant women counselled and tested for HIV
3. Antenatal clinics offering and referring for VCT

Source: UNAIDS, 2002a; Bertrand and Escudero, 2002b

Private sector clinics will often take the lead in providing prevention of vertical transmission services for those HIV-infected pregnant women who can afford to pay for interventions. Because such interventions are relatively expensive, the goal of national programmes is to extend their reach to less affluent members of society, through service provision in public facilities (Bertrand and Escudero, 2002).

PMTCT services tend to be based in district level hospitals. Currently, there are 17 antenatal hospital-based clinics providing PMTCT services. Ante-natal clinics report to their district hospital and the district hospitals report to HPSU.

There is a strong indication that there is a significant decrease between the number of women who test positive and the number of women who enroll in the PMTCT programme, due to the number of infants who sero-convert between birth and 18 months of age.

3. Orphans and vulnerable children services

Illustrative national indicators – Orphans and vulnerable children services:

1. Percent of children under 15 who are orphans
2. Percentage of orphans and vulnerable children whose households received, free of user charge, basic external support in caring for the child

Source: Bertrand and Escudero, 2002b; WHO, 2004a

HIV is changing the face of adult mortality. Earlier deaths leave behind orphans who must be cared for, generally by other members of the community. National AIDS programmes tracking orphanhood will be better equipped to plan for impact mitigation efforts (Bertrand and Escudero, 2002b).

The Department of Social Welfare is currently introducing the orphans and vulnerable children (OVC) Services programme nationwide. This process is said to involve the presentation of the OVC Policy to communities, the training of community leaders, and the development of tools for data collection.

Integration of OVCs into vital registration began December 2004. Establishment of the national OVC coordinating body is due March 2005. Its first task will be the review of existing monitoring and evaluation tools, including establishment of new tools from February 2005 onwards. The development and implementation of the M&E plan is scheduled to begin May 2005. OVC stakeholders training and skills development on M&E began during January 2005. Finally, anti-retroviral therapy (ART) for children living with HIV/AIDS is scheduled to be available December 2005.

UNICEF and the World Food Programme (WFP) conducted an orphan registration and found between 92,000 – 93,000 orphans in Lesotho. Of these, less than half receive a birth certificate, which prevents access to a variety of benefits, services, and educational opportunities. This has led to a focus on developing a vital statistic registration system. The attempt to establish the system has been difficult due to:

- Limited management
- Low computer competency
- Ministries want funding for specific projects and tend to overlook big picture issues
- Lack of flow of information within the Government of Lesotho

4. Anti-retroviral therapy services

Illustrative national indicators – Anti-retroviral therapy services:

1. Percentage of people with advanced HIV infection receiving antiretroviral combination therapy
2. Percentage of districts with at least one health facility providing antiretroviral combination therapy

Source: UNAIDS, 2002a; WHO, 2004a

Programmes for increased access to antiretroviral drugs (ARV) are eliciting increased commitment and support. Many countries are expanding their programmes to respond to the growing HIV/AIDS pandemic and the increased support becoming available. These programmes are naturally expensive and represent a serious commitment of funds and energy in the countries involved. The need for setting standards for M&E of these programmes at the national level and assuring that these investments are yielding the maximum benefit is clear. National M&E of programmes for increased access to ARVs should allow programmes to monitor their progress in

implementation, identify problems, refine and adapt their implementation strategies; assess the effectiveness and impact of their interventions; and test strategies for optimizing their effectiveness, impact, cost-effectiveness and sustainability (WHO, 2005).

Currently, there are four hospital-based ART service clinics. ART service providers use register forms to track clients' weight, medications prescribed, and CD4^{++} counts. The referral system is unclear. The majority of clients seen at ART clinics present with advanced HIV infection or AIDS.

The Research and Management Information Programme in the office of the Directorate is responsible for the overall design and implementation of the national ART-MIS, which recognizes the need for coordination of research and information on HIV/AIDS in the health sector. The responsibilities of the programme have been defined as follows:

- To coordinate, in conjunction with the Epidemiologist in the Health Planning and Statistics Unit, the development and implementation of a system for the collection, collation, analysis and utilisation of HIV/AIDS-related data and information
- To ensure that research aimed at improving the delivery of services for HIV/AIDS in Lesotho is undertaken

5. Care and support services

Illustrative national indicators – Care and support services:

1. Existence of comprehensive HIV/AIDS care and support policies
2. Percentage of facilities that provide comprehensive care referrals for HIV/AIDS care and support services (when these services are not available on site)

Source: WHO, 2004a

Setting standards for HIV/AIDS care services at all levels of the health system and allocating the required resources for M&E will allow progress to be made in measuring national and international goals. An additional benefit is that this allows health planners and implementing agencies and individuals at each level to base decisions for resource allocation and setting priorities on realistic data (WHO, 2004).

Care and support in the Lesotho context is defined as home-based care (HBC). HBC is very basic and includes bathing, feeding, and psychosocial support. According to an inventory undertaken by LAPCA in 2002/3 there are 66 groups providing home-based care in Berea, Butha-Buthe, Leribe, and Maseru.

The Directorate is responsible for the overall design and implementation of the national care MIS.

6. Sexually transmitted infections services

Illustrative national indicators – sexually transmitted infections (STI) services:

1. Percent of STI clients appropriately diagnosed and treated
2. Percent of STI clients receiving advice on condom use and partner notification and referral to HIV testing services

Source: Bertrand and Escudero, 2002b

Sexually Transmitted Infection (STI) programmes are focusing on syndromic management of STIs as the most practical approach in high prevalence, low resource settings. *Appropriate* diagnosis and treatment is assessed according to national guidelines covering these services (Bertrand and Escudero, 2002b).

STI services are provided by 52 sites throughout the country.

The Directorate is responsible for the overall design and implementation of the national STI-MIS. An STI Surveillance programme is being coordinated in collaboration with SADC, Department for International Development, United Kingdom (DFID) and WHO. This programme is currently in the planning stages. Ideally it will track STI-relevant bio-medical markers using laboratory-based diagnostic data.

7. Tuberculosis services

Illustrative national indicators – Tuberculosis services:

1. TB case detection rate
2. Treatment success rate
3. DOTS coverage
4. Surveillance of multi-drug resistant TB
5. HIV seroprevalence among TB clients

Source: WHO, 2004b

Closer collaboration between HIV/AIDS programmes and TB programmes is needed to improve diagnostic, care, and prevention services for people living with HIV and TB. The unprecedented scale of the epidemic of HIV-related TB demands urgent, effective,

and coordinated action. Collaborative TB/HIV activities aim to decrease the burden of disease in populations where HIV is fuelling the TB epidemic by expanding the scope of TB and HIV programmes and improving the quality of service provision. There is a growing need to monitor these activities and evaluate their impact in order to inform future expansion of the most effective. A firm evidence base is needed on which to plan for and improve future collaborative TB/HIV activities (WHO, 2004).

The *Lesotho National Tuberculosis Control Policy Manual* outlines the national plan for collection and use of TB programme data. 19 district hospitals and 232 clinics report using the TB registers. HPSU is responsible for the overall design and implementation of a national TB-MIS. The Communicable Disease Unit/MoHSW is responsible for national level TB M&E and operates integrated disease surveillance and response (IDSR). The IDSR strategy aims to improve the availability and use of surveillance and laboratory data to control priority infectious diseases that are the leading causes of death, disability, and illness in the African region.

In March 2004, the TB register forms changed to be brought in line with WHO standards. These forms are to replace the currently standardized and accepted forms in use in the district hospitals and health centres. TB Coordinators and Correctional Officers are already being trained on the new forms. The new forms are in the policy manual, but have yet to be widely distributed for use. TB registers are completed at health facilities by doctors, nurses, and TB coordinators (nursing assistance who have undergone in-service trainings). Forms are sent to district level hospitals for compilation. District hospitals report to the Disease Control Unit, which then reports to HPSU, Epidemiology Unit.

The data collection system is paper-based. Data are submitted to HPSU, Epidemiology Unit, where the data are entered into an Access database. The Disease Control Unit owns the data, but does not have the actual data file. Key in-country stakeholders can not access the data for secondary, in-depth analysis.

The Disease Control Unit is responsible for dissemination of TB data at the national level. Dissemination is achieved through the TB annual reports, which are compiled quarterly reports. Annual reports are sent to district hospitals and stakeholders (defined as "anyone working in collaboration with – or has an interest in – TB, including clients). This report is free of charge. The last annual report was produced in 2003. The 2004 Annual Report is scheduled to be released sometime after June 2005. The most recent Tuberculosis Annual Report was available 13 months after the data reference period ended.

G. ART client monitoring and management

Illustrative national indicators – ART client monitoring and management:

1. Percentage of designated laboratories with the capacity to monitor antiretroviral combination therapy according to national and international guidelines

Source: WHO, 2004a

Treating HIV-infected clients with ART is highly complex, given the lifelong requirement for ART, the need for best practices to support treatment efficacy, and the rapid evolution of scientific evidence. National guidelines and standard operating procedures are necessary to guide clinicians in providing ART and in evaluating performance, thereby ensuring quality assurance and proper management (FHI, 2004).

ART was initiated originally in Lesotho around 2000 by private practitioners. The public sector began as follows:

- Maluti Hospital — late 2002/early 2003
- Sebocha Outclient Clinic — 2004
- Sekantana (Bristol Meyers Squibb) — May 2004
- GOL ART programme — November 2004

1. Clinton HIV/AIDS Foundation

The Clinton AIDS Foundation (CHAI) is examining the Lesotho medical system to improve primary health care and ART delivery and is developing a pharmacy-based monitoring and data capture system. This system aims to demonstrate the interlocking of pharmacy and client logistics that will increase knowledge of ARV use and diagnoses as well as an inventory tracking system. This pilot is done in cooperation with the Director of Pharmacy Services, who also serves as HIV/AIDS Health Products Coordinating Services director.

Piloting of the CHAI model will begin at the district hospitals and then move to Health Service Area (HSA) clinics. The HSA clinics will use the system in a non-electronic format to link the prescription with the diagnosis and prescriber. In addition, in sites with limited access to the Internet or sites that are paper-based, a bread truck approach will be employed. That is, data will be collected from the ART centre pharmacist when the WFP truck delivers its food supplements to persons living with HIV/AIDS (PLWHA). A final incentive for pharmacists to adopt this system is that it is believed it will relieve the pharmacist of maintaining stock inventory.

2. Ontario Hospital Association – Tse'pong Clinic, Hlotse (Leribe)

As of 23 March 2005, Tse'pong Clinic in Hlotse/Leribe serves 1,124 clients of which 355 (excluding attrition rates) are on anti-retroviral therapy. Clients are initiated into treatment through testing, using standard VCT practice. Following testing, clients are triaged and registered. If clients are visibly ill, they are sent directly to the physician; if not, blood is drawn and later evaluated for $CD4^{++}$ counts done by a mobile unit run by UNDP. All clients are initiated at their first visit onto cotrimoxizole prophylaxis, due to the high prevalence of *Pneumocystis carinii Pneumonia* (PCP).

Tse'pong Clinic has significant constraints in collecting, managing, and using data: time, energy, and sufficient staff to see the high numbers of clients. Monitoring is based on clinic notes and the *Bukana*, which tracks weight, medications prescribed, and $CD4^{++}$ counts. The clinic maintains charts on each client, but completeness depends on energy level, time, and number of clients to be seen. The clinic uses a client tracking ARV form to collect: start date, original regimen, why the regimen changed, and to what regimen changed. However, at this early stage of the ART roll-out, the primary need in monitoring is for PCP prophylaxis failure.

MoHSW requested Tse'pong Clinic to use the Clinton AIDS data form to collect ART data for national M&E. (See Section IV.G.1. Clinton AIDS Foundation)

Adherence tracking is appointment and paper-based. The return date is noted and marked once client arrives for appointment. If the client is late, then that tardiness is counted as such and added to the late counts. Counts are made of number of clients who returned on time, number of clients who returned late, and number of clients lost to follow-up.

H. Community programmes activity monitoring (section moved from below)

OVC, HBC, and behaviour change communication (BCC) programmes have strong community-based components. The coordination and reporting – including monitoring and evaluation – for these programmes is under-developed and driven largely by specific funding agencies without an overall national strategy.

HPSU is responsible for coordinating data collection and reporting community based programme activities. Currently there is not a database of organizations providing information on a regular basis per thematic area of intervention.

Organizations and agencies collecting programme activity reports include:

- PSI collects data on programme activities
- CARE, which also supports a large number of civil society programmes.

- GOL has district AIDS offices with district AIDS Task forces, which technically are supposed to collect data at the district level from CBOs. This is currently not happening.
- Lesotho Congress of NGOs (LCN)
- NAS has developed tools and procedures to monitor GFATM grantees and is planning to expand this to all national programme partners in the context of the national programmatic database

There are a number of constraints inhibiting the collection of community based activity data:

- Training for data collectors, managers, and users on the importance of SI
- Paper based system
- No central data repository
- No one to manage a central data repository
- No one to analyze data and provide feedback to data collectors and programme implementers

Future national M&E initiatives to strengthen partner/stakeholder participation in the timely reporting of community based programmes include:

- A new M&E plan for HIV/AIDS under the NAC
- MoHSW VCT-MIS plan

I. National HIV/AIDS database

The ability to summarize national-level inputs to HIV and AIDS policy and programme and to track programme performance is greatly enhanced through development of routinized use of national database technologies. National databases can come in many different forms. Two broad types have proven helpful in the job of national programme partner coordination and reporting to national and international stakeholders. The first of these is a programmatic database, wherein is housed an exhaustive list of major HIV/AIDS service providers along with keys pieces of information regarding type, scale and geographic coverage of programme. Second, a national indicator database allows for tracking, aggregation and updating of standardized and context specific national indicators. Both of these are central to national M&E function.

At the moment, neither of these types of databases exist although both are part of the National M&E workplan now being developed by the national M&E workgroup. Methods for tracking of GFATM grantees is current being developed and could serve as a foundational for national programmatic database activities in the new M&E unit at NAs.

Regarding indicator database, NAS will push for a single system, accessible to all stakeholders, and housing the indicators that are collected with the same tools. Any future indicators and data collection tools need to be developed in relation to the national HIV/AIDS dataset. The development of a single national, HIV/AIDS dataset could first focus efforts to harmonize indicators and tools among donors. One proposal is for implementing organizations to report to donors who then report to NAS.

V. Key Findings

- The HIV/AIDS situation in Lesotho is an emergency and a multi-sectoral approach is needed to mitigate its impact.
- M&E is a valuable component of programme management and not just a means to satisfy reporting and accountability requirements.
- Increased advocacy efforts for the utility of M&E to provide data for evidence-based decision making and policy formation is much needed in Lesotho.
- Ultimately, coordination must be seen as a value to enhance the quality of information products. The assessment and technical workshop identified four broad areas of M&E activity requiring better coordination: health sector facility-based programme monitoring data, population-based surveys, community-based programme data, and private sector involvement in programme reporting.
- There is a lack of an in-place, national strategic plan. The last plan expired at the end of 2003 and the subsequent plan has yet to be implemented. The completion of this strategy, including a strong M&E component is crucial to mandating M&E capacity development activities
- NAS is the intended implementer of national HIV/AIDS M&E coordination activities. The newly formed National M&E workgroup, an advisory group of the NAS, is composed of representatives from a very wide range of public and private sector stakeholders. Due to the complexity of the bureaucratic and political situation, there is an overwhelming focus on the NAS to identify and resolve HIV/AIDS M&E problems.
- The HPSU collection, compiles, and houses a vast quantity of data. Because of limited human resources and insufficient coordination, these data have been highly underutilised. There exists opportunity for fuller analysis and dissemination of data..

A. Data systems issues

- Data acquisition and flow is not coordinated between key stakeholders, with partners using different forms and reporting to different units.
- Data collection at the community level has been difficult, with limited results seen. Therefore, the technical workshop identified that both national level and community level buy-in is key.
- There is lack of focus and activity in translating the data collected into usable information. This is a barrier to evidence-based programme planning.

- Appropriate technologies to collect, capture, and process data are underutilized. This result in a dependence on the central level to produce data tabulations and counts from paper records flowing from peripheral sites.

- Data systems are highly compartmentalized within the GoL offices and between the GoL offices and extra-government partners. This results in limited sharing of data within the health sector and between the health and other sectors working in HIV/AIDS.

- HMIS and other routine data activities are poorly resourced in terms of dedicated human and financial resources.

- In contrast, data collection activities that have garnered dedicated human and financial resources as one off projects (e.g. Surveys) tend to operate with greater success.

B. Capacity

- The coordination, reporting, and M&E for programmes with strong community-based components is under-developed and driven largely by specific funding agencies without an overall national strategy.

- Although surveys and research activities are supposed to to be approved by BoS, they do often proceed without BoS coordination, support, or knowledge. This is due in part to a lack of a national plan for collection and use of population-based survey data.

- Lesotho lacks a central research coordinating body, although BoS has a limited role to coordinate research activities. A proposed legislative action would make BoS accountable for all data, but data collection activities would remain delegated to the various ministries conducting evaluation and research.

- One important barrier to the success of a National M&E system is the lack of a national body to which data would be submitted and warehoused (i.e. no national database and national M&E standards) . At the moment, neither a programmatic database nor a national indicator database exist although both are part of the National M&E workplan now being developed by the national M&E workgroup.

- Common obstacles encountered during previous attempts to establish decentralized data capture systems:

    - Very limited computer competency
    - Poor understanding of data systems
    - No commitment to establish dedicated human resource for high quality data collection and management (insufficient resources)

- Focus on specific projects at the expense of system issues
- Lack of flow of information within the GoL creating a disincentive against development of good peripheral systems

C. Data quality and management

- The outpatient department tally sheet and the inpatient department IPD sheet are the basis for data collection in addition to other data collection forms for Maternal & Child Health and priority disease conditions. Delayed processing of these data result is reports that are out of date by the time they are published.
- The lack of standardized HMIS data capture methods, adequate management, and quality assurance from the time data are captured, reported to the district level, and then entered into an Access or Foxplus database at the national level results in incompleteness and and other threats to validity. Generally the HMIS data are considered unreliable.
- There are significant barriers to collect, manage, and use HMIS data for the purposes of M&E:
  - Insufficient staff
  - Inadequately trained staff
  - High patient burden per clinician (i.e. leaving little/no time to support collection and use of data)

D. Data ownership and secondary analyses

- Data are generally unavailable for secondary analyses
- The rules of data ownership and access are often not clear to groups who should be primary users of the data

E. Ethics

There is an inactive ethics board, an unstaffed Research Office in MoHSW, and an HMIS unit housed in the HIV/AIDS Directorate's office, resulting in limited oversight of human subject research activities.

VI. Recommendations

A. National strategies, plans, and systems development

- There is a need to create a framework for accountability. Institutions, organizations, and individuals need to be given specific mandates and responsibilities. For their part, the National M&E Workgroup is developing their strategy and work plan for which they will be held accountable. (First Meeting was held 31 May 2005)

- The national HIV/AIDS M&E plan and system needs to be informed by the national HIV/AIDS strategic plan. Before the revised strategic plan is finalized, an operationalised and costed M&E section needs to be incorporated. Advocacy for full funding of M&E and data systems components of national strategy need to be rigorously pursued.

B. Customise M&E to resource limitations

- Current human resource limitations on the ground require a short-term focus on "nuts and bolts" of programme reporting. It is recommended that improving the national HIV/AIDS M&E system starts with ensuring that the in-place manual system is set-up, running, and producing simple, focused reports before investing heavily in new technologies.

C. One M&E

- All of the various M&E plans, many developed by donors in support of the GoL, need to feed into a single national plan, ie."One-M&E". In particular, indicators need to be minimized and harmonized according to stakeholder reporting needs.

D. National M&E capacity building and M&E Resources

- Time and effort need to be spent to "flesh-out" a national M&E capacity building strategy.

- To identify available M&E resources in the country (and beyond) will require a focused M&E resource mapping. As part of this mapping, a proposal for data flows and M&E responsibilities will be developed.

E. The "M&E of M&E"

- The M&E Work Group needs to conduct an evaluation of their own work plan to ensure accountability Ideally, this would involve an external, peer-review process

- Incentives and censorship for M&E performance and non-performance amongst programme implementing partners need to be implemented to ensure that organisations and individuals are held accountable for their role in national M&E.

F. National databases

It is necessary to develop and maintain (at least) two national databases:

- A programmatic database to house an exhaustive list of major HIV/AIDS service providers along with keys pieces of information regarding type, scale and geographic coverage of programme
- A national indicator database to allow for tracking, aggregation and updating of standardized and context specific national indicators would be central to a functional national M&E strategic information system

Data collected at the peripheral level are to feed directly into one or both of these national level databases

G. Emerging Programme Practices

There is an urgent need to document emerging HIV/AIDS programme practices in Lesotho, and establish a forum within NAC to discuss and disseminate this information. In this context, the components of high quality delivery of care, treatment and prevention services can be ascertained and mandates to routinely measure quality components be established

H. Partnerships to Generate buy-in to the NAS and National HIV/AIDS Programme Monitoring

- Partnerships with civil society need to be strengthened so that NGOs contribute to national M&E capacity building efforts.
- Advocacy and education to promote the value of M&E needs to be conducted in various stakeholder groups, including but not limited to the CCM, UN Theme group, HIV/AIDS Directorate at the MOHSW, other Ministries, and the LCN.
- Towards the end of full participation in a National Programme Monitoring System, the NAS will need to decentralize some aspects of M&E capacity building to the district levels. Ideally, DATFs would be the focal points for this effort.
- Activities to determine how to identify and address community level programme M&E needs, involvement and empowerment need to be undertaken. Proposals to engage the community programme in M&E capacity development and full participation in programme reporting must be consistent with programme partner M&E needs for progamme improvement. Part of this strategy will need to involve identification of appropriate information product(s) for community-level programme consumption.

- Form a pilot plan (in 1 or a few district) to establish M&E needs and appropriate responses in resource constrained facility-based settings. This may take the shape of an international twinning-type activities to bring in short-term M&E advisors to inform data collection plans at lower levels, strategize resource mobilization, and develop a skilled cadre of staff at the district level.

I. Research coordination and ethical review

- The role of BoS in HIV/AIDS data collection and use in relation to other HIV/AIDS M&E stakeholders needs to be more clearly defined.

- There is an urgent need to establish an independent ethics review board.

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VII. Appendices

A. Appendix (1): Participant List

Participant's Name	Participant's position	Participant Organization
Berger, Phillip	Physician	Ontario Hospital Association (Tsepong Clinic)
Desmoulins, Bertrand	Representative	UNICEF
Faranof, Daniella	Country representative	PSI
Lerotholi, Kelello	Consultant	Sechaba Consultants
Lesenyeho, Mokohena	Programmer	Health Planning and Statistics Unit, Ministry of Health and Social Welfare
Letsie, Mosilinyane	Director, Disease Control	Disease Control Unit, Ministry of Health and Social Welfare
Mahloane, Tumane	Economic Planner	Health Planning and Statistics Unit, Ministry of Health and Social Welfare
Malebo, Masentle	Senior Statistician	Bureau of Statistics
Maraka, Monaphathi	National Coordinator	USAID, Regional HIV/AIDS Programme – Southern Africa, and PACT
Martinelli, Silvio	UNAIDS M&E Technical Advisor	UNAIDS
Mashologu, Yolisa		Health Planning and Statistics Unit, Ministry of Health and Social Welfare
Matela, Ntilo	Epidemiologist	People Living Openly With AIDS
Mitchel, Marni	Director/Founder	Ontario Hospital Association (Tsepong Clinic)
Mohale, Mamonyane	Pharmacist	Christian Health Association of Lesotho
Mohlabi, Teboho	Primary Health Care Coordinator	Lesotho AIDS Programme Coordinating Authority
Moleko, Nthabiseng	Communications Director	Health Planning and Statistics Unit, Ministry of Health and Social Welfare
Nyopa, Maleqhoa	Chief Statistician	National Blood Institute
Nzima, Masauso	Principal Laboratroy Technologist	National AIDS Secretariat
Oden, Rolli	M&E Technical Advisor	Clinton AIDS Foundation
Ramonono, Teboho	Consultant	Health Planning and Statistics Unit, Ministry of Health and Social Welfare
Rangoako, Thabiso	Statistician	Disease Control Unit, Ministry of Health and Social Welfare
Rumisha, Davis	Data Supervisor	Health Planning and Statistics Unit, Ministry of Health and Social Welfare
Rwabuhemba, Tim	Technical Advisor	UNAIDS
Tsietsi, Matsotang	UNAIDS Country Coordinator	Bureau of Statistics
	Chief Statistician	

B. Appendix (2): Distribution of Government of Lesotho and CHAL Public Health Facilities delivering HIV and AIDS services by intervention area and region

	Berea	Butha-Buthe	Leribe	Mafeteng	Maseru	Mohales'hoek	Mokhotlong	Qacha's Nek	Quthing	Thaba Tseka
Total Number of health facilities	17	22	21	11	63	12	10	12	10	20
Number of facilities providing ART	1	3	2	1	4	1	1	1	1	2
Number of facilities providing HB(Care)	14	14	22		16					
Number of facilities providing PMTCT	1	3	2	1	4	1	1	1	1	2
Number of facilities providing STI services	7	2	9	3	18	3	2	1	2	5
Number of facilities providing TB services	6	16	21	11	62	12	10	12	10	20
Number of facilities providing VCT services*	1	3	2	1	4	1	1	1	1	2

Source: MoHSW, Disease Control Unit; MoHSW, Health Planning and Statistics Unit; and Christian Health Association of Lesotho. *Count does not include PSI VCT sites

C. Appendix (3): UN Expanded Theme Group Participants

Government of Lesotho	Lesotho AIDS Programme Coordinating Authority Ministry of Health and Social Welfare, Health Planning & Statistics Unit Ministry of Health and Social Welfare, STI/HIV/AIDS Directorate
Foreign Governments	Canadian Consulate Chinese Embassy Department for International Development, United Kingdom Deutsche Gesellschaft fur Technische Zusammenarbeit Development Cooperation of Ireland European Commission German Consulate South African High Commission United States Agency for International Development/Regional HIV/AIDS Programme US Embassy US Peace Corps
Non-Governmental Organizations	Catholic Relief Services Clinton AIDS Foundation International Dispensary Association Foundation Lesotho Congress of NGOs Ontario Hospital Association – Africa (Tse'pong Clinic) People Living Openly with AIDS Population Services International Positive Action Positive Health Prevention and Access to Care and Treatment – USA Support to International Partnerships against AIDS in Africa
United Nations Agencies	Food and Agriculture Organization GFATM Joint United Nations Programme on HIV/AIDS United Nations Children's Fund United Nations Development Programme The World Bank World Food Programme World Health Organization

D. APPENDIX (4): HIV/AIDS Document Centres

Bureau of Statistics:

The Bureau of Statistics (BoS) maintains a library, which only houses its documents and documents produced in collaboration with other ministries. All documents in the library are for sale. When the documents are first produced, ministries are given a certain amount as part of the dissemination process. After the initial dissemination, ministries must purchase additional documents. The library has regular, daily business hours and is staffed by a librarian. The library displays the most recent BoS documents. There is not an ordered system to house and maintain documents. It is not possible to browse the shelves. Documents must be requested by title from the librarian. It is possible to review a list of documents on the website (www.bos.gov.ls). There are many more documents listed on the website than appear to be available at the library. Documents are not available for download from the website.

Ministry of Finance and Development Planning

The 2002 Population Sheet available is supposed to be readily available at the Ministry. It was not available on request, but one hanging on a wall was removed and given to the exercise.

Ministry of Health Document Centre

The Document Centre maintains an electronic search engine for all documents contained in the centre. It is possible to search by name, title, and subject. We found 3 out of 52 documents desired from a list produced by using a keyword search "HIV/AIDS". All documents are paper-based and supposed to have document numbers, but we found many without a document number. The documents are not housed in a standardized order, but are simply stacked in vertical piles on shelves, although shelves tend to be divided by disease (HIV/AIDS, TB, etc) .

Sechaba Consultants

There is a small library / resource centre at Sechaba Consultants HIV/AIDS relevant documents are housed on one shelf of one bookcase. They are numbered, but the numbers do not seem to relate to any order. One must browse through the shelf and through vertically stacked piles on the floor next to the bookcase to find relevant titles. The library is a reading room; however, to get a copy of the documents, one must purchase a copy of a document. If the document is unavailable, then there is a M0.60 per page fee for photocopying.

E. Appendix (5): Stakeholder Responsibilities

Stakeholders	Outlines of Responsibilities
National AIDS Commission	Making use of the data to monitor and evaluate the overall national response to HIV/AIDS
CEO NAC Secretariat	The CEO should be responsible for: • Promoting the M&E system within the public and private sectors, and civil society, where possible· • Use information from the M&E system to inform the national response Ensure that sufficient resources (financial and human) are available to implement the M&E system
National M & E Technical advisor(NAC)	As M & E technical advisor , this person will be responsible for: • Assisting the NAC to develop an overall M&E coordination plan, with manuals, systems, procedures, tools, a data base, flowcharts for data and clearly specified institutional roles and responsibilities and an implementation plan and budget • Strengthening NAC's monitoring systems, to ensure sound output and process monitoring • Supervise the implementation of the GFATM M & E plan • Supervise the implementation of the overall national M & E plan
M & E Manager (NAC)	The M & E manager at NAC is the pivot around which the M & E system will be functioning. This person will be responsible for: • Coordination of the implementation GFATM HIV/AIDS M & E plan • Coordination of the implementation National HIV/AIDS M & E plan • Arrange the dissemination of all information products as defined in this document • Ensure that all data is received for the GFATM HIV/AIDS M&E report – sending reminders and requests for information to all persons/agencies responsible for data sources (as defined in this document)
Data entry Clerk	The data entry clerk will enter activity report forms into the Access data base and send this data to the M & E advisor and manager for analysis
Institutions responsible for data sources commissioned by NAC	These agencies' responsibilities will be clearly defined in the agreement between NAC and the agency. However, in general terms these agencies will be responsible for providing good quality data sources that are based on international best practice, and that is relevant to the M&E system, as defined in this document.
Implementers of HIV/AIDS Interventions funded by GFATM investments	The Implementers of HIV/AIDS interventions funded by GFATM investments will be responsible for: • Completing the programme activity report Form on a monthly basis and submit it to NAC or its designated sub-contractor • Utilising the information products from LAPCA for decision making

F. Appendix (6): Strategic Information Systems Assessment Technical Workshop Participant Organizations

Government of Lesotho	Bureau of Statistics
Foreign Governments	Ministry of Health and Social Welfare, Disease Control Unit Ministry of Health and Social Welfare, Health Planning & Statistics Unit Centers for Disease Control and Prevention
Non-Governmental Organizations	Development Cooperation of Ireland United States Agency for International Development/Regional HIV/AIDS Programme Action Aid – Support to International Partnerships against AIDS in Africa
United Nations Agencies	CARE-Lesotho Christian Health Association of Lesotho Lesotho Congress of NGOs Ontario Hospital Association – Africa (Tse'pong Clinic) PACT-Lesotho Population Services International Support to International Partnerships against AIDS in Africa The GFATM
	Joint United Nations Programme on HIV/AIDS United Nations Children's Fund United Nations Development Programme World Health Organization

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May her soul rest in eternal peace.

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