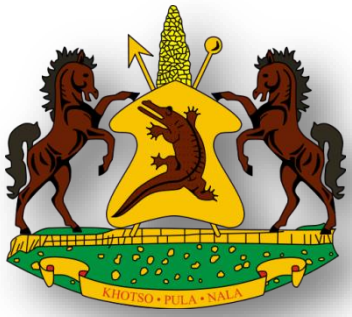

Revised National Monitoring and Evaluation (M&E) Plan on HIV

2014/15 – 2017/18

Revised March 2016

FOREWORD

The revised 2014/15-2017/18 Lesotho Monitoring and Evaluation (M&E) Plan for HIV response is based on the revised and extended 2011/12-2017/18 National Strategic Plan on HIV with strong elements of the Investment Approach. The current plan is designed to track and assess the core HIV programmes, critical enablers and developmental synergies, whose main goal is to reduce new HIV Infections and keeping people alive on treatment by 2020. In addition, it is designed to respond to reporting needs of Government of the Kingdom of Lesotho, Development Partners including the Global Fund, UN Family, US Government, and all international and national implementing partners, private sector, academia and researchers.

As one of the principles of "Three Ones", the 2014/15-2017/8 M&E Plan for HIV was revised with the main objective of strengthening systems and capacities for data collection and collation, and tools to improve the monitoring and evaluation of the AIDS response. It also emphasizes the need to strengthen the effective flow of information at all levels –facility, community, district and national. In addition, the M&E plan also outlines how information will be generated, packaged, disseminated and used by different partners at national, regional and international levels for programme design and implementation.

The revision of this M&E Plan spanned a period of two months –February- March 2016, and built on the earlier 2011/2-2015/16 M&E plan on HIV which followed key phases: preparation and planning; assessment of M&E structures and leadership; human resource availability and capacity needs; data sources; collection, flow and reporting; information use; M&E planning and integration; revision of the Plan and a stakeholder validation and consensus building workshop. In the absence of a National AIDS Commission (NAC), the Ministry of Health facilitated the roll-out of the 2011/2-2015/16 M&E plan to all partners and stakeholders involved in the AIDS response countrywide. With the re-establishment of NAC, the Ministry of Health will co-lead the implementation plan.

The M&E plan revision was led, managed and coordinated by Ministry of Health with technical support from the UN Family, UNAIDS in particular. It is worth mentioning that the revised M&E plan was subjected to external and internal reviews and validation. Also, assessment of the M&E systems and practices gathered from all categories of partners and stakeholders involved in the AIDS response informed the development of this plan. Furthermore, a rigorous, transparent, participatory and evidence-based process was used in determining the baseline values, targets, implementation period, and activities and their associated costs.

Finally, the implementation and tracking of annual results requires technical, financial and human resources and the collective will and total commitment of all partners. I wish to implore all national and international partners in the AIDS response to align their M&E plans to this national strategic document. As we move towards ending AIDS by 2020, it is my profound hope and trust that we will all stay on course and remain committed in the remaining of implementation period.

Dr Molotsi Monyamane
Minister of Health

ACKNOWLEDGEMENT

The revision and subsequent development of the 2011/2-2015/16 M&E plan has been a collaborative effort from the Ministry of Health, technical partners, and the Strategic Information technical working group. The Technical Support Facility (TSF) for Eastern and Southern Africa provided technical support through an International consultant, Mr Bernad Mwijuka, with financial support from the UN Family.

A number of key individuals and organisations supported the Ministry of Health during the revision and development of the current national Monitoring and Evaluation Plan on HIV. The MOH thus acknowledges the support of the following key individuals and organizations or agencies who committed their time into ensuring that the document is successfully completed. Particular gratitude is directed to:

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United States Government PEPFAR Program

ABBREVIATIONS AND ACRONYMS

ABC	Abstinence Be faithful and Condomise
AIDS	Acquired Immuno-Deficiency Syndrome
AIS	AIDS Indicator Survey
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ANC	Ante Natal Care
ART	Antiretroviral Therapy
AU	African Union
BCC	Behaviour Change Communication
BOS	Bureau of Statistics
BSS	Behavioural Surveillance Survey
CBO	Community Based Organisations
CCAC	Community Councils AIDS Committees
CCM	Country Coordinating Mechanism
CCP	Comprehensive Condom Programming
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CGPU	Child and Gender Protection Units
CHBC	Community Home Based Care
CITC	Client Initiated Testing and Counselling
CPWA	Children's Protection and Welfare Act (2011)
CRC	Convention on the Rights of the Child
CRIS	Country Response Information Systems
CSO	Civil Society Organisations
DACC	District AIDS Coordinating Committee
DHS	Demographic and Health Survey
DHIS2	District Health Information System
DPSC	Directorate of Policy Strategy and Communication
EID	Early Infant Diagnosis
ESP	Essential Services Package
EU	European Union
FBO	Faith Based Organisations
FIDA	Federation of Women Lawyers
FP	Family Planning
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with AIDS
GOL	Government of Lesotho
HAART	Highly Active Antiretroviral Therapy
HASI	HIV and AIDS Stigma Index
HDI	Human Development Index
HIV	Human Immune Virus
HMIS	Health Management Information Systems
HTC	HIV Testing and Counselling
IC	Infection Control
ICF	Intensified Case Finding
IDU	Injecting Drug Users
IEC	Information Education and Communication
IPPA	Independent Private Practitioners Association

IPC	Interpersonal Communication
IPT	Isoniazid Prevention Control
ISIA	Independent Sector Institute Assessment of the HIV and AIDS Sector
KAP	Knowledge Attitudes and Practice
KYS	Know Your HIV Status
LBTS	Lesotho Blood Transfusion Services
LCMPA	Legal Capacity of Married Persons Act
LCS	Lesotho Correctional Services
LDHS	Lesotho Demographic and Health Survey
LMPS	Lesotho Mounted Police Service
LOMSHA	Lesotho Output Monitoring system for HIV and AIDS
LVAC	Lesotho Vulnerability Assessment Commission
M&E	Monitoring and evaluation
MARP	Most At Risk Populations
MC	Male Circumcision
MCHC	Maternal and Child Health Care
MCP	Multiple Concurrent Partners
MDG	Millennium Development Goals
MDR-TB	Multi-Drug Resistance Tuberculosis
MGYSR	Ministry of Gender, Youth, Sports and Recreation
MOAFS	Ministry of Agriculture and Food Security
MOET	Ministry of Education and Training
MFDP	Ministry of Finance and Development Planning
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MOJCS	Ministry of Justice and Correctional Services
MOLCA-HR	Ministry of Law, Constitutional Affairs and Human Rights
MOLE	Ministry of Labour and Employment
MOLGC	Ministry of Local Government and Chieftainship
MOP	Ministry of Police
MOSD	Ministry of Social Development
MOT	Modes of Transmission (study)
MSM	Men who have sex with other Men
MTCT	Mother To Child Transmission
MTR	Mid-Term Review
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NISSA	National Information System for Social Assistance
NCPI	National Composite Policy Index/ Instrument
NSDP	National Strategic Development Plan
NDSO	National Drug Service Organization
NGO	Non-Governmental Organisation
NOCC	National OVC Coordinating Committee
NOP	National Operational Plan
NSP	National Strategic Plan
NSPVC	National Strategic Plan for Vulnerable Children
NTCP	National Tuberculosis Control Programme
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PREP	Pre Exposure prophylaxis
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PHDP	Positive Health Dignity and Prevention

PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-initiated Testing and Counselling
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PNC	Post Natal Clinic
PWD	People With Disability
RBM	Results Based Management
RH/FP	Reproductive health / Family planning
S&BC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SACU	Southern African Customs Union
SADC	Southern African Development Community
SAM	Services Availability Mapping
SGBV	Sexual and Gender Based Violence
SOA	Sexual Offences Act
SRCE	Self Regulating Coordinating Entities
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex Worker
TasP	Treatment as Prevention
TB	Tuberculosis
TIP	Trafficking in Persons
TTI	Transfusion Transmissible Infections
TWG	Technical Working Group
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VC	Vulnerable Children
VMMC	Voluntary Medical Male Circumcision
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WLSA	Women and Law in Southern Africa Research and Education Trust
XDR-TB	Extensively Drug Resistance – Tuberculosis

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SECTION ONE: INTRODUCTION & BACKGROUND

1.1 INTRODUCTION

The Government of Lesotho revised the five year national HIV and AIDS Strategic Plan (NSP) 2011/12-2015/16 to enhance the strategic focus of the response interventions in 2013 and beyond. In revising the strategic plan, Lesotho shifted the planning paradigm to evidence-based planning and investing for results. The NSP has also mainstreamed gender and human rights in its operational strategies and performance indicators.

To guide effective implementation, the revised Strategic Plan, the matching Monitoring and Evaluation (M&E) Plan 2014/15 – 2017/18 has been revised to effectively serve as a guide and tool performance measurement of the national response and for monitoring of the effects and patterns of the HIV epidemic.

The national multi-sectoral response to HIV and AIDS is anchored in the broader national social and economic development framework. Key in this national development framework are the Lesotho National Strategic Development Plan (LNSDP) 2012/13 -2016/17; Lesotho National Vision 2020; the National health policy and the National Multi-sectoral HIV and AIDS Policy. The AIDS response is also guided by the global and regional level response frameworks and commitments including: the Millennium Development Goals (MDG); the 2011 United Nations High Level Meeting (HLM) Political Declaration on HIV and AIDS; UNAIDS Strategy 2016 – 2021 that emphasizes 90% of PLHIV to know their HIV status; 90% of PLHIV who know their HIV status are immediately enrolled for treatment; 90% of PLHIV on treatment are monitored for viralogical suppression of HIV; Catalysing the next phase of treatment, care & support and; Advancing human rights & gender equality.

- ✓ Landlocked and surrounded by South Africa with a surface area of 30,355 square kilometres
- ✓ Population is estimated at 1,876,633 people
- ✓ 56.6% of the population lives below the poverty line
- ✓ 314,000 children and adults living with HIV
- ✓ TB/HIV co-infection is 74%
- ✓ Adult HIV prevalence is 23% & 24.3% among Pregnant women
- ✓ HIV prevalence among
  - Sex workers - 72%
  - MSM – 32.9%
  - IDUs is unknown
  - Inmates – 31%;
  - Factory workers --42.7%;
- ✓ About 19,000 new HIV infections occur annually
- ✓ More than two-thirds of new infections occur within stable relationships
- ✓ About 60% of children and adults living with HIV do not access treatment
- ✓ 78% of patients enrolled in treatment are retained after 1st year of initiation
- ✓ 58% of women and 36% of men know their recent HIV status
- ✓ 42% of women and 33% of men have accepting attitudes towards PLHIV
- ✓ About 8% of PLHIV and TB are malnourished and in need of nutritional support
- ✓ 42% of all households with ART and TB clients are most vulnerable, while 30% known to be vulnerable

FIGURE 1: COUNTRY CONTEXT AND HIV EPIDEMIC

The guiding regional programming frameworks include; the South African Development Community (SADC) Maseru Declaration; and the African Union Roadmap for Shared Responsibility and Global Solidarity for HIV, TB, and Malaria in Africa.

1.2 COUNTRY DEVELOPMENT CONTEXT

The Kingdom of Lesotho is landlocked and surrounded by South Africa with a surface area of 30,355[i] square kilometres. The population is estimated at 1,876,633 people[ii]. Seventy-seven per cent (77%) and 23% of the population live in rural and urban areas respectively. Fifty eight per cent (58%) of the population is under 19 years of age. Women make up 51% of the total population.

Fifty six per cent (56.6%) of the population lives below the national poverty line. 43.4%[iii] live on one dollar a day and are considered to live in vulnerable households often headed by a female[iv]. The population growth rate has declined from 1.5% in 1996 to 0.08% in 2006. This is the lowest population growth rate in Southern Africa countries. Life expectancy at birth has improved from 45.9[v] in 2010 to 48.7 years in 2013[vi].

The current Gross Domestic Product (GDP) is US$1.6 billion with an estimated growth rate of 4.4% in 2010[vii]. The adult literacy rate is estimated at 89.6%, with 13% of the people aged 25 years and older having at least a secondary education.

Agriculture contributes 7% of the GDP while manufacturing contributes 17%. Diamond mining and quarrying contribute approximately 9% of the GDP. The contribution of service industry is estimated at 60%.

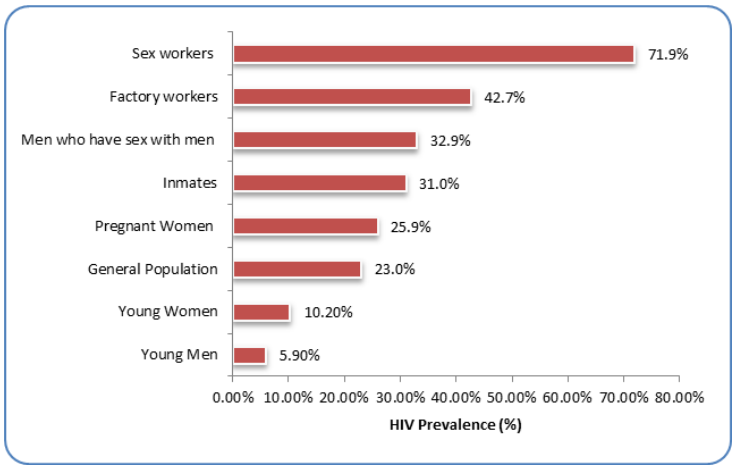
The main sources of revenue for Lesotho have been remittances from Basotho employed mainly in South Africa and other foreign countries, revenue from the Southern African Customs Union (SACU), and royalties from the export of natural resources such as water and diamonds. The Government of Lesotho, the mining sector in South Africa and the Lesotho textile industry are the major sources of employment[viii].

1.3 THE EPIDEMIOLOGY OF HIV IN LESOTHO

Lesotho has a generalised HIV epidemic, with possible small pockets of concentrated (i.e. men who have sex with men) sub-epidemics. HIV prevalence among people aged 15-49 is estimated 23%ix, x. HIV prevalence in urban areas is 27.2%, higher when compared to that of rural areas at 21.1%. The increased urban prevalence may be attributed to a number of factors including rural urban migrations where most people settle in informal settlements where vulnerability to HIV is increased when they exhibit higher risk taking behaviours such as transactional sex. The Modes of Transmission analysis report of 2009 noted that both urban and rural prevalence seems to be stabilising. Currently, 19,000 new HIV infections (17,000 among adults and 2000 among children) occur annually in Lesotho.

Data form the 2009 LDHS 2009 show that HIV prevalence is lowest (3.5%) among young people aged 15-19 years (women - 4.1%; men - 2.9%). Among adults aged 20-24 years, the prevalence is estimated at 16.3% (women - 24.1%, men - 5.9%)xi. The highest prevalence is among people aged 30-39 years at over 40%. Overall prevalence is higher in Women (26.7%) than in men (18%)xii aged 15-49 yearsxiii. It is highest (42.3%) among women aged 35-39 years and men (40.2%) aged 30-34 years.

Estimated HIV prevalence for 2014 is 23.4% and is projected to remain stable for next few years. However, new HIV data from the 2014 LDHS will confirm this assumption. The prevalence among pregnant women attending ANC was 28% in 2009, 24% in 2011 and 26% in 2013 (ANC Sentinel Surveillance 2013). Syphilis prevalence was 2% in 2009, 3% in 2011 and 3% in 2013 ANC sentinel surveillance. Prevalence of syphilis in urban area (3%) was slightly higher than that of rural (2%). The 2011 survey also revealed that ANC clients with a positive Syphilis test had higher HIV prevalence of 38.8% in 2011 and 40% in 2013. Among syphilis none-reactive clients the prevalence was 23.9% in 2011 and 25% in 2013[1]. Traditional high risk populations – MSM, sex workers and inmates - have HIV prevalence ranging between 31% and 72%.



The prevalence varies among different subgroups as may be seen in the chart. HIV prevalence among sex workers is estimated to be 3 times higher than for the adult population (72% compared to 23%), largely because of widespread violence, criminalization, stigma and discrimination, lack of funding and targeted programmes; HIV prevalence among MSM is estimated to be 1.4 times higher than for the adult population (33% compared to 23%); and prevalence of HIV in prison populations is estimated to be 31%1.3 times higher than in the general population (31% compared to 23%). Nearly one-in-three (31%) of the estimated 2500 inmates are living with HIV.

The Modes of Transmission analysis of 2009 indicates that the prevalence differentials between women and men could be due to biological susceptibility, age of sexual debut and age-mixing patterns in sexual relationships[xiv]. The Modes of Transmission (2009) data analysis [xv] shows that almost half of new infections are likely to come from individuals with one sex partner 48.5% (35.2% - 61.8%). Individuals with more than one sexual partner will contribute 23.75% (16.5%-21.0%) while partners of individuals with more than one sex partner will contribute 21.5% (15.3% - 27.7%). Sex workers will contribute 0.5%, while their clients are expected to contribute 0.7%. However, the partners of clients of sex workers will contribute up to 1.75% (1.7%-1.8%). Overall discordance in males is estimated at 7.2% while in women it is estimated at 9.2% (LDHS, 2009). The HIV epidemic is mostly heterosexual and the risk factors include both cross border and internal migration, high risk sex
An estimated 3-4% of all new infections is likely to occur among men who have sex with men (MSM) and their female partners. At the time of this review, there were no data on injecting

[1] Lesotho HIV Sentinel Surveillance 2013

drug users (IDU) in Lesotho. It is assumed that blood transfusion will not contribute to new infections because 100% of donated blood is screened for HIV as a standard procedure.

1.4 Goals and Objectives of the M&E Plan

The overall Goal of the M&E plan is to support the generation and use of strategic information in decision making and optimal resource allocation for national AIDS response.

The specific objectives are

i. To increase capacity and strengthen systems for leadership, organization, planning, partnerships, coordination of HIV and TB monitoring, evaluation and management
ii. To increase human resource, logistical and strategic capacity and systems for monitoring and evaluation
iii. To enhance systems and capacity for routine HIV and TB programme data collection, management, support supervision and data quality assurance
iv. To increase capacity and systems for routine logistics and supplies monitoring and quality assurance
v. To strengthen capacity and systems for routine HIV and TB financial monitoring, budget and expenditure analysis
vi. To strengthen capacity and systems to generate strategic HIV and TB information through biological and behavioural surveillance, surveys and research and
vii. To strengthen capacity and systems for HIV and TB Information dissemination, utilization, learning & Knowledge Management

1.5 Guiding Principles and considerations

The M&E plan revision/ development process and provisions have been guided by a number of key principles, factors and considerations below:

a. Anchorage to the National HIV and AIDS Strategic Plan, overall, M&E and Strategic Information Systems and Development Frameworks
b. Responsive to key national, regional and global reporting requirements (including Annual Joint Reviews, AU Roadmap, UN Global Commitments (HLM) Commitments, Global AIDS Response Progress Reports (GARPR) , 90-90-90 targets and Universal Access Reports
c. Promotion of the “three ones” principle to have a ”one M&E System” for HIV & AIDS Response.
d. Multi-sectoral thematic focus
e. Coverage of entire results chain / measurement levels:
f. Responsiveness to all programme levels:
g. Responsive to entire length of the Programming Cycle

h. Comprehensive but specific enough coverage to the Information on HIV epidemic, response status and access for all "populations groups" including the "Most at Risk or (MARPs) or "key populations"
i. Compliance with contemporary and technically acclaimed approaches and requirements such as the 12 features of a good Strategic Information, WHO new treatment guidelines, GFATM top indicators and New Funding Model eligibility
j. Effectiveness and Efficiency of strategies
k. Mainstreaming and in-built synergies
l. Evidence based, experiential learning and "best practice" promotion and transfers
m. Contextual relevancy and technological appropriateness
n. Partnerships and Networks promotion and development
o. User-friendliness for ease of application by all categories of stakeholders
p. Standardization and respect to innovation and peculiar contexts
q. In-built resource mobilization and human resource capacity development for Sustainability
r. Promotion of national leadership and ownership

1.6 M&E PLAN REVISION AND DEVELOPMENT PROCESS AND METHODOLOGY

The initial development process of the 2011/12-2015/16 took place between February and March 2014 and assumed five (5) interlinked and overlapping stakeholder participatory phases of: Planning; Assessment; re-vision/ re-formulation; Validation and; Popularization. The plan revision/development methodology appraised by the multi-sectoral Technical Working Group (TWG) coordinated by MOH. The methods adopted were: briefings, key informant Interviews and group consultative meetings from all relevant stakeholders – Government, CSOs including PLHIVs, FBOs, private sector, academia and development partners including UN and USG. The Ministry of Health and International consultant led the development process. The follow-on 2014/15-2017/18 M&E Plan revision was undertaken during the months of February and March 2016 and was led by the ad hoc national M&E working group.

1.7 STRUCTURE AND ORGANIZATION OF THE M&E PLAN

The M&E Plan examines the status of monitoring and evaluation in the national response; presents the results framework of all the core programme areas and other strategic interventions; the results corresponding indicators; the needed data sources; the data collection, management and reporting; the institutional and management arrangements; and the costed implementation plan.

The M&E Plan is structured into the following FIVE sections:

Section 1: Introduction and Background
Section 2: Status of the Monitoring and & Evaluation System
Section 3: National Core Indicators and Results Framework

Section 4: Data Sources, Collection, Flow, Management and Reporting
Section 5: Institutional, Management and Coordination Arrangements & Costing

The M&E plan also has an annexures of costing of the M&E plan & Implementation Plan and Summary status of the M&E in the national HIV response as of 2015; assumptions for target setting; and 2015-2020 national and district targets by core intervention areas

1.8 M&E Plan Foundations and Development Process

The 2011/2-2015/16 M&E plan revision and development was led by the Office of the Prime Minister and coordinated by the Ministry of Health (MOH) through a stakeholder participatory process. A cross section of partners involved in the national HIV and AIDS multi-sectoral response were engaged. These were civil society organisations (CSOs) including People Living with HIV, faith based organisations (FBOs), Private Sector, and Development Partners including the United Nations System (UN) and United States Government (USG). The follow-on 2014/15-2017/18 M&E Plan revision was undertaken during the months of February and March 2016 and was led the ad hoc national M&E working group.

The key response situation and response analysis that served as foundations for the M&E Plan revision were: the 2012 Independent Sector Institutional Assessment of the HIV and AIDS Sector (ISIA) under taken in 2012; the NSP 2011/12 – 2015/16 Mid Term Review (MTR); the Health Sector 2012/2013 Joint Review (AJR); the NSP 2011/12 – 2015/16 revision and; finally; the M&E Plan Revision as presented in Figure 2.

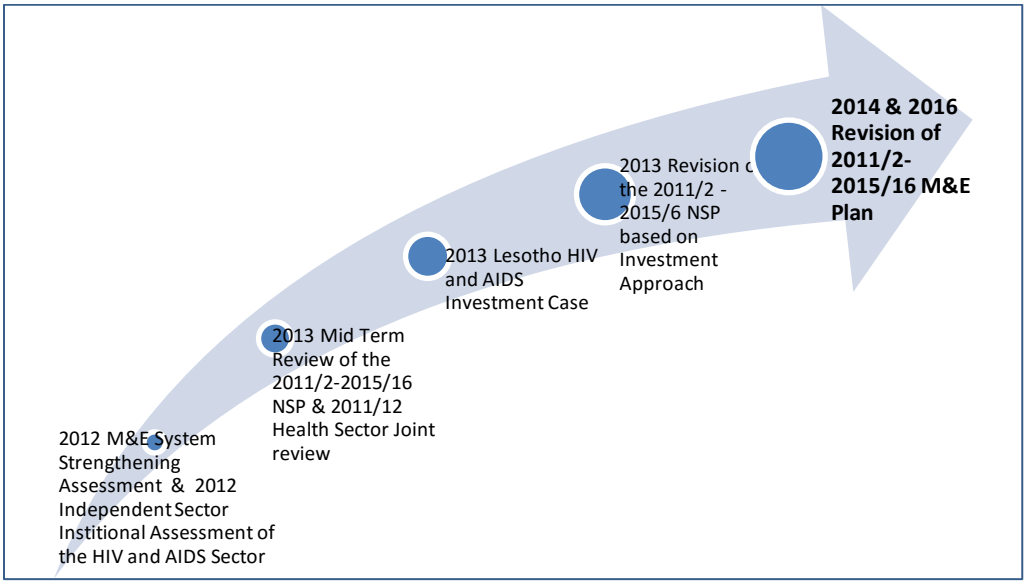


FIGURE 2: FOUNDATIONS OF THE M&E PLAN REVISION/ DEVELOPMENT

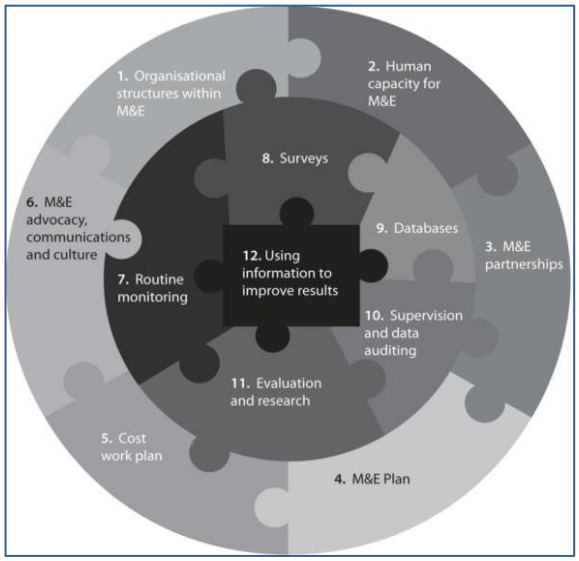
SECTION TWO: STATUS OF MONITORING & EVALUATION SYSTEM

2.1 INTRODUCTION

This section present the current status of the monitoring and evaluation including the existence, structures, functionality or operational realities and contexts in line with the twelve (12) thematic elements/ components as key features of a good National HIV and AIDS M&E system (Figure 3). In addition to the 2012 MESST assessment, a rapid M&E system assessment was undertaken in February 2014 to inform the development of the revised M&E Plan on HIV. The key findings of this assessment are presented below and details are in the assessment report with a summary matrix.

2.2 CURRENT STATUS OF THE 12 COMPONENTS OF AN M&E SYSTEM

FIGURE 3: FEATURES OF A GOOD M&E SYSTEM



2.2.1 ORGANIZATIONAL STRUCTURES WITH M&E FUNCTIONS

The national HIV and AIDS response in Lesotho has previously ever attained a full complement of "three ones" with the National AIDS Commission (NAC) as the overall "one National Coordinating Authority"; there is a recently revised 2011/12- 2017/18 National Strategic Plan and the response has also been steered towards a semblance of a "one M&E System".

NAC was the lead agency for M&E of HIV and AIDS response under the overall leadership and stewardship of the Office of the Prime Minister until December 2011 when it was closed. The lack of a NAC adversely affected the building of a "one M&E system". However, NAC was re-established again in December 2015 based on the findings of an Independent Sector Institutional Assessment of the HIV and AIDS Sector.

Overall, the organizational structures responsible for M&E, with either exclusively or specifically M&E and as part of programme management functions, are in place with in most categories of stakeholders and are functional with varying effectiveness and efficiencies. Government ministries, district councils and decentralized departments such as the ministry of Health, national CSOs, international CSOs/ NGOs, development partners, networks and self-regulating associations have M&E units or desks which are however weak. All categories of stakeholders consulted highly valued the having of such structures.

The MOH through the directorates of M&E, Planning and Disease control is currently fostering the "one M&E system to some extent". This is mainly through the auspices of its technical working group (TWG) that has multi-sectoral membership. The MOH has made impressive efforts to steer the M&E perspectives of the multi-sectoral response with support from the office of the Prime Minister, Ministry of Development Planning, other government departments, development partners and other national stakeholders.

Some of the notable multi-sectoral M&E related achievements registered under the multisectoral M&E stewardship over the past two years include the development of the Lesotho two-year Global AIDS Response Progress Report (GARPR); the development of the National HIV and AIDS Strategic Plan 2011/12-2015/16; the setting of district service coverage for the health sector interventions and; the now underway revision of the national HIV and AIDS multi-sectoral M&E Plan 2011/12- 2015/16.

However, the absence of a National AIDS Commission (NAC) for a four-year period has led to disjointed M&E actions at national and district levels from a multi-sectoral perspective with the more significant effect being with the non-health sector based response.

2.2.2 Human Capacity for Monitoring and Evaluation

The MOH, line ministries, NGOs, development partners and umbrella organizations for self-regulating or coordinating entities have M&E units (Divisions/Directorate/units/ desks) responsible for M&E, management information systems and research with staff.

The units have written mandate to execute its M&E functions. Government M&E responsible structures have both employees in established positions and adhoc /provisionally partners supported posts for M&E at National, sectoral and district and facility levels. These include M&E officers, Research officers, AIDS officers in District Health Management Teams (DHMTs); data entry clerks, information officers dedicated full-time to data management and M&E. M&E responsibilities are clearly defined in job descriptions at both National and district level responsible staff

The consultations revealed that there has not been regular M&E system assessments in both public and non-public sectors, at sectoral levels, at national and decentralized level since 2012 to adequately establish the strength of the M&E Human Resources (often required every 2-3 years). The staff have been trained in HIV related M&E at all levels using SADC HIV and AIDS M&E training curricula. JICA also supported about 4 staff to be master trainers in M&E based on the HIV regional curriculum. The different projects also undertake human resource development of their M&E staff.

However, there is no coherent national M&E capacity building programme and work plan. There is also no M&E HR capacity reference directory of training curricular, trainers and trained personnel and any well-structured University / college level comprehensive M&E training tailored to then national response needs.

2.2.3 Partnerships for the M&E System

There are a number of task oriented partnerships, working groups, committees and other fora' that support M&E needs on the AIDS response including national reports, studies, data validation, target setting and information sharing. The MOH has a Strategic Information (SI

TWG) with a multi-sectoral membership and active participation of stakeholders aligned mainly to the health sector.

The TWG also supported the development of the Lesotho 2-year Global AIDS Response Progress Report (GARPR); the development of the National HIV and AIDS Strategic Plan 2011/12-2015/16; The revised NSP has revised to cover until 2017/18 and; the now underway revision of the national HIV and AIDS multi-sectoral M&E Plan 2011/12- 2015/16.

However, the performance of the current arrangements, structures and expected partnerships for planning, coordination and technically supporting the management of M&E system is not to the desired levels beyond the health sector. There is no national M&E TWG that is inclusive on most stakeholders and the national CSOs and the other line ministries being the most invisible. The partnerships at the decentralized levels have also to a great extent been rather inactive since the closure of NAC secretariat. There is dire need to sustain a semblance of a national multi-sectoral M&E TWG that is very inclusive of all sectors and categories of actors even as the response transitions to the restored NAC or an equivalent multi-sectoral coordination body.

2.2.4 Multi- Sectoral M&E Planning

Lesotho has a draft multi-sectoral M&E Plan for the period 2011/12 – 2015/16 aligned to the then Strategic Plan. The draft plan was a key strategic reference documents for the response in general and M&E programming in particular. This draft National HIV and AIDS Multi-sectoral five-year plan had most of the good elements to strengthen the national M&E system.

This M&E plan that was never launched is not out of tandem with the revised NSP. The M&E plan is now under revision partly to align it with the revised NSP 2011/12 – 2015/16 results framework, indicator sets, and management arrangements and; to the requirements of the new GFATM funding model.

At the sectoral level, the MOH is yet to revise its overall M&E plan. Other ministries, individual CSO organizations and networks or self-regulating entities such as Lesotho Network of AIDS Service Organization (LENASO), Lesotho Network of People living with HIV (LENEPWHA), Lesotho Council of NGOs (LCN), Lesotho Inter-religious AIDS Consortium (LIRAC) and Christian Health Association of Lesotho (CHAL) have M&E activities reflected in their respective annual work plans.

2.2.5 Costing and annual roll out of a National HIV M&E Workplan

The draft M&E plan though not launched had been costed. The revised M&E Plan will have a detailed annualized workplan costed along with the National Operational Plan of the revised NSP. A review of the work plans indicated that at the MOH, other line ministries, individual CSO organizations and networks or self-regulating entities have M&E activities costed.

2.5.6 Communication, Advocacy and Culture for M&E

The consultations established that the Government of Lesotho, development partners and other national stakeholders attach high priority to the development of M&E across all development and service delivery in all sectors, including the HIV and AIDS Sector, and at

decentralized level. This commitment has translated into establishment of M&E positions, counterpart funding for some key M&E activities, utilization of the data in planning and involvement of the relevant M&E and MIS staff in planning and programme reviews. Financial resources were made available by government and partners to support M&E systems strengthening especially in the development of tools, reporting and M&E staff training. M&E Advocacy, Culture and practices could be improved with regular M&E reviews/ assessments and inclusion of having M&E structures in appraisals by HIV and AIDS Granting agencies and other funding sources including those to central government ministries and to decentralized districts and entities.

2.5.7 Routine Programme Monitoring

Routine HIV programme monitoring in the Lesotho national AIDS response is mainly undertaken by the MOH and the donor funded projects. The MOH and the projects have developed routine data collection tools, data verification, quality assurance and audit mechanisms and reporting, tracking and feedback. The MOH, Ministry of Social Development and health sector projects have data collection, reporting tools, data quality assurance mechanisms and report tracking. Routine data on ART, PMTCT, male circumcision, condoms, TB, HTC and STI is regularly collected

Generally, organizations that generate routine health data report to DHMT but do not (or are not expected) to compile their own regular (ie quarterly and national) institutional composite reports. Reports on their national performance status are mainly provided by the MOH central level.

A number of challenges are also faced including: late receipt of routine reports through the HMIS mainly due to the backlog of the data entry and different report generation expectations; lack of adequate training of data entry clerks to support data entry; underreporting partly fuelled by the forwarding of incomplete data gap created by the lack of LOMSHA- Lesotho Output Monitoring System for HIV and AIDS. This is also compounded by the closure of NAC with non-health sector routine data, where it exists, is either not being collated and not reported into the national service coverage reports; too frequent changes in the data capture tools; the HMIS where the routine data is entered mainly gives out the data on request and not the expected quarterly reports usually needed for reporting in the national HIV and AIDS response; lack of consensus on the need or extent of parallel reporting as a strength to enable data collaboration or as a source of inconsistence.

2.5.8 Surveys and Surveillance

The Lesotho national response gets vital information on the monitoring of epidemic from surveillance and surveys. The MOH generates a surveillance report every 2 years. A number of population based surveys have been undertaken including: the Lesotho Demographic and Health Survey 2009; 2009 drug resistance survey by EGPAF, HIV surveillance survey in the private textile factories by ALAFA, 2007, 2009, 2011 & 2013 ANC Sentinel Surveillance on HIV and syphilis.

Other notable achievements include: modes of transmission study (MOT) undertaken in 2009; 2013 and 2015 Cohort analysis studies; 2014 SW and MSM Biologic and Behavioural survey and size estimates; Drug resistance in 2009 and 2014; 2014 Demographic Health Survey.

NASA was done in 2009 & 2011; targets and estimates of indicator values generated by the National Estimates team; annual Health sector reviews are conducted and the report is disseminated to the national partners; Lesotho Correctional Services HIV Sero-Prevalence and Behavioural Study in 2011 and; 2013 stigma index survey for PLHIVs.

2.5.9 National and sub national data bases

Impressive achievements have been registered with the functioning of the now web based Health Management Information Systems (DHS2) data base under MOH; previously the LOMSHA under NAC and the Social Welfare Response Information (SWARIS) under Ministry of Social Development. The functioning and adequacy of these data bases varies a lot and is not yet to the satisfaction of stakeholders. The stakeholders are expecting more than what these databases are currently able to effectively offer to the response. The data bases also need inter-operability, need to generate all the data needed in the breakdown needed; are yet to be decentralized and do not generate the information outputs as per the frequency needed by the response M&E system.

2.5.10 Support supervision and data auditing

The status of support supervision and data auditing is associated with the performance of routine monitoring. The MOH and the directly supported donor project coordination offices are the ones undertaking regular and quarterly supervisory visits. However; the joint supportive supervision is not done adequate. There is need to develop and implement joint support supervision quarterly between related NSP core programmes or strategic intervention areas and developing capacity of the districts, self-regulating entities to undertake regular supporting supervision and have written guidelines for support supervision and data quality assurance. There was no documented evidence of the last data audit of key HIV programmes although data verification exercises are undertaken and findings not widely shared.

2.5.11 Evaluation and Research

MOH has developed a national health sector HIV and AIDS Research agenda. The ministry has a draft Strategic Plan for Health Research (SPHR) 2013/14 – 2017/18 that includes HIV and AIDS priorities. MOH also has an established technical and ethical research committee with elaborate terms of reference as required under the National Health and Social Welfare Research Policy (NHSWRP) of 2008. This committee's TORs are generic to the whole health sector but are guided by the World Health Organization (WHO) guidelines on technical and ethical research.

However, there is a need to: develop a current research agenda beyond the health sector; support other key actors and especially universities to have review boards that can enhance the capacity of the response to meet research needs and including the non-health sector; establish HIV and AIDS research networking group and regularly produce research and evaluation inventory or compendium

2.5.12 Data Dissemination, Utilization and Documentation

For the results of an M&E system to have effect on policy development and programming, the right information needs of stakeholders must be identified and provided for in generation and availability of the user friendly information products.

Currently the information products from both routine and non-routine sources include: quarterly progress reports; surveillance reports; assessments reports; survey reports; strategic and operational plans; brochures; fact sheets; study Reports; data bases and websites and; policy guidelines. These information products have been shared through a number of ways including: national & international conferences, stakeholder programme planning and reviews, stakeholder forum held twice a year, websites, data bases and hard and electronic circulated mails.

However a number of stakeholders indicate that is "not readily accessed" when needed. The stakeholders feel that information (not raw data) is "guarded" from them and is mainly accessed at dissemination meetings and only "through contacts" or "connections" that are more personal than official. Above all, documentation of best practices are rarely available and replicated although Lesotho has a number of identified best practices or models of HIV including Mother Baby Pack, Know Your Status Campaign, Revitalization of HIV Prevention model etc.

SECTION THREE: NATIONAL MONITORING AND EVALUATION FRAMEWORK

3.1 INTRODUCTION

The national multi-sectoral response is anchored in the broader national social and economic development framework. At national level the response priorities are aligned to Vision 2020, National Strategic Development Plan 2012/13 -2016/17, National health policy and the National Multi-sectoral HIV and AIDS Policy. At the global level the NSP is responsive to Lesotho's regional and global commitments and in particular the Millennium Development Goals (MDG), the 2011 Political Declaration on HIV and AIDS, the SADC Maseru Declaration, and the African Union Roadmap for Shared Responsibility and Global Solidarity for HIV, TB, and Malaria in Africa.

The following are the priority commitments for the Kingdom of Lesotho for its national HIV and AIDS response

i. Reduce new HIV infections by 50% by 2018.
ii. Reduce AIDS related deaths, and in particular PLHIV with TB/HIV co-infection by 2018.
iii. Eliminate mother to child transmission while keeping mothers alive.
iv. Improve efficiency and effectiveness of the national response planning, coordination and service delivery.

It is also anticipated that effective implementation of these objectives, will contribute to Lesotho's achievement of the 90-90-90 targets

3.2 NSP CORE PROGRAMMES, CRITICAL ENABLERS AND DEVELOPMENT SYNERGIES

To achieve the above commitments, Lesotho has prioritised five-core programme, whose effective and efficient implementation is likely to result to the desired results. The prioritisation is premised on both national and global evidence of the programmes efficacy. It is in these programmes that Lesotho will invest adequately to ensure achievement of desirable results. These programmes are -

i. Treatment, Care and Support.
ii. Elimination of Mother to Child Transmission of HIV.
iii. Voluntary Medical Male Circumcision.
iv. Condom promotion and distribution.
v. Prevention of new infections among key populations through targeted programmes.

Successful implementation of the above-prioritised core programmes will also depend on the extent critical social and programme enablers are identified and adequately implemented. The social enablers that have been identified include: political commitment and advocacy, laws, legal policies, and practices, community engagement and mobilization, stigma reduction, use of mass media and local responses to change risk environment. The programme enabler's range from community centred design and delivery, programme communication (to galvanise support for behaviour change

programmes), procurement and supply chain management, gender equality and gender-based violence interventions, research and innovation in addition to engaging local policy decision makers.

TABLE 1: NSP CORE PROGRAMMES, CRITICAL ENABLERS & DEVELOPMENT SYNERGIES

Core programmes/interventions 1. Treatment Care and Support –ART and TB 2. Elimination of Mother to Child Transmission (eMTCT) 3. Voluntary Medical Male Circumcision (VMMC) 4. Condom Promotion and Distribution **5.** HIV Prevention among Key Populations at Higher Risk of HIV Infection	**Enabling environment interventions** 6. Laws, legal policies and practices 7. Stigma Reduction and Discrimination 8. Human Rights, Gender Equality and Gender-Base violence 9. Coordination and Management 10. Resource Mobilization and Management 11. Strategic Information Management
Cross-cutting programmes/interventions 12. Social and Behaviour Change Communication (SBCC) 13. HIV testing and Counseling (HTC)	**Development Sectors Synergies /interventions** 14. Social Protection of Households affected by HIV and AIDS 15. Health & Community Systems Strengthening

Development Synergies between social protection, systems (health and community) strengthening, food security, care and support of orphan and vulnerable children will be strengthened. The NSP will support interventions promoting a paradigm shift from social welfare to social development through multi-sectorial coordination with joint work plans and budgets

As is the national development framework, the National HIV and AIDS M&E framework guarantees focus on: multi-sectoral response, multi-thematic interventions, participation by both public and non-public sectors and all programme and service delivery levels; the national, the decentralized an community levels.

3.3 NATIONAL CORE INDICATORS AND RESULTS FRAMEWORK

This section is the main axis of the M&E Plan since it presents the performance framework of the national HIV response guided by the revised NSP. The performance framework presents the overall impact, outcome and output results contributed to by all the NSP interventions by core programmes, critical enablers and development synergies; the matching indicators, data sources, baseline and set target values over the remaining NSP duration (2015/16 – 2017/8).

The indicator definition used in the performance framework is mostly referenced from the GFATM (http://www.theglobalfund.org/en/me/documents/toolkit/), WHO Indicator Registry (http://www.who.int/gho/indicator_registry/en/) and UNAIDS Indicator Registry (http://www.indicatorregistry.org/).

According to Table 2 below, a total of 90 indicators will be tracked and used to monitor and evaluate the implementation of the revised NSP - 5 impact indicators, 39 Outcome indicators and 46 output indicators. Further details are shown in table 5.

TABLE 2: INDICATORS SUMMARY MATRIX

	Indicators		
NSP Intervention Areas or Programmes	**Impact**	**Outcome**	**Output**
Core programmes track	**4**	**8**	**22**
1. Treatment Care and Support	1	1	6
2. TB/HIV		1	2
3. Elimination of Mother to Child Transmission (eMTCT)	2	1	7
4. Voluntary Medical Male Circumcision (VMMC)		1	3
5. Condom Promotion and Distribution		2	2
6. HIV Prevention among Key Populations	1	2	2
Cross-cutting programmes track	**1**	**8**	**5**
7. Social and Behaviour Change Communication (SBCC)		7	2
8. HIV testing and Counselling	1	1	3
Enabling environment track		**9**	**8**
9. Laws, legal policies and practices		2	1
10. Stigma Reduction and Discrimination		1	1
11. Human Rights, Gender Equality and Gender-Base violence		2	1
12. Coordination and Management		2	1
13. Resource Mobilization and Management			1
14. Strategic Information Management		2	3
Development Sectors Synergies track		**5**	**11**
15. Social Protection of Households (Populations Or Highly vulnerable population groups) affected by HIV and AIDS		3	2
16. Health & Community Systems Strengthening		2	9
GRAND TOTAL	**5**	**39**	**46**

3.4 PERFORMANCE INDICATORS AND TARGETS

Performance indicators are arranged in the following order –

a. overall impact indicators
b. core programme indicators: treatment, care and support; eMTCT, VMMC, condom promotion and distribution, key populations
c. cross-cutting programme indicators: SBCC and HTC;
d. critical enabler indicators – laws, legal policies and practices; stigma reduction & discrimination; Human rights, Gender Equality and Gender-Based Violence; coordination & management; Resource mobilization; strategic information management
e. development sectors synergies: social protection of households and highly vulnerable population groups
f. Health and community systems strengthening

3.4.1 OVERALL IMPACT INDICATORS

The key results or impact of implementing the NSP HIV interventions is to reduce the new HIV infections and to keep those on treatment alive and improving quality of life. Four (4) prevention indicators and one treatment indicator are tracking impact results of the HIV interventions.

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
Impact	Prevention	Adult 15-49 HIV Incidence	2.0% 2014 UNAIDS Estimates			1.5%		<1%
Impact	Prevention	Percentage of most-at-risk populations who are HIV infected	SW -71.9% MSM – 32.9%					CSW <50% MSM <20% TBD
Impact	Prevention	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	2012 -34.9 %	50%	60%	70%	80%	>90%
Impact	Prevention	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	MTCT at 6 weeks - 5.90% (2014 Spectrum)			<3%		<2%
Impact	Treatment	ART retention 12 months after initiation	2015 – 82.7%	85%	85%	>85%	>85%	>85%

3.4.2 TREATMENT, CARE & SUPPORT INDICATORS

The key results that will be achieved under treatment, care and support is to enrol at least 80% of the eligible paediatric and adult people living with HIV on lifesaving antiretroviral treatment and retain at least 85% of them after 12 months of initiation. The rapid scale-up of the treatment programme will also be measured by these indicators.

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	TREATMENT , CARE AND SUPPORT							
	ADULT AND PAEDIATRIC ART							
	Result 1: At least 80% of eligible Adult and Child PLHIVs reached with lifesaving antiretroviral treatment and ART services scaled up by 2020							
Outcome	ART	Percentage of adults and children living with HIV receiving antiretroviral therapy	2015 - Adults 41%	55%	65%	70%	75%	80%
			2015 - Children 40%	60%	70%	75%	80%	85%
Output	ART	Number of adults (15+ years) with advanced HIV infection receiving antiretroviral therapy (ART)according to national guidelines	2015-121,661	171,600	208,650	230,300	252,750	276,000
Output	ART	Number of children (0-14 years) with advanced HIV infection receiving antiretroviral therapy (ART)	2015- 7,644	10,800	12,600	12,750	12,800	12,750
Output	ART	Number of health facilities that offer ART according to national guidelines	2015-198	200	210	220	220	230

Output	ART	Number of adult HIV+ patients enrolled in ART receiving nutritional support		31,200	32,100	32,900	33,700	34,500
Output	ART	Number of paediatric HIV+ patients enrolled in ART receiving nutritional support		10,800	12,600	12,750	12,800	12,750
Output	ART	Number of village health workers trained	2013 - 1036	7000		7000		>7000
Output	ART	Number of health care workers trained in provision of ART according to national and international standards		>500		982		982

3.4.3 TB/HIV INDICATORS

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	TB/HIV							
	Result 1: TB deaths in people living with HIV reduced by 50% by 2020							
Outcome	TB/HIV	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	2015- 79% (MoH)	80%	85%	90%	95%	>95%
Output	TB/HIV	% of TB patients tested positive for HIV and on ART	2015-73%	70%	68%	65%	60%	<60%
Output	TB/HIV	Number of health care workers trained on management of co-infections according to national and international standards		>500		982		982

3.4.4 EMTCT INDICATORS

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	ELIMINATION OF MOTHER TO CHILD TRANSMISSION OF HIV (eMTCT)							
	Result 1: Mother-to-child transmission of HIV during pregnancy, child birth and breastfeeding reduced to less than 5% by 2020 Result 2: Access to lifesaving treatment for HIV+ pregnant women increased to 90% by 2015/16 and AIDS-related maternal deaths substantially reduced							
Outcome	eMTCT	Percentage of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission	2014 – 74%	80%	85%	87%	90%	95%
Output	eMTCT	Number of pregnant women who received HIV counselling and testing for PMTCT and received their test results	2014 = 25,331	39,900	42,750	45,600	47,880	51,300

Output	eMTCT	Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission	2014 - 8165	8,800	9,350	9,570	9,900	10,450
Output	eMTCT	Number of health facilities providing the minimum package of PMTCT services according to national standards or guidelines	2010 -191	207	207	210	210	218
Output	eMTCT	Number of infants born to HIV positive women receiving ARV prophylaxis within two months of birth	2012 – 5580 MoH DNA PCR Database	>10,000	>10,000	>10,000	>10,000	>10,000
Output	eMTCT	Number of health care workers trained in the provision of PMTCT services according to national and international standards	2013 -600	650	700	700	800	>900
Output	eMTCT	Number of HIV-positive pregnant women receiving therapeutic nutritional support	TBD	1,000	1,000	1,000	1,100	1,100
Output	eMTCT	Number of children receiving PCR testing	2012-10531	10,450	10,450	10,450	10,450	10,450

3.4.5 Voluntary Medical Male Circumcision (VMMC) Indicators

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	Voluntary Male Medical Male Circumcision (VMMC)							
	Result 1: Quality Voluntary Male Medical Scaled Up and 80% of males circumcised by 2018							
Outcome	VMMC	Percentage of men age 15-49 who report having been circumcised	15-24 = 42.1% 15-49 =51.6% LDHS, 2009					15-24 = 70% 15-49 =80% LDHS, 2009
Output	VMMC	Number of medical male circumcisions performed	2014 - 36245	60,000	60,000	45,000	25000	
Output	VMMC	Number of health facilities providing medical male circumcision according to national standards	2014-35	35	>35	>35	>35	>40
Output	VMMC	Number of health workers trained in performing medical male circumcision	2014->35	>100	>150	>200	>250	

3.4.6 Condom Promotion and Distribution Indicators

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	CONDOM PROMOTION AND DISTRIBUTION							
	Result 1: Condom use among key populations and general population engaged in risky sexual behaviour increased by at least 50% by 2020							
Outcome	Condom Promotion for KP	Percentage of SW and MSM reporting use of a condom with their most recent partner	SW-83% MSM- 74% 2014 IBBSS			SW->90% MSM->80%		

Outcome	Condom Promotion	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	15-49yrs women 53.9% Men 65.3%					15-49yrs >women 60% >Men75%
			15-24yrs women 67.2% Men 78.2% LDHS, 2014					15-24yrs >women 80% > Men 80%
Output	Condom Promotion	Number of male condoms distributed	30.0 million MoH, 2014	32,3m	34,2m	36,1m	36,1m	38,0m
		Number of female condoms distributed	1.33 million MoH, 2014	1,7m	1,8m	1,9m	1,9m	2,0m
Output	Condom Promotion	Number of health care workers, outreach workers and peer educators trained in condom promotion and distribution	2012 - 55	120	120	120	120	120

3.4.7 HIV Prevention among Key Populations & SBCC Indicators

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	PREVENTION							
	Result 1: Key Populations and their clients adopt safer sexual behaviour & reduce sexual transmission of HIV by 50% by 2020							
	SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION							
	Result 1: Comprehensive knowledge about HIV and AIDS increased by at least 50% by 2020 and general and key populations adopt safer sexual behaviour practices							
Outcome	SBCC	Percentage of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by age and sex)	15-24yrs: women 37.6% Men 30.9% LDHS 2014					15-24yrs: women 55% Men 45%
Outcome	SBCC		15-49yrs: women 42.3% Men 32.2% LDHS 2009					15-49yrs: women 63% Men 48%
Outcome	SBCC	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (disaggregated by age and sex)	15-24yrs women 7.8% Men 22.1% LDHS 2009					15-24yrs women 4% Men 11%
Outcome	SBCC	Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months (disaggregated by age and sex)	15-49yrs women 6.6% Men 26.7% LDHS 2014					15-49yrs women <4% Men 15%
Outcome			15-24yrs women 5.1% Men 22.7% LDHS 2014					15-24yrs women 3% Men 15%

Output	SBCC	Number of young people (15-24) and adults (15-49) reached with SBCC interventions	Adults Young People	713,400 437,000	787,800 439,000	865,200 440,000	945,000 441,000	1,026,400 441,000
Output	KP	Number of key populations reached with SBCC interventions	SW MSM Inmates	1,950 3,480 1,560	2,310 4,165 1,690	2,760 4,880 1,890	3,105 5,625 2,100	3,550 6,350 2,240

3.4.8 HIV TESTING AND COUNSELLING INDICATORS

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	HIV TESTING AND COUNSELLLING							
	Result 1: HTC services scaled up and at least 80% of the general population know their HIV status by 2020							
Outcome	HCT	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results	15-49yrs women 58% Men 36.4% LDHS, 2014					15-49yrs Women80% Men 65%
			15-24yrs women 54% Men 28.6% LDHS, 2014					15-24yrs women 80% Men 60%
Output	HCT	Number of people who received counselling and testing for HIV and received their test results	2015 – 619,167	905,400	996,450	1,089,200	1,185,000	1,284,000
Output	HCT	Number of fixed and mobile facilities providing counselling and testing according to national guidelines	2013 - 287	287	300	300	310	320
Output	HCT	Number of health care workers and other service providers trained in counselling and testing according to national guidelines	2014-~800	800	800	900	900	900

3.2.9 LAWS, LEGAL POLICIES & PRACTICES & STIGMA REDUCTION AND DISCRIMINATION INDICATORS

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	Laws, Legal Policies & Practices							
	Result 1: Existing laws and policies are strengthened for social protection of the PLHIV and other vulnerable groups							
	Result 2: Stigma & discrimination towards PLHIVs is reduced by 50% by 2020							
Outcome	SD	Percentage of population expressing accepting attitudes in relation to people living with HIV	15-49yrs women 42.3% Men 32.9% LDHS, 2009					15-49yrs women 60% Men 50%
			15-24yrs women 41.3% Men31.1% LDHS 2009					15-24yrs women 60% Men 50%
Outcome	HR	Percentage of PLHIV experiencing stigma & discrimination as a result of HIV status	2013>10% Stigma Index					
Outcome	SD	Percentage of PLHIVs reported to have had their human rights violated	2013 - 10% Stigma Index					< 5%
Outcome	LLPP	System for officially documenting cases of stigma and discrimination exist	2015, NO					YES
Output	LLPP	Number of PLHIV support groups trained in human rights and advocacy issues	2012-150	200	200	200	300	300

3.2.10 HUMAN RIGHTS, GENDER EQUITY AND GENDER BASED VIOLENCE INDICATORS

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	human rights, gender equity and gender based violence							
	Result 1: Gender coordinating mechanisms related to HIV/AIDS established and functional							
Outcome	Gender	Gender coordinating mechanisms related to HIV/AIDS established and functional	2015, NO			YES		YES
Output	Gender	Number of policy makers and program planners trained on gender mainstreaming	2014>30	50		60		80

3.2.11 Coordination, Decentralized Response

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	COORDINATION, DECENTRALIZED RESPONSE, RESOURCE MOBILIZATION AND MANAGEMENT							
	COORDINATION & INSTITUTIONAL STRENGTHENING							
	Result 1: Coordination mechanisms at national and sub-national levels strengthened							
	Result 2: National HIV/AIDS Strategic Plan is funded							
Outcome	Coordination	Community, district & national AIDS coordinating structures strengthened and fully functional	2015-No			Fully Functional		Fully functional
Outcome	Coordination	% of government's contribution to total HIV/AIDS spending annually	2014 – 26%	30%	40%	40%	45%	50%
Output	Coordination	Number of coordinating structures (CACCs, DACs, CSOs, FBOs, Ministries & Private Sector) strengthened & fully functional to coordinate the AIDS response	2015=Not strengthened and fully functional			Fully Functional		Fully functional
Output	Financial Resources	Amount of funds mobilised to fund the NSP	2013 = $87.26mn					$600mn

3.2.12 Vulnerable Children and Households

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	IMPACT MITIGATION							
	VULNERABLE CHILDREN (OVC) & HOUSEHOLDS							
	Result 1: Social and economic protection is ensured for orphans and vulnerable children.							
Outcome	OVC	Percentage of OVC aged 0-17 whose households received free basic external support in caring for the child	2011 - 8.3% MoSD			25%		50%
Outcome	OVC	Proportion of the poorest households who received external economic support in the last 3 months.	2011 - 8.3% MoSD			25%		50%
Outcome	OVC	Current school attendance among orphans and non-orphans aged 10-14	Total Ratio =0.99; Male Ratio=0.98; Female Ratio=0.99 LDHS, 2009					Total Ratio = 1.0; Male Ratio=1.0; Female Ratio=1.0
Outcome	OVC	Percentage of mothers or primary caregivers who report having identified a standby guardian who will take care of the child in the event she/he is not able to do so	women 13.4%, men 22.6% LDHS, 2009					women 25%, men 50%

Output	OVC	Number of OVCs provided with support (education, health, Psychosocial Support, paralegal, nutrition, cash transfer)	2011- 27,000	30,000	40,000	50,000	60,000	70,000
Output	OVC	Number of vulnerable households provided with support (education, health, Psychosocial Support, paralegal, nutrition, cash transfer)	2013- 20,000	25,000	30,000	40,000	45,000	50,000

3.2.13 Procurement and Logistics Management System

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	PROCUREMENT AND LOGISTICS MANAGEMENT SYSTEM STRENGTHENING							
	Result 1:Logistics and supply chain management system strengthened and stock-out of major commodities reduced							
Outcome	PSCMS	% of facilities that experienced stock-out of commodities annually (by ARVs, OI drugs, Condoms, reagents)	TBD	< 10%		< 10%		< 10%
Output	PSCMS	Number of facilities experiencing stock-out of male & female Condoms annually	TBD	< 5		< 5		< 5
Output	PSCMS	Number of facilities experiencing stock-out of ARVs annually	TBD	<5		<5		<5
Output	PSCMS	Number of facilities experiencing stock-out of OI drugs annually	TBD	< 5		< 5		< 5
Output	PSCMS	Number of facilities experiencing stock-out of laboratory reagents annually	TBD	< 5		< 5		< 5
Output	PSCMS	Number of staff trained in procurement and logistics management system according to national and international standards	25	30	30	30	30	30

3.2.14 Laboratory Services

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	LABORATORY SERVICES STRENGTHENING							
	Result 1: Laboratory services are strengthened for effective treatment							
Outcome	Laboratory Services	Percentage of health facilities with capacity to perform clinical laboratory tests for HIV patients	**2013-90%**	**95%**	**95%**	**95%**	**100%**	**100%**
Output	Laboratory Services	Number of laboratories with capacity to perform clinical laboratory tests for HIV patients including CD4 and Viral Load monitoring according to national guidelines	2015-18	18	18	20	20	20
Output	Laboratory Services	Number of health care workers trained in the provision of laboratory-related services	2014-20	20		20		20

		according to national and international standards						
Output	Laboratory Services	Number of viral load tests performed according to national and international standards	2015 - 18232	28,100	31,600	32,800	34,000	35,200

3.2.15 M&E, RESEARCH & INFORMATION MANAGEMENT

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	TARGET YEAR				
				2016	2017	2018	2019	2020
	M&E, RESEARCH & INFORMATION MANAGEMENT							
	Result 1: M&E, research and knowledge management systems at the national and sub-national systems are strengthened							
Outcome	M&E	% of health facilities submitting reports on time	2012 - 92% MoH			95%	95%	100%
Output	M&E	Number of HIV/AIDS related researches and studies conducted	2013 - 5			10		10
Output	Training	Number of staff trained in M&E, surveillance, DHIS and or HMIS	2014-125	250	250	250	300	300

3.2.16 Other Key Indicators

Key Populations
Percentage of Key Populations who are HIV-Infected
Number of MSM, SW, inmates & factory workers for tested for HIV & received their results
Number of HIV+ MSM, SW, inmates & factory workers receiving ART
Number of male and female condoms distributed among MSM, SW, inmates and factory workers

STI Treatment
Percentage of people reporting symptoms suggestive of STIs and seeking treatment from clinical services (disaggregated by sex)
Number of people with STIs treated at health facilities
Number of health care workers and other service providers trained in STI treatment according to national guidelines

Sexual and Reproductive Health
Percentage of health facilities offering integrated family planning services as part of PMTCT
Number of health care workers trained on integration of sexual reproductive health services and PMTCT services
Number of health facilities with integrated SRH and HIV services

Post Exposure Prophylaxis
Percentage of health facilities with post-exposure prophylaxis (PEP) available
Number of people provided with post-exposure prophylaxis (PEP)
Number of health facilities with HIV post-exposure prophylaxis (PEP) available
Number of health care workers trained in the provision of PEP services according to national and international standards

Blood Safety
Percentage of donated blood units screened for HIV in a quality assured manner
Number of donated blood units screened for HIV in a quality assured manner
Number of health facilities strengthened to screen blood and other TTIs in quality assured manner
Number of health care workers trained in blood safety according to national and international standards

Opportunistic Infections Treatment Number of adults and children enrolled in HIV care and treatment receiving cotrimoxazole prophylaxis Number of health care workers trained on OI management according to national and international standards
PLHIV/HBC Number of PLHIV network members receiving cash transfers and/or alternative livelihood support Number of home based care kits distributed
TB/HIV Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV Number of HIV positive clinically malnourished clients in need of therapeutic or supplementary food accessing the food
Enablers and Synergies Existence of comprehensive HIV/AIDS care and support policies, strategies and guidelines.* Number of laws and policies reviewed to make them more supportive to HIV response. Number of local organizations provided with technical assistance for HIV-related policy development Number of organisations (public, private, NGOs) with active HIV Workplace Policies and programmes (Health and Wellness Programmes) Existence of a policy on SGBV Existence of national coordination guidelines developed with stakeholder consensus Existence of a National HIV and AIDS Resource mobilization strategy

SECTION FOUR: DATA SOURCES, MANAGEMENT & REPORTING

4.1 INTRODUCTION

Identification and description of the right and feasible or appropriate data sources is essential for the timely generation of the quality data needed for construction of the indicators presented in the performance framework.

Section four provides guidance on what sources of data will be vital for generating the needed data; how the data will be collected; how data and at what stage the data from different sources will be aggregated, analysed; stored, retrieved and or accessed when needed. The Section also outlines the reports and other information products to be produced; the arrangements for reporting, information sharing and feedback; the major data/information users and purposes for which data/information will be generated and; dissemination feedback arrangements.

4.2 KEY DATA SOURCES

The Monitoring and Evaluation Plan will make use of routine and non-routine / periodically generated data; primary and secondary data as well as quantitative and qualitative information. Over the plan period, 2016-2018, it is expected that data will be collected from the sources as summarized in table 3 below.

The table provides a summary of different categories of data sources; the institutions with lead responsibility for ensuring that the data is collected and analysed; the likely supporting partners; the frequency of collection; the current status or functionality of the source and when the next round of data collection is envisaged for the non-routine sources.

TABLE 3: KEY DATA SOURCES FOR THE NATIONAL HIV AND AIDS M&E PLAN

Data Source	Lead Institutions	Likely supporting partners	Reporting Frequency	Planned
Routine Programme Data				
1. Health sector programme data mainly covering: HCT, ART, PMTCT/ANC,STI, TB, Condoms, Laboratory (from HMIS or programme data bases or data sets)	MOH	WHO, PEPFAR, UNICEF, UNDP, EGPAF, ICAP, URC, PSI	Quarterly	
2. Non health public sector programme data	**NAC** , MoSD	Key projects	Quarterly	
3. Routine programme data from nonpublic sector- *(health, non-health sector interventions by nonpublic sector agencies ie Self Coordinating Entities (SCE) for CSOs, FBOs, CBOs, PLHIV networks, Private sector, Research.* COPAR (Community Programme AIDS reporting)	**NAC**		Quarterly	

Data Source	Lead Institutions	Likely supporting partners	Reporting Frequency	Planned
4. Field Monitoring and Support Supervision data (Separate and joint monitoring)	**NAC, MOH**	Ministries, SR/CE	Quarterly	
5. Sentinel surveillance surveys *(Plus non health surveillance)*	MOH & NAC	Ministries, SR/CE	Every 1- 2 years	2016 and 2018
Non Routine Sources				
6. Population based Bio and behavioral Surveys - Demographic and Health Surveys (LDHS), PHIA , TB Prevalence, ANC Sentinel Surveillance, Early Infant Diagnosis, ART Cohort	**MOH,** BOS NAC	PEFAR, GFATM, UN	2-5 years	2019 LDHS 2016-7 PHIA 2014 TB Study 2016, 2018 ART Cohort
7. Behavioural Surveillance Surveys (BSS)- usually population specific	**MOH,** BOS NAC	PEPFAR, GFATM, UN	Biennially (2-3yrs)	TDB
• IBBSS for Key Populations – SW, MSM	MoH, PACT	PEPFAR, UN, GFATM, PSI	(2-3yrs)	2017
• IBSS for factory Workers	PACT	GFATM, GoL	(2-3yrs)	2017/8
8. Stigma Index Survey & Nutritional & Vulnerability Assessment	LENEPWA	GFATM, UN	2-3 years	2016
9. Quality of Health services delivery and related HIV Services Assessments and Facility Surveys	**MOH, NAC,** Ministries	PEPFAR GFATM, UN	Biennially	TBD
10. HIV and AIDS Workplace Survey	MoLE	GFATM, UN	Every 2 -3 years	2017-8
Other Essential Assessments and Special Studies				
11. National Response Independent Assessment (including the Joint Annual Reviews- AJRs, Mid Term reviews (MTR) of various sectoral Strategic plans & End of NSP term reviews- ETR).	**NAC, Ministries**	PEPFAR, GFATM, UN	1-2 years, End of NSP review in 2017	AJR 2016-18 NSP review 2017/18
12. Stakeholders and Service Mapping	**NAC**	PEPFAR, GFATM, UN	Biennial	2016, 2018
13. Resource Mapping/NASA	**NAC, MoH**	PEPFAR, GFATM, UN, CHAI	Biennial	2016-2018
14. HIV /AIDS operational research & special studies including: OVC situation reviews, specific interventions; Modes of Transmission (MOT); Cohort analysis; Drug resistance , ART Adherence and retention study	**NAC,** MOH, BOS	PEPFAR, GFATM, UN	1-2 years	VC Sitan 2015 MoT 2017 Cohort Analysis 2016 Drug Resistance 2017
15. Social Economic Impact Studies (SEIS)	**NAC,** MOH, BOS	PEPFAR, GFATM, UN , MoF, MoDP	Every 3 -5 yrs	TDB
16. National HIV/AIDS Estimates and Projections	**NAC,** MOH,	UN, USG	Annually	2016-2018
17. Investment Case & sustainability analysis	**NAC, MOH, BOS**	PEPFAR, GFATM, UN	Every 2 years	2016/7

Institutions in* ***bold indicate the overall lead institution***

The next sub sections elaborate the set up and management of the respective data sources, especially with respect to the data flows within "one National HIV and AIDS M&E System in Lesotho". From each of these data sources there are a number of indicators that will be derived.

4.2.1 HEALTH SECTOR PROGRAMME DATA

MOH is responsible for monitoring the facility based and other community health HIV services including HTC, ART, TB-HIV, ANC/ PMTCT, MC and STI. The health sector is also responsible for the OI management, care, blood products safety, PEP, treatment & care programmes for Key Populations (MARPs), Universal precautions for infection control, and clinical care, condom distribution and Community /Home Based Care (CHBC). The MOH has developed (and will review) its own data collection tools for routine reporting of HIV/TB information on each of these services in collaboration with NAC and other implementing partners. Routine data from Procurement and Logistics Information Management System will also be generated related to commodity and drug stock-outs.

All health facilities in the country providing any of these services, regardless of ownership will be required to submit routine reports to the District Health Management Team offices and to MOH every month and aggregated quarterly reports. MOH will enter this data into the programme sub data bases and ultimately the HMIS, undertake the needed analysis and generate reports. The Ministry plans to decentralize the entry of data into the web based HMIS to the district level and subsequently to the hospital and lower health facility levels. This data source will also include data from national facilities such reference laboratories, blood bank, referral hospitals that may not be reporting to the DHMT, community health workers (CHW) and outreaches under taken by the health facilities.

For this data source the overall responsibility for supportive supervision and data quality assurance will lie with the MOH, assisted by the DHMT. The NAC and development partners working through the M&E TWG will support the MOH in supportive supervision and data quality assurance and occasional auditing.

4.2.2 NON HEALTH FACILITY PROGRAMME DATA

The National AIDS Commission (NAC) will review and harmonize existing data capture and reporting tools under the Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) especially for the non-clinical or non-health related services. The data collected is from non-clinical based interventions such as SBCC, CHBC, enabling environment interventions, Condom Promotion and Distribution; health and community systems strengthening interventions. This will enhance capturing of data on all non-health sectors HIV activities /services implemented by public, NGO and private sector implementing partners.

This routine data source requires strengthening and will not be limited to the ministries and NGOs whose activities have been funded through NAC but will cover all Government Ministries, Departments and Agencies (MDAs) and private sector institutions implementing HIV and AIDS activities. This source will be vital in production of routine data for computation of non-health output level indicators. Data on social protection captured under SWARIS will also be fed into the LOMSHA data base.

The implementing partners (IP) reporting under LOMSHA will include public sector ministries, departments and agencies; NGOs, Self-Regulating Entities (SRCE) such as LENASO, LENEPWHA, LIRAC, CBOs; private sector non clinical service providers. The IPs will complete the LOMSHA routine Service Coverage Reporting (SCR) forms or fill the web based/ electronic entry screens on a monthly basis, collate it on a quarterly basis. This data will be integrated into the respective organizational, sectoral or constituent data bases, undertake limited analysis of key parameters or output indicators and submit specified collated data

sets and summary reports to NAC. NAC will aggregate data and undertake data quality assurance, enter it into the LOMSHA data base, do further analysis to generate national output indicators and analytical reports and provide feedback to the implementing partners.

4.2.4 Field Monitoring and Support Supervision

Field monitoring and support supervision will be undertaken by organizations responsible for the HIV and AIDS response coordination including: NAC, MOH, other MDAs, Umbrella agencies/SRCE; DAC and Development Partners. Major National Project's coordination units such as GFCU, other PRs for Global Fund, USG and other partners constitute another key source of data through field monitoring and support supervision. These agencies/ organizations and projects will be expected to have guidelines for support supervision and quality assurance and share reports from the field monitoring and support supervision undertaken.

To strengthen decentralization of M&E as a critical part of the response management, the ministries, NGOs, SR/CE reporting under LOMSHA will be expected to support their respective district based offices to collate data, do quality assurance, give feedback to respective community level service providers, undertake limited analysis and report to District AIDS Committee/ coordinator. The IPs will be expected to undertake regular support supervision, quality assurance and occasional audits; track respective sector or constituencies reporting and provide feedback.

The field monitoring and support supervision reports will complement the data from the regular reporting generated using the SCR and other regular reports from the IPs or grantees and sub grantees, that have been entered in their respective sub institutional/ organizational and project data bases and produce reports as part of the routine progress data reports. The field monitoring and support supervision will also be vital for data quality assurance since the submitted reports will be collaborated with the raw data/ records at the SDPs. These reports will enrich the one M&E system.

4.2.5 HIV Surveillance and Surveys

The computation of outcome and impact indicators which are essential for measuring the mid-term and long-term results of the NSP rely on data generated through surveillance, surveys, operations or implementation research and evaluations. Population and facility based biological HIV surveillance along with the behavioural surveillance are an important component of this HIV and AIDS M&E plan to produce both bio-makers and social-behavioural indicators.

This source is very important since it generates information that is used to monitor trends and patterns of the HIV and STI epidemic. Surveillance and surveys are essential in determining the magnitude of Lesotho's HIV, TB and STI epidemic. Protocols and data collection tools for surveillance and surveys shall be based on international quality, technical and ethical guidelines from WHO, UNAIDS, Measure evaluation, PEPFAR customized into national guidelines. Key among the biological HIV/TB/STI surveillance in the Lesotho national HIV response will comprise:

- HIV & STI surveillance at ANC clinics
- HIV Sero prevalence survey or AIDS Indicator Survey (AIS)
- TB Prevalence Study

- Demographic and Health Survey plus (DHS+)
- Bio-behavioural surveillance among key populations including sex workers (SW), men who have sex with men (MSM), Inmates and mobile populations.
- Routine indicative prevalence data from health services. Indicative HIV, TB & STI prevalence data accruing from service delivery such as HIV/TB/STI screening clinics, PMTCT services and HTC and blood safety services will be continuously collected and analysed by the MOH to complement the other sources biological surveillance data.
- HIV Drug Resistance (DR)
- Early Infant Diagnosis of HIV
- ART Cohort Analysis
- CD4 and viral load monitoring central to patient and treatment monitoring.
- HIV and AIDS estimates and Projections will provide denominators and proxy incidence data

4.2.7 Quality of Health Care Survey

The MOH, which implements a largest proportion of HIV and AIDS interventions through health facilities, will be undertaking regular surveys of health facilities. These surveys will collect data on both the quantity and quality of these services provided at health facilities. The assessment of the quality of care or of HIV service provision required will be done as out sourced independent surveys. MOH will be responsible for the quality of health related HIV services survey every two years, resources permitting. The data from this source will also be submitted to NAC as part of one M&E system.

4.2.8 Thematic Evaluations, Assessments and Service Delivery Surveys

Specific thematic assessments and evaluations will also be undertaken to generate data that will deepen the understanding of the performance of the different thematic interventions. A specific Evaluation or assessment of ART, PMTCT, HTC, STI, Condom or VMMC programme is likely to produce deeper analysis and understanding of the key sub theme beyond what is routinely reported on ART or assessed as part of overall national or joint sector response or assessment as a track on prevention or treatment and care.

However, need for deeper investigation will not rule out the wider thematic component or wider response evaluation that examines the inter-relationships within a thematic area or even between different thematic areas (i.e. ART adherence and community and family level support structures that could fall in two NSP tracks or thematic areas). MOH and other thematic lead actors will be responsible for the quality of service delivery surveys and assessments expected every two years, resources permitting. The data from this source generated by the agencies commissioning the evaluation studies will also be submitted to NAC through the relevant sector or TWG as part of one M&E system.

4.2.9 Workplace HIV and AIDS Programme Survey

Workplace surveys covering a sample of public and private sector agencies shall be conducted to assess the adherence to the policy provisions and regularly assess the extent to which HIV and AIDS prevention and care have been mainstreamed in workplaces and programmes. The establishments to be surveys shall be selected on the basis of the size and nature of work force and also selected to provide a representative sample. These surveys undertaken every two years shall be steered by Ministry of Labour and Employment and the

findings fed into the one M&E System. The survey will be guided by workplace survey protocols produced by UNAIDS and ILO.

4.2.10 HIV AND AIDS STAKEHOLDERS AND SERVICE PROVIDERS MAPPING

National mapping of HIV and AIDS services/ interventions and Service providers will be conducted every two years. This will build an inventory and database at NAC, Districts, sectors and umbrella agencies and will greatly aid the, equitable planning, development, coordination and monitoring of the national response. This will minimize duplications, overcrowding of areas and inequitable Programme interventions.

Mapping information will support the production of service maps against geographical areas to produce an atlas and maps on different services in HIV and AIDS across the country. These maps will be useful for monitoring of service distribution and an analysis of possible relationship with observed levels of different outcome and impact indicators.

In addition to the stakeholder mapping, hotspots data on HIV/TB by district and sub-district levels will be generated to guide localized and underserved areas.

4.2.11 RESOURCE TRACKING, HIV/AIDS ACCOUNTS, BUDGET & EXPENDITURE ANALYSIS

An HIV/AIDS National Spending Assessments (NASA)/ Resource Mapping will be undertaken every one-two years, resources permitting. Data on HIV finances in regard to the sources (categories, domestic and external); amounts available and gaps facing the response; proportionate uses (between factors of production), beneficiary populations, funding channels and service providers will be derived from the undertaking of NASA.

This data is important for relating the expenditure on the prevention and care and treatment interventions against the patterns of the new infections and burden of the epidemic already established through modes of transmission studies and impact surveys. The care expenditure against the epidemic burden; cost effectiveness of various services or interventions as well the likely sustainability of the response funding will be ascertained.

To help institutionalize resource, a financial monitoring/ resource tracking form shall be circulated as part of LOMSHA to be filled at the end of every financial year. This will require stakeholders to submit summaries of information on resources accessed and committed to HIV and AIDS interventions in the financial year. NAC will also work with the Office of the Prime Minister, the Ministries of Finance, Development Planning and Local Government to institutionalize HIV/AIDS resource tracking into the financial reporting system of the accounting and expenditure framework over the next two years.

HIV resource tracking will also be complemented by HIV and AIDS budget analysis, national Accounts analysis and unit cost studies by independent researchers and advocacy groups. These analyses will be useful for advocacy purposes, promotion of cost-effective approaches and will also help in prioritization of interventions that will have been regarded as more effective and building an equitable response.

4.2.12 RESEARCH, EVALUATION AND SPECIAL STUDIES

A number of research undertakings in form of operations/ implementation research, investigative, basic research, special studies targeted at various thematic tracks of the

response will be undertaken as an important data source. Other investigations will assume an approach of data mining, meta-analyses and triangulation of the existing data sets to enhance the understanding of the epidemic and the effectiveness of the response.

This data source is vital for understanding the enabling and prohibiting factors at play towards the attainment of the planned results or changes contributed to or caused by the response interventions. These include the Modes of Transmission study, secondary data analysis of DHS+.

The National HIV and AIDS M&E Technical Working Group (TWG) and the National Research and Surveillance Committees will spearhead the development of a national HIV/AIDS research and evaluation agenda. This agenda will also incorporate the agenda of the health sector research agenda on HIV. The TWG will also streamline the TORs for the ethical and technical reviews, support the establishment, supervise the operations internal review boards and guide the reporting, regular compilation and dissemination of the findings.

The TWG will also produce the policy and programme implications and guides on translating evaluation and research findings into policy and programmes development. The TWG will also make deliberate drive to enhance local research capacity within the national public sector, private sector and training and research institutions.

4.2.13 Social Economic Impact Studies (SEIS)

Specific Socio Economic Impact studies by highly specialized organizations will be supported to help identify the macro effects and impacts of the epidemic on the various population groups and geographical areas. These studies will help in assessment of the contribution of HIV towards the attainment of the Millennium Development Goals (MDG), UN High Level Meeting (HLM) targets based of macro development indicators like the Infant Mortality rates, maternal mortality rates, human development indices including poverty index and economic growth rates. These will be commissioned by the ME TWG.

4.2.14 Independent Assessments, Annual Joint, Mid Term and End of term Reviews

Determination of the performance of the NSP will also be derived from annual Independent Response Assessments, Annual Joint Reviews (AJR), Mid Term Reviews (MTR) and End of Term (ETR) or Terminal Reviews. These assessments help to take stock of the progress made along the National operational plans and NSP targets and provide information for more strategic response re-programming.

4.2.15 HIV and AIDS Estimates and Projections

The National M&E TWG with support from NAC, MOH and BOS will ensure that the Estimates and Projection Package (EPP) and Spectrum modelling tools will continue to be used to establish baseline and target values of the M&E Plan. ANC sentinel surveillance, survey, and programmatic data all contribute to these models which are also used to estimate the number of PLHIV, deaths due to AIDS, number of OVC and pregnant women in need of prevention of mother to child transmission (PMTCT). This exercise is conducted annually.

4.2.16 Modes of Transmission (MOT) Study

A know your epidemic/ know your response study (KYE/KYR) or Modes of transmission (MOT) modelling based studies will be undertaken to determine expected number and patterns of new HIV infections. New epidemiological data from 2014 LDHS and 2015 ANC Sentinel Surveillance will be used to update the MoT. On the basis of a description of the current distribution to the new infections and patterns, priority interventions will be intensified. MOT synthesis will also assess the relative alignment of resource allocation to HIV transmission patterns and AIDS burden and guide the strategic directions of the response.

4.2.17 Cohort Analysis and Drug Resistance Surveys

Other important sources of information for the management of the response will be ART Cohort analysis and drug résistance surveys. These sources are now part of the response but they require strengthening. Cohort analysis will be undertaken, initially as separate studies but eventually as part of routine based on the extent to which the data collection tools will allow, to generate information on retention of patients on treatment and survival. Key information on ART retention at 6,12, 24 and 36 months will be generated and used in the ART adherence and retention programming. Drug resistance will be vital for informing policy with regards to planning for what drug regimens to avail to those failing on treatment.

4.3 Key Information Products

The M&E plan will ensure that the varying information needs of the different stakeholders are met by packaging the available information to meet the diverse needs. A number of information products, packaged differently for the different audiences will be produced including the following:

1. LOMSHA, HMIS, DHIS2, SWARIS Service Coverage Reports (Quarterly and Annual Progress Reports)
2. HIV Surveillance reports
3. Brochures, leaflets, fact sheets
4. Information and Assessment reports
5. NASA reports
6. Budget and expenditure analysis reports
7. Assessment and review reports (Joint Annual Review (JAR) reports, Mid Term Review (MTR) Reports
8. M&E Calendar & Wall Charts
9. Estimates and projections reports
10. Biennial UNGASS/GARPR Report
11. Research and Survey Reports
12. Assets registers and inventory, PSM reports
13. HIV interventions and providers Mapping reports and Mapping Atlas

To the extent possible and depending on the indicators being reported upon, the information products above will contain information/data analysed by sex, age group, social status/ groups and location (Districts and Community). This will be done to enhance the use of information to manage and plan the response.

4.4 Addressing Ad hoc and Emerging Information Needs

Much as the main reference frame for the M&E plan is NSP, the M&E plan will also cater for needs beyond the NSP results framework as long as the extra information needed is considered critical to the response management and performance assessment. From time to time, situations may arise where some stakeholders might have information needs that are not adequately covered by the information products in the National HIV/AIDS M&E Plan. Such requests shall be made in writing to NAC, MOH or other partners in the response which will in turn be considered whether they can be accommodated within available resources based on technical appraisal by the ME TWG.

Information needs may emerge that require re-analysis of the existing data or the collection of raw data beyond what is routinely collected. Depending on the information needs in question and their relevance to the management of the national response, the TWG will assist to commission an activity to generate such information with support from the relevant partners if resources are available or give the necessary technical guidance to the stakeholders in need of such information.

4.5 Data and Information flow arrangements in the National response

4.5.1 Introduction

With the different data sources and a multiplicity of actors, it is important that simple data, information flows and reporting framework is built and secures the consensus of stakeholders to synchronize and smoothen the M&E function in the response Figure 4. illustrates the flow of data/ information right from the community level service delivery points to the national repositories of the "one M&E System".

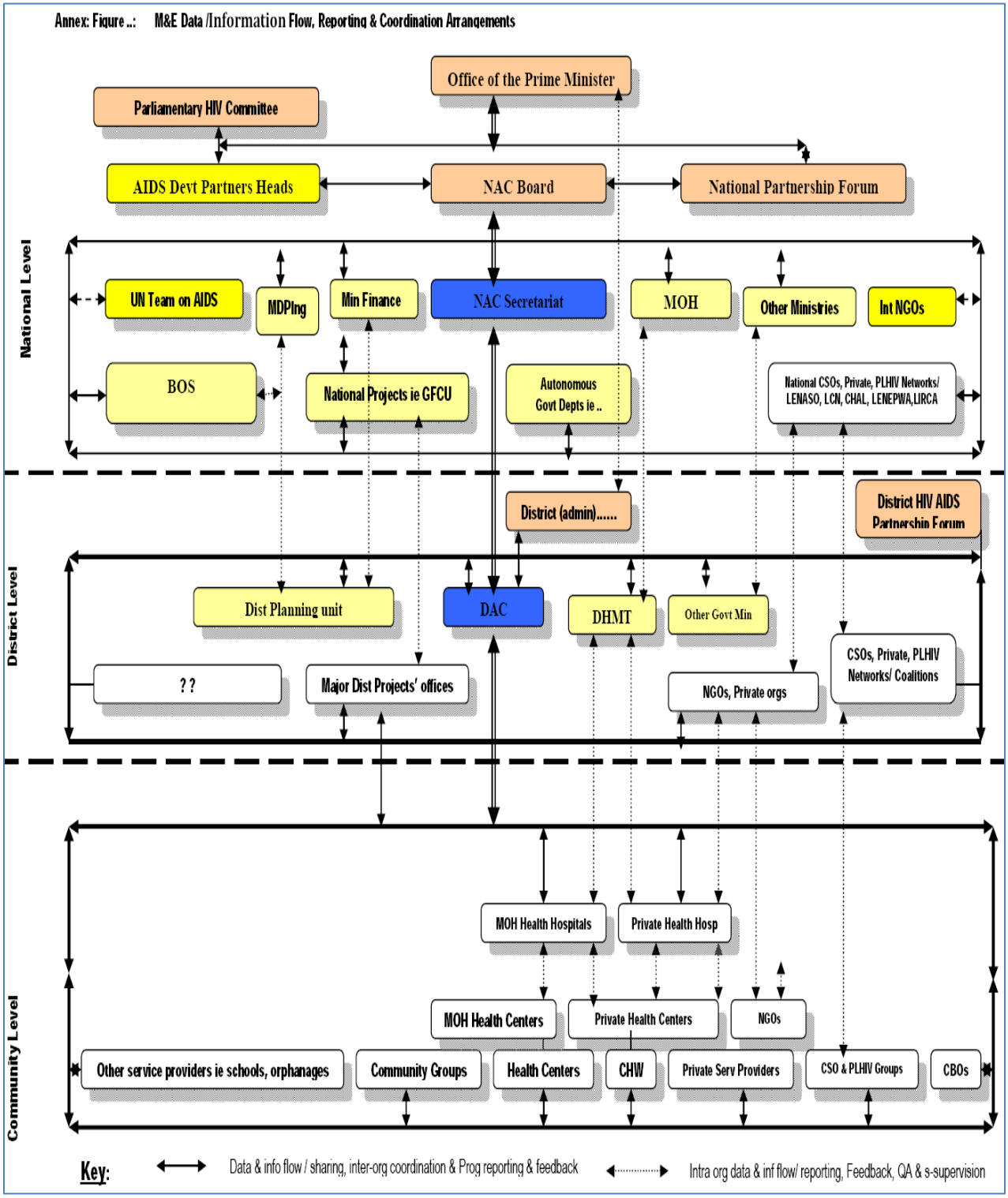
The structure also indicates the coordination, reporting and partnerships at each of the national, sectoral and district levels. The arrangements also provide for the continued reporting and other functional linkages expected between the individual agencies or offices in the field and their mother organizations /offices or sectors to which they are affiliated at national level.

The information flow system also emphasizes the need for feedback at all levels between those who generate and submit the information and those who collate, analyze, store and disseminate the information. NAC will support the establishment and functioning of fast data and information flows in the response through the multi sectoral response set up as elaborated by the NSP and the decentralized system represented by the Districts and self-coordinating entities (SCE) structures and adoption of relevant technologies.

4.5.2 Information Flow and M&E Coordination

Figure 3 indicates data and information flows, sharing, data quality assurance and feedback links, coordination of M&E and Research within the national HIV and AIDS response.

FIGURE 4: M&E INFORMATION FLOW



National level: Overall, the Office of the Prime Minister will be responsible for development of the necessary M&E policy guidelines, framework, strategies and directing /guiding the

coordination of the "one M&E system". The NAC shall be the "One National Coordination" and "One M&E authority". To ensure accountability and good governance, the NAC secretariat shall be supervised and given oversight office by Office of the Prime Minister, a NAC board; the Parliamentary HIV & AIDS Committee and the National HIV and AIDS Partnership forum representing all stakeholders.

The NAC shall, through the auspices of the national M&E TWG, execute the M&E trustship and leadership function in regular and close collaboration with MOH, MDP and BOS. The sustenance of "one M&E system" will also require close participation and support of the AIDS Development Partners (ADPs); Major National Networks or SRCE and coalitions of CSOs, FBOs, Private sector coalitions, PLHIV networks; major national projects and programmes such as the GFATM and PEPFAR.

The NAC will receive quarterly reports on pre-provided reporting forms from the national level actors and DACs for aggregation, analysis for national reporting. This will be based on TWG approved work plan, provide the needed M&E technical logistics and support along with the ADPs and respective umbrella, SCE and organizations.

District level: At the District level, this semblance of actors will be replicated with the DAC as the structure office under the oversight of the District Council, the District HIV and AIDS Stakeholders' partnership forum. Close collaboration with the District Health Management Team (DHMT), District planning office will be central.

DAC will be expected to receive quarterly reports on pre-provided NAC reporting forms from other District and community level based service providers for aggregation, analysis and onward reporting and; provide the actors with needed M&E technical logistics and support along with their respective national level mother offices. An existing Stakeholders' forum or District planning committee sub-committee shall serve as the M&E TWG.

4.6 INFORMATION DISSEMINATION

Stakeholder buy-in into the M&E Plan will, to a large extent, depend on the user friendly nature of the information products generated under this plan. There is no point at all in collecting and sharing data/information that is not shared or is availed in a form that cannot be used or will not be used.

The ultimate use of information shall serve to direct HIV control efforts at all levels: national, Sectoral, District and the Community levels. Information from the monitoring and evaluation of the national response will be disseminated widely to various stakeholders using different channels that will include the following.

a) The Lesotho National HIV and AIDS Partnership Forum that brings together stakeholders' at national and district levels will be used to share the information products of this Plan and those sourced from elsewhere. The stakeholders' partnership fora at national and district levels will enable all categories of stakeholders share the HIV status reports and other resources key for the strategic development and technical references for the national response interventions. It will also be the channel for sharing information on the national AIDS response in the preceding implementation period with key focus on the scope of service coverage, the best practices and management of challenging and emerging issues.

b) Quarterly HIV TWG at NAC, coordination and planning meetings with the HIV and AIDS Focal Persons in the ministries at national levels
c) National level quarterly coordination meetings with HIV/AIDS and M&E Focal persons from SCEs including: national and international NGOs, networks of PLHIV, Coalitions, Professional and trade associations, Private sector associations and federations, and the research and teaching institutions
d) District level quarterly HIV and AIDS Committee and Coordination meeting/forum. These will also be used to monitor progress of implementation of the HIV and AIDS and M&E activities within the Districts, share any available HIV/AIDS information, identify the lessons learnt, challenges and constraints and then map way forward strategies.
e) Use of the print and electronic media by having airtime and newspaper space and pull outs in the widely circulated newspapers.
f) Websites and electronic platforms or common email addresses. This will require regularly uploading and updating the NAC, MOH and other selected intranets, websites and repositories
g) The NAC, sectoral (MOH and other line ministries), district, other public and private Resource Centers and Libraries
h) Stakeholder Mailing lists—electronic and manual

i) Stakeholder dissemination workshops and Research Conferences

j) Coordination meetings of the Self Coordinating Entities (SCEs)

k) Training Workshops and Seminars

l) National exhibitions at different fairs and days that involve exhibitions

m) National and International Conferences

SECTION FIVE: INSTITUTIONAL MANAGEMENT & COORDINATION ARRANGEMENTS AND COSTING

5.1 OVERALL NATIONAL COORDINATION OF M&E PLAN

5.1.1 NATIONAL AIDS COMMISSION (NAC)

The NAC, as the "One Coordinating Authority", and; the Secretariat of the "one Plan of Action", the NSP, shall support the planning, monitoring and evaluation the National HIV and AIDS response in line with the "one M&E System" principle. The NAC shall be expected to support the strengthening and sustenance of coordination arrangements in both public and non-public sectors and with all the different categories of stakeholders in the national response at all programme levels, on or not on project support or funding.

The NAC shall also be responsible for leading and supporting the mobilization of the strategic, human, logistical and material resources for the implementation of the Monitoring and Evaluation Plan at all programme levels and in all sectors. To develop the "one M&E system the NAC will also be responsible for promotion and popularization of the adopted plan; guiding the development and supporting the partnerships needed for M&E, supporting the development of the standard and harmonized data collection and reporting tools; establishment and sustaining the functioning of a master national HIV and AIDS data base while also supporting the sub national ones; data bases inter-operability; guiding the undertaking of HIV and AIDS Research; guiding the data management; development of user friendly information products and dissemination and; promotion of utilization of the M&E and information products.

During the strengthening process of the re-established NAC, MoH will continue with the interim coordination because of its comparative advantage in implementing most HIV/TB interventions.

5.1.2 M&E TECHNICAL WORKING GROUP (M&E TWG)

The National HIV and AIDS Multisectoral M&E Technical Working Group (M&E TWG) working in collaboration with the various sectoral and thematic TWGs, shall provide the overall technical oversight and strategic direction to the roll out and implementation M&E plan. The TWG will ensure that the implementation of the Plan meets the technical and stakeholders' expectations and not just the NAC and MOH aspirations.

The NAC M&E Unit shall provide the secretariat to the M&E/TWG which will, among other functions, lead the strategic and operational planning for Monitoring and Evaluation needs of the response, develop and mobilize of strategic resources needed, help build the M&E culture, mobilize support to the M&E efforts by stakeholders and monitor the compliance to the provisions of the Plan by different stakeholders, including the critical role assigned to NAC under this Plan. *During the strengthening process of the re-established NAC, MoH will continue with the interim coordination because of its comparative advantage in implementing most HIV/TB interventions*

The TWG shall operate as forum guided by independent technical interpretation of the NSP and M&E plan by the members, supported by NAC as a secretariat. The TWG will serve as the

stakeholders' forum which will among other functions ensure that the NAC and other lead stakeholders like MOH, Ministries of Social Development, Education, Gender, Labour and Justice play their pivotal roles in the execution of the M&E plan as prescribed in the NSP or M&E plan. The TWG will also be expected to guide and support the major national data collection and research related to HIV and TB and other thematic TWGs for quality assurance and promotion of coherence to the "one M&E system.

5.1.3 MINISTRY OF HEALTH (MOH)

The MOH which is charged with leading the planning, management and coordination of all HIV and AIDS interventions under the health sector shall be responsible for the overall sector technical guidance for M&E and supporting the rest of the implementing partners in the sector.

The MOH will ensure that the huge volume of information from the health sector is fed into the "One National M&E System" of the response. The Directorate of Disease Control will also support synchronization and inter-operability between their rich and wide data bases and the other non-health sector response data bases managed by the NAC, other line ministries and MDAs, SRCE for completeness and consistence in reporting. The sector shall also sustain the functioning of the health sector M&E TWG that brings together a wide range of actors across different sectors including partners outside the MOH. The Health Sector HIV/AIDS response M&E plan, once developed, will be anchored to the national multi sectoral M&E Plan/M&E plan.

5.1.4 OTHER LINE/SECTOR MINISTRIES

The monitoring and evaluation of a multi sectoral HIV and AIDS Response requires active participation of the key line ministries. The sectoral HIV and AIDS Desks/ Focal Persons/ focal points, planning and M&E units shall lead the planning, implementation, coordination and monitoring of all HIV and AIDS interventions in the respective sectors.

The respective ministry HIV and AIDS units with the support of the planning units shall coordinate the development and implementation of M&E of HIV and AIDS activities in the sector implementing public and non-public departments and agencies. Key line ministries like those of Social Development, Education, Gender, Labour and Justice shall be key sources of information for the computation of output indicators from the routine reporting supported by the respective sector Management Information systems (MIS) such as the SWARIS—Social Welfare Response Information System; the EMIS- Education Management Information System. The sector ministries will also be key in leading and coordinating assessments, surveys and research that will generate the data for the computation of outcome and impact indicators relating to their respective sectoral mandates.

5.1.5 BUREAU OF STATISTICS (BOS)

The Bureau of Statistics (BOS) is the national body mandated to lead and guide the collection, compilation, analysis, validation, quality assurance and dissemination of all official and other statistical information in the country. The BOS will technically support the Multisectoral M&E TWG, MOH M&E TWG and other stakeholders in ensuring that methodologies used in collecting data, generation of scientific representative samples, management of data during research and the monitoring and evaluation of HIV and AIDS activities are complaint with the national and international standards and specifications or technical protocols. The BOS will

be playing a lead role in questionnaire designs, development of methodologies for surveys, censuses or routine data collection and has to ensure that the NAC updates it on the values of the HIV indicators baselines and targets set in the NSP and this M&E Plan.

The BOS will involve the NAC and the M&E TWG in planning for the HIV/AIDS, Reproductive Health and related Social Economic household and impact surveys so that the content makes enough provisions for the generation of strategic information needed by the AIDS response. The outcomes and impact level indicators are normally derived from wide or large sample population based surveys, such as the LDHS, Household surveys that the NAC or MOH on their own are not likely undertake due to the massive resources needed and thus are cost-effectively done by multi-sectoral concerted efforts.

5.1.7 Umbrella agencies and self-Coordinating Entities (SCE)

For effective reach during the implementation of the M&E plan, use shall be made of the wide networks strategic niche or positioning of umbrella agencies, SCE and networks that coordinate the various constituencies of actors in the national response. These SCE that include LENASO, LENEPWHA, LCN, LIRAC and other umbrella agencies shall play a key role in the monitoring of several HIV and AIDS programmes at the National, District and Community levels.

The non-public sector networks i.e. the CSO and FBO networks are also key to, in addition to mobilization of stakeholder buy-in for reporting; provide alternative assessment of the national response when preparing the UNGASS/GARPR report every two years important component in constructing an indicator on national programme effort Index and commitment Policy Index (NCPI). The umbrella agencies and SCEs shall be supported by the NAC and development partners to develop the required management and M&E capacities and in turn support and guide the collection of data, reporting and management of the data required under the Plan; compilation and submission of routine reporting Forms, undertaking of supervision visits; quality assurance; M&E and management capacity building; report production and; utilization of data to improve the way that they plan and manage the implementation of HIV/AIDS interventions at different levels in the country.

The networks and umbrella organizations of NGO/CSO/FBO shall also be represented by the relevant technical persons in the HIV and AIDS M&E/ SI TWGs at National, sectoral and district. These SCE and networks shall also be vital for developing and keeping inventories and data bases and websites to be used as channels for dissemination of the HIV and AIDS information products.

5.1.8 AIDS Development Partners

Development partners who include United Nations Agencies, Bilateral and Multilateral agencies, international NGOs shall be expected to support the implementation of the M&E plan through funding and technical assistance.

Strong formal reporting and information sharing linkages between the NAC, MOH, Ministries, SRCE and the various AIDS Development Partners (ADP) in the country shall be strengthened and sustained to foster effectiveness of generation and management of strategic information. The development partners working groups like UN Joint Team on AIDS will also be expected to share regular progress reports with the NAC, other line sectoral ministries and implementing partners.

5.1.9 District and Community HIV and AIDS Coordinating Committees (DACCs & CACCs)

Institutional and Coordination arrangements for the implementation of the National HIV/AIDS response shall provide for the formation and/or strengthening of HIV/AIDS stakeholders fora/committees at district levels. The DACCs, the DHMT and Social Development Officer, other line ministries' decentralized departments shall be members and supportive of these committees, among others.

These committees will be vital for coordinating the AIDS response including its monitoring and evaluation. The NAC and line ministries will support the functioning of these district level stakeholder Committees to ensure vibrant decentralized response generation and management of strategic information. This support shall be defined by the National ME/SI TWG and will be reflected in the M&E implementation plan and the Integrated Annual Work Plans. These structures shall also support evaluation activities normally executed by the national level agencies but implemented at the population level.

5.2 Data Quality Assurance (DQA) and Audit

The quality of data and information generated by the M&E plan is central to creation of an enabling environment to attain the aims of the NSP. The NAC, in collaboration with other national partners will spearhead the strengthening of Data Quality Assurance (DQA) through development and adoption of DQA Protocols for the different core programmes or interventions of the NSP.

Data Quality Assessment focusing on the validity, reliability, integrity, precision, timeliness and completeness of the data being generated will enable organizations, programs and projects to strengthen their data management and reporting systems. Each of the routine and non-routine data sources will also have DQA measures specified as part of the protocols. The ME/SI TWG will review the DQA protocols guidelines when need arises but at most every 2-3 years to ensure sustained relevance, appropriateness and technical compliance. Provision shall also be made for the processes and schedule for data quality audits that will be occasionally commissioned by the different M&E/SI TWGs.

5.3 National and sub national HIV/AIDS Databases

International M&E guidelines and supported practices by UNAIDS, World Bank, WHO, PEPFAR require national responses to have national and sub national databases. Notable of these databases under this plan will be the National HIV and AIDS Master database at BOS, at NAC fed mainly by LOMSHA, the HMIS and DHIS2 run by MOH. This will be further developed and supported by partners to meet AIDS response reporting. The databases shall be developed/reviewed to enable easy access and have inter-operability, migration and export of data and to enhance the sharing of information. The NAC National HIV and AIDS database to serve as the main national repository for data from routine programme monitoring; population based surveys, surveillance, research, financial monitoring and other relevant sources as shall be defined by the ME/SI TWG.

The national and sub national databases shall have user friendly standard operating procedures or database management protocols to ensure that it's data are updated regularly,

consistently and on time and accessed with relative ease even in the largely resource constrained settings with poor connectivity.

The data uploaded shall ensure the necessary desegregation including: by geographical areas, by NSP thematic areas, target /beneficiary population and service provider categories. NAC will encourage and work towards the creation of geo referenced HIV and AIDS data fed by the Mapping as one of the data sources. Once such data exists, relevant geo referenced data will be used to create maps and data atlases for inclusion in M&E information products for enhanced strategic information management.

All line ministries, SR/CEs such as LENASO, LENEPWHA, LCN, development partners, major projects and programmes coordination units shall be expected and supported to build and run sub national data bases. These data bases shall be fed by data from the respective implementing partners and programmes coordinated. All these sub national data bases shall however make sure they use the national guidelines and definitions and policies and shall be complaint, not contradictory, to the sector lead institutions.

MOH strategic information (HMIS/DHIS2) guidelines, protocols and forms/tools for health sector interventions; MSD (SWARIS) guidelines/ protocols and forms for OVC, other protection and social development interventions; Ministry of Education and Training using EMIS forms protocols. These sub national data bases shall not issue national status reports /indicators beyond their programme areas and shall be required to have the sector lead agencies on their M&E working groups to ensure consistency.

The sub national databases and datasets shall also use the unique identifiers system of services, providers, locations, beneficiaries developed by the national multi-sectoral M&E TWG to avoid duplication. Once these provisions are made, this will be a strength for the response as it will provide cross referencing and will translate into no significant extra cost or parallel system in nature since it is part and parcel of their management (with M&E not being divorced or entirely outsourced by Management).

5.4 Logistical and Technical Assistance M&E Plan

Focal / coordinating units for the implementation of the M&E plan which include: NAC M&E unit; the MOH Directorate of Disease Control, the sectoral ministries' planning and HIV and AIDS Units; the District (DHMT, DACC, ministry departments) and which are responsible for M&E; the Secretariats of Stakeholders' Self Regulating/Coordinating Entities (SR/CE), umbrella agencies and networks shall be supported with minimum necessary logistics by NAC and development partners.

This is necessary to ensure regular and sustained execution of their respective minimum core functions central to the sustenance of generation and management of monitoring and evaluation data. The core functions include: planning, coordination, field monitoring, supportive supervision, data capture, quality assurance, management, reporting and feedback for their respective constituencies.

The minimum logistics required by the units responsible for coordinating HIV and AIDS interventions to undertake their core functions shall be elaborately defined and reviewed from time to time by the National M&E/SI TWG.

Informed by the assessment of needs undertaken every two years, the ME/SI TWG working through NAC or outsourcing to an appropriate service provider shall mobilize and provide logistical and technical support using common M&E plan budget/ funding under the National Operational Plan or the identified development partners may provide technical support services directly as long as it's in line with the NOP.

The undertaking of major and specialized M&E/SI activities in the Plan such as surveillance, the ME/SI TWG through NAC shall specifically, as has been the case in the past, solicit technical support from the specialized agencies such as UN System to help in availing non regular resource persons /technical assistance to assist the such planned undertakings.

In event of availing such non-regular or external technical support, the following considerations are important for execution of effective procurement of the technical assistance:

- the development of a clear scope of work contained in a terms of reference and;
- the assignment be appraised by a national TWG
- shall be undertaken in close partnership with regular technical staff of the client department and/or national consultant, where possible, so that mentorship and capacity building as well as the national response memory is enhanced for sustained response purposes.

5.5 Human Resource Capacity Development

Strong Human resource capacity for the stakeholders is vital for the successful implementation of the M&E plan activities and development of systems in this plan. The priority capacity building needs for both the coordination units and stakeholders based on the Monitoring and Evaluation Systems and practices assessment undertaken as part of the plan development are reflected in this plan.

The National multi-sectoral M&E TWG shall develop and have an M&E capacity building programme implemented covering the key offices responsible for coordination and M&E of the response at national and sub national levels. The capacity building programme shall also enable stakeholders' access the data bases with information on the reference resources, M&E curricular, M&E trainers and available opportunities for building M&E capacity.

A practical capacity building programme that effectively combines dominant hands-on component through work and supervisory attachment, complemented by membership and conceptual and technical skills development through a national based institution (ie university) shall be developed. This programme shall also involve partnership with external institutions and partners for a limited duration to give enough time to develop systems, mentor national counterpart institutions and provide enough opportunity, time and space for the local counterparts to practice, correct misapplication and to grow.

5.6 Sustained Advocacy for HIV M&E

The NAC with support of MOH, other sectoral /Line ministries, SCEs, other stakeholders and development partners shall undertake the needed high level advocacy to enhance and sustain the M&E culture in the national response.

Advocacy for HIV and TB SI generation and management shall also be part of the National Advocacy and Communications strategy, if developed. The NAC will also guide the stakeholders on what proportion of financial and technical resources should be reserved for strategic information generation and management.

5.7 Performance Assessment of the Monitoring and Evaluation system

Strengthened generation and availability of strategic information is one of the priorities of the enabling track of the NSP which shall be jointly assessed based on the indicators and targets reflected in this plan. This will, among other mechanisms, be undertaken through the annual independent assessments and the Joint reviews.

However, to ensure a thorough assessment, the ME/SI TWG shall undertake an M&E Systems Strengthening every two years using the standard published assessment tool. These assessments will create opportunities for redirection of efforts in the national response by allowing for the use of lessons learned and addressing of any challenges, gaps and constraints that may be affecting an effective implementation of the M&E PLAN. Schedules for conducting these reviews have been reflected in the Implementation plan.

5.8 Minimum Conditions for Effectiveness

The M&E assessment findings presented in section one of this plan indicate that the national response has registered key and significant system development achievements. These progress milestones, among other aspects, relate to M&E planning, routine data collection for programme management and performance management as well as for national and international level reporting requirements. These achievements notwithstanding, a number of yet significant weaknesses that threaten the quality of the response and it's performance were also identified.

To ensure that effective Monitoring and Evaluation Systems are built and; for the already attained achievements and benefits to the national response to be sustained, the following are the minimum and necessary conditions given on the current realities in the national HIV and AIDS response landscape:

i. Establishment of an elaborate and strengthened coordinating structure at the NAC to improve the current arrangements to effectively offer strategic leadership and guidance. Without this the center or a "one M&E system" cannot "hold and endure".

ii. Provision of core or a minimum thresh hold investment in M&E systems development in form of a project or any very coherently designed national undertaking to support the strengthening and mainstreaming and sustenance of M&E technical & management capacity building, planning, management/coordination and implementation by the key Units/ desks or offices responsible for M&E plan

    The investment will include: funding for strategic resources development; Human resource skills development; coordination resources; field monitoring, support supervision and data quality assurance; data collection and management; production

of appropriate information products and; advocacy, mobilization and dissemination capacity.

iii. Sustained support for multi-response development by ensuring that there are core resources and management support for the units responsible for HIV and AIDS coordination and monitoring at national, sectoral and decentralized levels. This will enable these units undertake their core functions and thus a sustained management of the multi-sectoral response beyond the projects and the health sector which has a relatively better capacity that is to some reasonable extent already institutionalized M&E.

iv. Lack of a landscape of this multi sectoral support translates into a big vacuum of very limited action or absence of participation of key line sectors at the national and District and Community level. Without HIV and AIDS mainstreaming and response, the generation of the vital non health sector indicators expected from sectors will at best be ad hoc and, more importantly, it may not be possible to generate indicators on the HIV and AIDS interventions supposed to reach some of the most vulnerable population such as in schools; population groups under social welfare like OVCs, elderly, community social support structures; population groups in the leisure industry; work places.

v. Project based and gradual institutionalization of sustained support to decentralized response initiatives (DRI) strengthening. The districts and service delivery facilities and sites/offices have to be supported to undertake operational planning; budgeting for HIV and AIDS as part of their plans; coordination; mobilization and advocacy which will in turn provide an enabling environment for generation of strategic information at the decentralized and service delivery levels.

5.9 COST OF IMPLEMENTING THE NATIONAL M&E PLAN

During the period of implementation of the revised M&E plan (2014/5 – 2017/8), the twelve components of strengthening the plan will cost about USD17.4 million. The costs are broken down by component:

TABLE 4: COST OF IMPLEMENTING M&E STRENGTHENING COMPONENTS

Component	Cost USD
1. Institutionalization of M&E system	187,300
2. Human Capacity building for M&E	236,718
3. Establish M&E Partnership	138,900
4. Development of M&E Plan	115,500
5. M&E Advocacy and communication	205,500
6. Routine HIV and AIDS Monitoring	1,159,084
7. Surveillance and Surveys	13,016,223
8. Research and Evaluation	1,522,824
9 Supportive Supervision and Data Auditing	427,055
10. Data Dissemination and Use	574,000
ALL COMPONENTS	**17,583,104**

TABLE 5: 2015/16-2017/18 NATIONAL MONITORING & EVALUATION COSTED INTEGRATED IMPLEMENTATION PLAN

M&E COMPONENT	ACTIVITIES	TIME FRAME			SUPPORTING ORGANISATIONS					
		2015/16	2016/17	2017/18	MOH	NAC	UN	PEPFAR/USG	GF	TOTAL
1. Institutionalization of M&E system	1.1 Conduct M&E system strengthening Assessment				43,500	-	50,700	-	-	94,200
	1.2 Establishment/Strengthening of M&E units within organisations				12,000	5,000	10,000	70,000	-	97,000
			Sub-total		55,500	5,000	56,800	70,000	-	187,300
2. Human Capacity building for M&E	2.1 Conduct M&E capacity building needs assessment				64,500		10,000	-	-	74,500
	2.2 Develop M&E capacity building program				22,000	-	10,000	-	-	32,000
	2.3 Conduct Capacity Building				50,000	-	30,000	-	50,218	130,218
			Sub-total		136,500	-	50,000	-	50,218	236,718
3. Establish M&E Partnership	3.1 Establish & maintain national and district M&E TWGs				15,200	10,000		-	-	25,200
	3.2 Support national and district M&E TWGs to convene monthly meetings				16,000	24,200	12,000	29,300	32,200	113,700
			Sub-total		31,200	34,200	12,000	29,300	32,200	138,900
4. Development of M&E Plan	4.1 Develop HIV & TB M&E Plan Road Map/ Action Plan							-	-	-
	4.2 Review and development of HIV and TB M&E plans				20,000	10,000	60,500	-	-	90,500
	4.3 Costing HIV & TB M&E Plans				10,000	5,000	10,000	-	-	25,000
			Sub-total		30,000	15,000	70,500	-	-	115,500
5. M&E Advocacy and communication	5.1 Conduct M&E advocacy and communication situation				42,500	-	-	-	-	42,500
	5.2 Develop M&E advocacy and communication strategy				58,300	-	-	-	-	58,300
	5.3 Implement M&E Advocacy and communication				30,000	16,500	18,200	20,000		84,700
	5.4 Review and assess the effects of M&E advocacy and				10,000	10,000		-	-	20,000
			Sub-total		140,800	26,500	18,200	20,000	-	205,500
6. Routine HIV and AIDS Monitoring	6.1 Review and updating of data collection tools				15,000	-	15,000	95,000	156,516	281,516
	6.2 Rollout of revised data collection tools				20,000		20,000	72,000		112,000
	6.3 Rollout of DHIS2 at district and hospital levels							235,900	79,668	315,568
	6.4 Re-establishment & rollout of LOMSHA					120,000	30,000	50,000	250,000	450,000
			Sub-total		35,000	120,000	65,000	452,900	286,184	1,159,084

M&E COMPONENT	ACTIVITIES	TIME FRAME			SUPPORTING ORGANISATIONS					
		2015/16	2016/17	2017/18	MOH	NAC	UN	PEPFAR/USG	GF	TOTAL
7. Surveillance and Surveys	7.1 Workplace Survey				-	59,300		-	-	59,300
	7.2 Health Accreditation				28,600		-	-		28,600
	7.3 Modes of Transmission				-		-	-	234,790	234,790
	7.4 Lesotho National AIDS Spending Assessment/ HIV				50,000					50,000
	7.5 HIV ANC Sentinel/PMTCT Surveillance				10,000	10,000	20,000	-	113,507	153,507
	7.6 Integrated Behavioural Surveillance Survey for Key				-		-	-	166,358	166,358
	7.7 Lesotho Population based HIV Impact Assessments				-	-	-	9,973,400	-	9,973,400
	7.8 TB Prevalence Survey				-	-	-		2,237,672	2,237,672
	7.9 Model-based HIV and TB Estimates				-	22,000	20,000	20,000		62,000
	7.10 ART Cohort Survey				-	-	-		50,596	50,596
		Sub-total			88,600	91,300	40,000	9,993,400	2,802,923	13,016,223
8. Research and Evaluation	8.1 End-term evaluation of NSP				-	20,000	50,000	30,000		100,000
	8.2 Target TB/HIV program evaluation/review				-	72,100	79,300	174,400	150,886	476,686
	8.3HIV/TB Joint Reviews				20,000	10,000	50,000	20,000	95,338	195,338
	8.4 HIV TRaC study				-	-		100,000	-	100,000
	8.5 Capacity building in HIV and AIDS research				-	29,700	-	47,900	-	77,600
	8.6 National HIV and AIDS Research Coordination				49,500	54,500				104,000
	8.7 Conduct HIV and AIDS Impact Assessment				72,000	134,100	110,300	152,800		469,200
		Sub-total			141,500	320,400	289,600	525,100	246,224	1,522,824
9 Supportive Supervision and Data Auditing	9.1 Develop Supportive supervision mechanism				20,000	-	-	-	-	20,000
	9.2 Implement Supportive supervision Mechanism				32,400	21,100	23,200	25,600		102,300
	9.3 Conduct on-site data verification				60,700	-	48,800	-	58,356	167,856
	9.4 Conduct routine data quality assessment								136,899	136,899
		Sub-total			113,100	21,100	72,000	25,600	195,255	427,055
10. Data Dissemination and Use	10.1 Data Dissemination Schedule development				4,000	-	-	-	-	4,000
	10.2 Information Products National level				10,000	10,000	10,000	10,000		40,000
	10.3 Information Products - District report				50,000	50,000	50,000	50,000		200,000
	10.4 Information Products - Community reporting				40,000	40,000	40,000	40,000		160,000
	10.5 Dissemination of DHS results at all levels					50,000	20,000			70,000
		Sub-total			104,000	150,000	120,000	100,000	100,000	574,000
ALL COMPONENTS	**ALL ACTIVITIES**				**876,200**	**783,500**	**794,100**	**11,216,300**	**3,713,004**	**17,583,104**

TABLE 6: ANNEX 1: SUMMARY OF STATUS OF M&E IN NATIONAL RESPONSE AS OF 2015

Component	Strengths and opportunities	Weaknesses & disabling factors* & gaps	Proposed priority actions
1. Organizational structures responsible for M&E	i. Government through MOH supporting Multisectoral response framework with NSP & M&E revision ii. MOH has TWG with multi-sectoral membership iii. MOH, line ministries, NGOs, development partners and umbrella organizations for self-regulating / coordinating entities have M&E units (Divisions/Directorate/units/ desks) responsible for M&E, management information systems and research.	i. Lack of a NAC or another purposively designated "one HIV and AIDS M&E coordinating structure or agency" ii. Weak organizational and M&E structures at the umbrella organizations iii. A significant number of M&E positions are filled though not established iv. There are inadequate numbers of M&E staff in the M&E Units v. Limited multi-disciplinary scope of the M&E staff towards inclusion of Statisticians, Economist, Sociologists, epidemiologists, and demographers, IT specialists and database managers in some of the key M&E agencies. vi. Inadequate explicitness in how the M&E and MIS functional relationship.	i. Re-establish NAC or another purposively designated "one HIV and AIDS M&E coordinating structure or agency" ii. Strengthen organizational and M&E structures at the umbrella organizations
2. Human Capacity building for M&E	i. The MOH, line ministries, districts NGOs, development partners and umbrella organizations or Self-regulating / self-coordinating entities have staff responsible for M&E functions. ii. M&E responsible structures have both employees in established and adhoc /provisionally partners supported posts at National, sectoral and district and facility levels iii. There is training in HIV and AIDS M&E training at overall national, national sub national or national-sectoral, regional /SADC and international levels. iv. There is a SADC HIV and AIDS M&E training curricular being used. v. The different projects also undertake HR development of their M&E staff and also take in other implementing partners with funding as part of available grants from Global fund and other projects.	i. Lack of coherent national M&E capacity building programme and workplan ii. Lack of regular M&E system assessments in both public and non-public sectors, iii. Lack of a comprehensive Capacity Building curriculum and a well-coordinated plan for HIV M&E iv. Lack of an inventory on HIV M&E capacity resources v. Lack of a well-structured college or university level institutionalized M&E training tailored to the M&E needs at national, sectoral, decentralized and community response needs. vi. High turnover of staff including M&E personnel	i. Develop a national coherent M&E capacity building programme and workplan ii. Establish a stakeholder tailored, hands-on /practical and fellowship inclusive of mentorship HIV M&E capacity building programme with the participation of Lesotho based institutions i.e. college or universities. iii. Establish an inventory (or component of an existing data base) of HIV M&E capacity building resources i. Develop a well-structured M&E Career paths as part of mitigating the high turnover of M&E staff ii. Conduct regular M&E Capacity assessments and adequately share the information iii. The MOH TWG should share the full information on available training opportunities—national and regional. iv. On-going training interventions should be planned involving the lead actors and umbrella agencies in the different stakeholder categories i.e. with respective secretariats of self-coordinating entities. Training for CSO—

Component	Strengths and opportunities	Weaknesses & disabling factors* & gaps	Proposed priority actions
	vi. High prioritization of M&E across the board		the selection and content be planned and executed with LENASO involvement even when being implemented by a competitively selected service provider. iii. Establish well functionally defined and complementary relating M&E and MIS positions in the key coordinating organizations.
3. Partnerships for M&E	i. Existence of a functional MOH has Strategic Information Technical Working Group (SI TWG) with a multi-sectoral membership. ii. Existence (though not vibrant) of Self – regulating/ self-regulating entities or networks and associations including LENASO, LENEPWA, LCN that provides a platform for supporting and rolling out M&E interventions and operational mechanisms for feedback through reports. iii. An almost universal willingness of the stakeholders to be part of response governance and stewardship through membership of such TWGs. iv. The District Multi-sectoral Partnership Forum provided a good plat form for sharing data and other strategic information. The forum also enhanced district and community level coordination	i. No National M&E TWG that is inclusive on most stakeholders and the national CSOs and the other line ministries. ii. Non-functioning M&E TWG at district level iii. Weak M&E leadership structures in the Umbrella or Self-regulating networks agencies iv. Inadequate engagement of civil society and private sector in data collection, validation, utilization and dissemination of data. Although CSO and private sector continue to collect data at their level, data is not reported as NAC is closed v. No designated desk or secretariat for coordination of Multi-sectoral M&E. It's apparently an ad hoc added task for MOH as the government decision is awaited.	i. Revive the M&E TWG that is inclusive on most stakeholders ii. Revive or revitalize the functioning of District M&E TWG or AIDS Committee whose responsibility includes HIV M&E. Provisionally, support and guide the AIDS officers, counsellor and information officer to serve as a TWG to enhance data verification on the health sector routine data reporting. iii. Enhance the inclusiveness of the MOH Strategic Information Technical Working Group (SI TWG) to provisionally play a more effective multi-sectoral function. iv. Extend support to the Self coordinating entities (SCEs)/ umbrella agencies to develop M&E functional structures as key response constituent partners. v. Undertake a stakeholder mapping of all HIV and AIDS stakeholders vi. Revive or reconstitute a national partnership forum
4. M&E Plan	Though not completed and launched, the draft M&E Plan had: i. was aligned to the then NSP results framework; ; ii. baseline and target values for a good number of indicators but missing ones not generated yet, iii. M&E Capacity building provided for; iv. provided for research and evaluation arrangements; v. provided for data/information flows;	i. indicated the routine and non-routine data sources ii. indicated data collection arrangements iii. data quality assurance mechanisms; iv. elaborated on data and information flow arrangements v. indicated the information products; vi. had implementation and management arrangements. and; vii. a costed workplan	i. The draft M&E plan is now under revision mainly to: ii. re-align it with the revised NSP 2011/12 – 2017/18 core programmes, other strategic intervention, results framework, and management and coordination arrangements iii. review the indicators sets, iv. to meet requirements of the new GFATM funding model v. have it more action or operational oriented. vi. Have it more complaint with the new WHO

Component	Strengths and opportunities	Weaknesses & disabling factors* & gaps	Proposed priority actions
	vi. indicated data quality assurance mechanisms		guidelines, among other requirements, that require more use of the CD4 and Viral load in the monitoring.
5. **Costing and annual roll out of a Workplan**	i. work plans at the MOH, other line ministries, individual CSO organizations and networks or self-regulating entities have M&E activities costed ii. Revised M&E Plan will have a detailed annualized workplan costed iii. Revised NSPs National Operational Plan is being costed	•	•
6. Advocacy, communication and the culture of M&E	i. Establishment of M&E positions ii. counterpart funding for some key M&E activities iii. utilization of the data in planning and involvement of the relevant M&E and MIS staff in planning and programme reviews iv. government and partners to support M&E systems in the development of tools, reporting and M&E staff training v. M&E Advocacy, Culture and practices could be improved with regular M&E reviews		i. Granting agencies and other funding sources including those to central government ministries and to decentralized districts and entities
7. Routine program monitoring	i. existence of national guidelines that document the procedures for recording, collecting, collating and reporting programme monitoring data from health information system for managing routine data. This is mainly on STI, ART, HTC, PMTCT, VMMC, Laboratory ii. existence of national guidelines that document procedures for recording, collecting, collating and reporting routine programme monitoring data from civil society/community-based systems for data, especially for the health sector interventions iii. existence of national guidelines that	i. generally, CSOs facilities (i.e. CHAL with 8 Hospitals and 42 other health facilities) that generate routine health data report to DHMT but do not (or are not expected) to compile their own regular (ie quarterly and national) national institutional composite reports. Reports on their national performance status is provided by the MOH feedback ii. There is a challenge of late receipt of routine reports through the HMIS mainly due to the backlog of the data entry. iii. there is a challenge of having or training of data entry clerks to support data entry. iv. There is a challenge of underreporting partly fuelled by the forwarding of incomplete data. This is also partly due to the ownership of some	i. there is need to discuss, based on the merits and de-merits, parallel reporting systems (as has been with HIV/TB routine data) can be maintained provided they use the same tools without undermining the health sector HMIS. ii. Harmonize the frequency of generating regular output monitoring report through HMIS and the national HIV and AIDS response reporting needs iii. Specifically verify the reported/submitted of data to minimize underreporting partly fuelled by the forwarding of incomplete data partly due to the ownership of some facilities, programmes/ interventions where joint efforts to support SDP teams are in place.

Component	Strengths and opportunities	Weaknesses & disabling factors* & gaps	Proposed priority actions
	document instructions on how data quality should be maintained from the health information system(s) iv. there is routines reporting by the projects in the private or CSOs implementing HIV interventions. v. routine health interventions data projects of international CSOs and Foundations such as AHF get to the MOH monthly through DHMT and (in some cases quarterly through regional offices) vi. generally, CSOs facilities (i.e. CHAL with 8 Hospitals and 42 other health facilities) generate routine health data report to DHMT vii. operational definitions of routine monitoring (program output) indicators (from the national /MOH M&E system) are systematically used by all organizations delivering similar services all program areas viii. Organizations delivering the same services use standardized data collection forms and reporting forms. ix. Process of decentralization of data quality assurance are underway x. . xi. there have been exercises and procedures to reconcile discrepancies in reports and to provide feedback, through the SI TWG at MOH and have reconciliation of discrepancies in reports. xii. Results/ Outputs of routine program monitoring contributing to the indicators defined in the national M&E plan xiii. financial resources/investments for HIV are monitored and reported	programmes/ interventions where joint efforts to support SDP teams are in place. v. the stakeholders indicate the gap created by the lack of LOMSHA- Lesotho Output monitoring system for HIV and AIDS since the closure of NAC. Stakeholders indicate that the non-health sector routine data, where it exists, is either not being collated and not reported into the national service coverage reports vi. A challenge of too frequent changes in the data capture tools is faced by the service delivery points. There is need for stability on what tools to use for some reasonable time and when changes are needed, participation of the service providers should be sought out beyond the MOH head office vii. the HMIS where the routine data is entered mainly gives out the data on request and not the expected quarterly reports usually needed for reporting in the national HIV and AIDS response viii. there is lack of consensus on the need to for parallel reporting systems (as has been with HIV/TB routine data) but synchronized with HMIS/DHIS2.	iv. Revive LOMSHA- Lesotho Output monitoring system for HIV and AIDS since the closure of NAC or an equivalent information system to ensure capture the that the non-health sector routine data into the national service coverage reports v. Minimize the frequent of changes in the data capture tools and where there is need provide reasonable time and ensure participation of the service providers who actually collect the data through filling the same forms vi. Provide for the generation of data needed for cohort analysis reports from the routinely reported data to avoid having it as a separate exercise.

Component	Strengths and opportunities	Weaknesses & disabling factors* & gaps	Proposed priority actions
	xiv. the MOH is piloting the electronic capture of medical records in 4 districts to be rolled out to all eventually. xv. the entry of routine data from the facilities and districts in now done at the national level but are to be decentralized to districts xvi. There is a drive towards web based reporting systems xvii. the data collection tools are also reported to be cumbersome. There are varying views between MOH and SDP on whether this is the case of the service providers supposed to fill them are not competent enough or just that they are overloaded either work since the numbers are not adequate.		
8. Surveys and Surveillance	i. Surveillance reports have been produced every 2 years has been important determining levels and trends of HIV and STI (and other OI) prevalence. ii. The Demographic and Health Survey (DHS), the latest of which was the 2009 based of the a scientifically derived samples of the general population have been the basis for more reliable data for computation of national outcome and impact indicators. iii. A modes of transmission study (MOT) was undertaken in 2009 that was useful in deepening the understanding of the sources of the new infections, patterns of the epidemic and providing new planning information for re-aligning the prevention component of the response. iv. A planned drug resistance survey v. ALAFA HIV study among the factory workers vi. Cohort analysis studies.	i. The BSS have not been as regular as desired for both the general and key populations ii. Workplace and facility based surveys not undertaken as regularly as required except for the ALAFA covered factories	i. Include the needed surveys in the M&E workplan: o the LDHS 2014(already done and awaiting results), o AIDS Indictor survey, o drug resistance survey, o NASA, cohort studies, o BSS for both general and key populations, workplace surveys o Social economic Impact studies

Component	Strengths and opportunities	Weaknesses & disabling factors* & gaps	Proposed priority actions
	vii. LDHS planned for 2014 viii. Key population survey and size estimates undertaken in 2014 and covered ; SW and MSM ix. Drug resistance in 2009 and 2014; x. TB prevalence survey is on-going and another planned for 2016; xi. NASA was last done in 2009 but Resource mapping for 2014 and 2015 done xii. LENEPWA is conducted stigma index survey in 2013 xiii. Health sector reviews (Annual Joint Review) are conducted and the report is disseminated to the national partners. The Ministry of Health has completed the Health Sector Joint Annual Review for 2014/15. xiv. The Lesotho Correctional Services have also conducted a HIV Sero-Prevalence and Behavioural Study in 2011 xv. Targets and estimates of indicator values generated by the National Estimates and Projects coordinated by UNAIDS and MOH		
9. Data bases	i. Establishment of the following data bases fed by the key Information management systems in place: ii. HMIS/DHIS2 data base, iii. The LOMSHA data base. Stakeholders were trained on the use of the Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) though it has not been operationalized partly due to the closure of NAC iv. Other sectors and partners have some stand alone of M&E systems with the data bases the OVC data base in place-cross check v. Reasonable access to ICT by most offices of the different categories of	i. Incomplete and insufficient desegregation of data outputs for the HIV response from HMIS ii. LOMSHA closed with NAC and now there is no data base for the results from non-health sector interventions (other than on the OVC) iii. The data bases are not linked with the national Bureau of Statistics (BOS). The BOS is the national database for all development issues including HIV and AIDS.	i. Consider supporting the DHIS 2 software adoption used by other responses to enhance the extent to which the HIV & AIDS response data can be synchronized with HMIS—follow this option out-cross check ii. Synchronize the report generation frequency by HMIS and the reporting needs of the response. iii. Revive the LOMSHA iv. Enhance the inter-operability of the different data bases (HMIS, DHIS2 LOMSHA, OVC, Logistics data base—check these out and BOS)

Component	Strengths and opportunities	Weaknesses & disabling factors* & gaps	Proposed priority actions
	coordinating offices, districts, umbrella agencies that could enhance electronic and web based data bases rollo out. vi. Collaboration with Bureau of Statistics BOS) and MOH vii. Ministry of Social Development, Social Welfare Response Information System (SWARIS) data base with OVC data.		
10. Support supervision, data quality assurance and audit	i. existence of national guidelines that document instructions on how data quality should be maintained (e.g., avoiding double counting, assure reliability and validity) ***ii.*** The MOH and Organizations with assigned responsibilities responsible for receiving reports from lower levels and service delivery facilities do verify their completeness, timeliness and identify obvious mistakes before aggregating the data	i. Limited support supervision by other ministries and CSOs due to logistics and lack of role clarity ii. The lack of specific data flow channels and management of data being reported denies the response the counter checking/ data collaboration mechanisms	i. Support all sectors, networks at national and district level to develop capacity for support supervision and data quality assurance
Evaluation and Research.	i. Existence of an MOH Research and Evaluation Ethical and Technical Committees with clear TOR and procedures of coordinating and appraising research. ii. MOH has a draft Strategic Plan for Health Research (SPHR) 2013/14 – 2017/18 that includes HIV and AIDS priorities An annual joint review of the response iii. The MOH also conducts Annual Joint Reviews of the sector including the HIV in health sector iv. A national Health Research Coordination office is part of established MOH structure and is housed at the MOH head office v. The Research Unit has three staff as part of the wider SI unit. vi. MOH organizes a National research	i. Lack of an overall National Multi-sectoral HIV research and evaluation agenda ii. Leading national institutions such as the Universities, health training institutes have no Internal Review Boards (IRB) to ensure ethically and technically complaint research iii. Lack of a research and evaluation inventory or compendium? iv. Lack of an HIV and AIDS research networking group or Self-regulating team v.	i. Develop a national Multi-sectoral HIV research and evaluation agenda ii. Strengthen and Sustain the coordination for HIV and AIDS research and evaluation across all sectors beyond MOH iii. Support other national institutions such as the Universities, health training institutes to establish Internal Review Boards (IRB) iv. Produce a national research compendium or inventory and update it ever 2-3 years v. Develop an operational plan/ workplans to build capacity and provide support for basic, operational and evaluative research in HIV and AIDS at national and district levels vi. Establish the full complement of staff at the Research unit vii. Support and institutionalize the annual assessments covering all sectors viii. Government should lead and own estimates, modelling and target setting processes with support from UNAIDS, WHO and other

Component	Strengths and opportunities	Weaknesses & disabling factors* & gaps	Proposed priority actions
	forum twice a year		partners. ix. Enhance the documentation, sharing and utilization of research results for policy development and programming
11. Data/ Information dissemination and use	i. A wide collection of useful information products on HIV and AIDS epidemic and national response , especially by the MOH/ health sector partners include: o quarterly and annual reports; HMIS data base o annual joint reviews reports o surveillance reports o assessments reports o population based surveys reports o reports such as the 2009 LDHS report o Modes of Transmission Study Report o Bi-annual health sector reports o brochures o fact sheets ii. Other dissemination is done by the health sector through: o national conferences & workshops o stakeholders and implementing partners programme reviews meetings held quarterly by the ministry o stakeholder forum held twice a year, o websites o hard and electronic circulated mails	i. Limited and not timely circulation of vital information products to implementing partners ii. No resource centre that is easily accessible by all stakeholders iii. Websites not being timely updated iv. Limited utilization of available information available at the service delivery points and decentralized levels. v. Lack of comprehensive and systematic dissemination guidelines (Check again) with well-defined audiences, appropriate channels, appropriate information packaging and sustained schedule. vi. Harmonize the expectation and conceptualization on modalities, frequencies and packaging of response information	i. Assess the information needs of all categories of partners, stakeholders and the public. ii. Develop systematic dissemination guidelines and workplans/schedule with targeted audiences; iii. Develop comprehensive and systematic dissemination guidelines. iv. Establish and strengthen information or resource centres where relevant and user friendly HIV information can be accessed v. Establish mailing lists for both hard copies and through electronic platforms vi. Make use of the HIV and AIDS relevant self regulating entities, networks, coalitions, federations, associations, action groups, councils, committees and commissions as resource centre that can be replenished regularly.

ANNEX 2: ASSUMPTIONS FOR NATIONAL AND DISTRICT TARGET SETTING

ART Assumptions:

1. District population disaggregated by sex and district was used
2. HIV prevalence by sex and district was applied to get the HIV population. It was assumed the HIV population distribution for adults and children was the same for the districts
3. Adult and child HIV populations were then calculated from the total PLHIV and targets for the years 2014, 2015, 2016 & 2017.
4. The adult and child targets were based on the aggressive 90-90-90 targets from the revised NSP of reaching 80% target by 2020
5. The 2014 Spectrum outputs were used for the adult and children living with HIV
6. Key populations living with HIV are accounted for here - MSM, sex workers, factory workers, inmates
7. All pregnant women, TB patients, under five, and those on 2nd line treatment have been prioritised for Viral Load monitoring
8. Less than 2% of adults and 7.7% of children are on 2nd line drug regimen

PMTCT Assumptions:

1. District female population disaggregated by expected pregnancies, ANC HIV prevalence was used to estimate exposed infants to HIV
2. ANC HIV prevalence by district was applied to expected pregnancies get the exposed infants to. It was assumed the HIV population distribution for pregnant women was the same for the districts
3. Proportions of exposed infants by district were then applied to the In-need and targets for the years 2014, 2015, 2016 & 2017.
4. The PMTCT in-need targets were based on the aggressive 90-90-90 targets from the revised NSP & eMTCT scale up plan of reaching 95% target by 2020
5. For EID, 95% of PMTCT in-need targets were applied for testing all exposed infants with DNA PCR

TB/HIV Assumptions:

1. District population disaggregated by sex and district was used
2. HIV/TB prevalence by sex and district was applied to get the TB-HIV co-infected population. It was assumed the HIV population distribution for adults and children was the same for the districts
3. Co-infection proportions calculated from the total and applied to the targets for the years 2014-2020.
4. For IPT, the ART targets for 2014, 2015,2016 & 2017 were used and assumed to include those on care and treatment
5. The targets were based on the aggressive 90-90-90 targets from the revised NSP of reaching 85% target by 2020
6. The 2014 Spectrum outputs were used for the target of reaching the co-infected on ART

VMMC Assumptions:

1. District adult (15-49 years male population disaggregated by district was used
2. 80% coverage of the adult male population disaggregated by district was applied
3. It was assumed that the scale-up of VMMC will plateau between 2015 and 2017 @ an average of 60,000
4. It was also assumed that the prepex device rollout will not be rapid and the scale in hospitals will remain the same. However, the rollout of VMMC at health facility will depend on the approval of the policy, human resource and VMMC facilities
5. Hence the revision of the s-targets from the national VMMC strategy was based on current capacity and rollout plan. The approximately 320,000 VMMC is assumed to be met by march 2018.

HTC Assumptions:

1. children 0-9 years, Adolescent 10-14 years and adult 15-49 years population by district was used
2. Percentage of the population that know HIV status by district was obtained from LDHS to determine the percentage that do not know their HIV status.
3. The percentage that do not know their HIV status was applied to adolescent 12-14 years and adult 15-49 years population by district to get the absolute numbers by district.
4. The district proportions were then applied to the national NSP targets for 2014-2020 Based on the aggressive scenario
5. It was assumed that HTC from other HIV related programmes were accounted for - eg PMTCT, MC, TB, EID, Blood screening, key populations
6. Age of consent for HIV testing starts at 12 years

Condoms Assumptions:

1. Adult 15-49 years population was used for the period 2014-2020
2. 75% of the adult population is sexually active as per LDHS
3. According to WHO, sexually active population on average are expected to have 100 sex acts per year.
4. It is assumed that every sex act requires a condom. However, It does not take into account sex acts wherein a condom may not be advisable, i.e. when a couple is trying to have children.
5. There the estimated need per year is calculated as follows: adult population*75%*100
6. The NSP target uses 80% coverage by the year 2017 upto 2020.
7. The distribution by district is based on PSI and MoH/NDSO distribution of male and female condoms and the proportions are used to derive district targets
8. It is assumed that 5% of the total condoms are female for the period 2014 to 2020.

SBCC Assumptions:

1. It is assumed that the adult and young populations 15-49 years and 15-24 years respectively are sexually active and at risk of contracting STIs including HIV
2. This target group will be reached for sensitization and demand creation for HIV services including HTC, VMMC, PMTCT, Condoms, TB screening, Blood screening etc
3. The district populations were based on the 2006 Census and 2014 projections.

Key Populations (sex workers, MSM, In-mates, Factory/migrant workers)Assumptions:

1. 2013 Key Population size study estimated percentage of MSM among men aged 15-49 in Maseru was 2.16%. The proportion was assumed for all districts due to lack of district specific data
2. 2013 Key Population size study estimated percentage of FSW among women aged 15-49 in Maseru was 1.24%. The proportion was assumed for all districts due to lack of district specific data
3. The number of in-mates in Lesotho is estimated to be between 2600 and 2800. The 2014 Correctional Services 2014 provides proportions of inmates by district, and these were applied to the national targets to obtain district targets
4. The 2013 Labour Statistics report shows job seekers by district and these proportions were used to estimate district estimates of factory/internal migrant workers. Most of the factory/migrant workers are concentrated in Butha-Buthe, Leribe, Mafeteng, Maseru and Qacha's Nek.

TABLE 7: ANNEX 3: 2015-2020 NATIONAL TARGETS BY INTERVENTION AREA

	Program	Baseline	2015	2016	2017	2018	2019	2020
ADULT TREATMENT	Adult (15+ yrs) ART Coverage	41%	50%	55%	65%	70%	75%	80%
	Adult PLHIV (15+ yrs)	295,000	303,000	312,000	321,000	329,000	337,000	345,000
	Adult PLHIV (Receiving Treatment)	121,661	151,500	171,600	208,650	230,300	252,750	276,000
	Newly Initiated on treatment	27,296	29,839	49,939	37,050	21,650	22,450	23,250
	Adult PLHIV (Receiving 2nd Line Treatment)	1,875	2,273	2,574	3,130	3,455	3,791	4,140
	Number requiring VL Monitoring		2,273	2,574	3,130	3,455	3,791	4,140
	Number requiring nutritional support	29,500	30,300	31,200	32,100	32,900	33,700	34,500
PEDIATRIC TREATMENT	Pediatric ART (< 15 yrs) Coverage	40%	50%	60%	70%	75%	80%	85%
	Pediatric PLHIV (< 15 yrs)	19,000	19,000	18,000	18,000	17,000	16,000	15,000
	Pediatric PLHIV (Receiving Treatment)	7,644	9,500	10,800	12,600	12,750	12,800	12,750
	Pediatric PLHIV (Receiving 2nd LineTreatment)	589	732	832	970	982	986	982
	Number requiring nutritional support		9,500	10,800	12,600	12,750	12,800	12,750
VIRAL LOAD	Number Requiring Viral Load Monitoring - (targeted all HIV+ Pregnant women, TB/HIV Co-infected patients, all HIV+ children and adults on 2nd line drugs	18,232	25,400	28,100	31,600	32,800	34,000	35,200
PMTCT	PMTCT Coverage	74%	75%	80%	85%	87%	90%	95%
	Pregnant women PLHIV (15-49 yrs)	11,000	11,000	11,000	11,000	11,000	11,000	11,000
	Pregnant women PLHIV (15-49 yrs) on Treatment	8,165	8,250	8,800	9,350	9,570	9,900	10,450
	Proportion of exposed infants < 8 weeks tested (DNA PCR)	10733	10,450	10,450	10,450	10,450	10,450	10,450

	Program	Baseline	2015	2016	2017	2018	2019	2020
TB/HIV	TB Notifications	10,900	10,500	10,100	9,900	9,800	9,700	9,600
	HIV+ TB Incidence Cases	13,200	12,800	12,700	12,800	13,000	13,200	13,200
	TB/HIV -ART (Population Based) Coverage	53%	75%	80%	85%	90%	95%	95%
	HIV+ TB Not on ART	9,100	8,900	9,100	9,300	9,400	9,400	9,300
	TB/HIV Patients receiving ART	4,866	6,675	7,280	7,905	8,460	8,930	8,835
	IPT	64,854	60,800	60,800	60,800	60,800	60,800	60,800
VMMC	VMMC cumulative coverage	26%	42%	52%	70%	84%	91%	
	Numbers to be circumcised (annual)	36,245	55,000	60,000	60,000	45,000	25000	
	Numbers to be circumcised (cumulative)	85,005	140,005	170,971	230,971	275,971	300,971	
HTC								
	HTC Coverage	19%	41%	50%	54%	58%	62%	66%
	Population of adults 20-49 years	863,800	863,800	888,000	913,200	938,900	964,700	990,300
	Population of adolescents (10-19 years)	455,300	453,500	451,600	450,100	449,000	449,000	450,100
	Population of Children (0-9 years)	476,300	480,700	485,200	489,500	493,600	497,200	500,200
	Total Population	1,795,400	1,798,000	1,824,800	1,852,800	1,881,500	1,910,900	1,940,600
	Numbers to be tested adults 20-49 years	58,522	357,194	440,594	491,126	543,529	598,236	655,233
	Numbers to be tested adolescents (10-19 years)	261,715	187,529	224,068	242,067	259,926	278,437	297,809
	Number to be tested Children (0-9 years)		198,777	240,739	263,257	285,745	308,327	330,958
	Total number to be tested	337,546	743,500	905,400	996,450	1,089,200	1,185,000	1,284,000
	Facility (PITC)	268,284	400,000	480,000	500,000	520,000	540,000	560,000
	Outreach/Community (Mobile, Door-to-door)	69,262	343,500	425,400	496,450	569,200	645,000	724,000
		619,167 (2015)						
Condoms	Male Condoms	30,014,324	31,350,000	32,300,000	34,200,000	36,100,000	36,100,000	38,000,000
	Female Condoms	1,333,980	1,650,000	1,700,000	1,800,000	1,900,000	1,900,000	2,000,000
	Total Condoms	31,348,304	33,000,000	34,000,000	36,000,000	38,000,000	38,000,000	40,000,000

		AJR 2013/4						
	Program	**Baseline**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
SBCC	Population of adults 15-49 years	1,014,000	1,038,000	1,061,000	1,086,000	1,110,000	1,135,000	1,160,000
	SBCC Adults Coverage		40%	44%	48%	52%	56%	60%
	SBCC Adult Population Target		584,000	713,400	787,800	865,200	945,000	1,026,400
	Population of Young People 15-24 years	429,000	433,000	437,000	439,000	440,000	441,000	441,000
	SBCC- Young People Coverage		40%	44%	48%	52%	56%	60%
	SBCC- Young People (15-24yrs) Target		173,200	192,280	210,720	228,800	246,960	264,600
Key Populations	Sex Workers Coverage		25%	30%	35%	40%	45%	50%
	Number of SWs	6,300	6,300	6,500	6,600	6,900	6,900	7,100
	Coverage (Numbers)		1,575	1,950	2,310	2,760	3,105	3,550
	MSM Coverage		25%	30%	35%	40%	45%	50%
	Number of MSM	11,400	11,400	11,600	11,900	12,200	12,500	12,700
	Coverage (Numbers)		2,850	3,480	4,165	4,880	5,625	6,350
	In-mates Coverage		55%	60%	65%	70%	75%	80%
	Number of in-mates	2,500	2,600	2,600	2,600	2,700	2,800	2,800
	Coverage (Numbers)		1,430	1,560	1,690	1,890	2,100	2,240
	Mobile/Migrant Population Coverage		25%	30%	35%	40%	45%	50%
	Number of mobile/migrant population	59,000	60,000	61,000	61,000	62,000	63,000	64,000
	Coverage (Numbers)		15,000	18,300	21,350	24,800	28,350	32,000

TABLE 8: ANNEX 4: 2014-2020 NATIONAL AND DISTRICT TARGETS

Adult ART Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	4,838	4,988	7,035	8,554	9,442	10,362	11,316
Berea	14,953	15,417	21,746	26,441	29,184	32,029	34,976
Leribe	18,912	19,498	27,502	33,440	36,910	40,508	44,234
Mafeteng	12,315	12,697	17,908	21,775	24,034	26,377	28,804
Maseru	31,666	32,648	46,050	55,993	61,802	67,827	74,066
Mohale's Hoek	10,995	11,336	15,990	19,442	21,459	23,551	25,717
Mokhotlong	5,717	5,895	8,315	10,110	11,159	12,247	13,373
Qacha's Nek	4,090	4,217	5,948	7,232	7,983	8,761	9,567
Quthing	7,477	7,709	10,873	13,220	14,592	16,015	17,488
Thaba-Tseka	7,037	7,255	10,233	12,443	13,734	15,073	16,459
Total	**118,000**	**121,661**	**171,600**	**208,650**	**230,300**	**252,750**	**276,000**
Paediatric ART Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	312	389	443	517	523	525	523
Berea	963	1,204	1,369	1,597	1,616	1,622	1,616
Leribe	1,218	1,523	1,731	2,019	2,043	2,051	2,043
Mafeteng	793	991	1,127	1,315	1,331	1,336	1,331
Maseru	2,040	2,549	2,898	3,381	3,422	3,435	3,422
Mohale's Hoek	708	885	1,006	1,174	1,188	1,193	1,188
Mokhotlong	368	460	523	611	618	620	618
Qacha's Nek	263	329	374	437	442	444	442
Quthing	482	602	684	798	808	811	808
Thaba-Tseka	453	567	644	751	760	763	760
Total	**7,600**	**9,500**	**10,800**	**12,600**	**12,750**	**12,800**	**12,750**

TABLE 9: ANNEX 4: 2014-2020 NATIONAL AND DISTRICT TARGETS

Viral Load Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	4,838	1,041	1,152	1,296	1,345	1,394	1,443
Berea	14,953	3,219	3,561	4,004	4,157	4,309	4,461
Leribe	18,912	4,071	4,504	5,064	5,257	5,449	5,641
Mafeteng	12,315	2,651	2,933	3,298	3,423	3,548	3,673
Maseru	31,666	6,816	7,541	8,480	8,802	9,124	9,446
Mohale's Hoek	10,995	2,367	2,618	2,944	3,056	3,168	3,280
Mokhotlong	5,717	1,231	1,362	1,531	1,589	1,647	1,706
Qacha's Nek	4,090	880	974	1,095	1,137	1,179	1,220
Quthing	7,477	1,609	1,780	2,002	2,078	2,154	2,230
Thaba-Tseka	7,037	1,515	1,676	1,884	1,956	2,028	2,099
Total	**118,000**	**25,400**	**28,100**	**31,600**	**32,800**	**34,000**	**35,200**
Nutritional Support Adults							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	1,209	1,242	1,279	1,316	1,349	1,382	1,414
Berea	3,738	3,840	3,954	4,068	4,169	4,271	4,372
Leribe	4,728	4,856	5,000	5,145	5,273	5,401	5,529
Mafeteng	3,079	3,162	3,256	3,350	3,433	3,517	3,600
Maseru	7,917	8,131	8,373	8,614	8,829	9,044	9,258
Mohale's Hoek	2,749	2,823	2,907	2,991	3,066	3,140	3,215
Mokhotlong	1,429	1,468	1,512	1,555	1,594	1,633	1,672
Qacha's Nek	1,023	1,050	1,081	1,113	1,140	1,168	1,196
Quthing	1,869	1,920	1,977	2,034	2,085	2,135	2,186
Thaba-Tseka	1,759	1,807	1,861	1,914	1,962	2,010	2,057
Total	**29,500**	**30,300**	**31,200**	**32,100**	**32,900**	**33,700**	**34,500**

TABLE 10: ANNEX 4: 2014-2020 NATIONAL AND DISTRICT TARGETS

Nutritional Support children							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	312	389	443	517	523	525	523
Berea	963	1,204	1,369	1,597	1,616	1,622	1,616
Leribe	1,218	1,523	1,731	2,019	2,043	2,051	2,043
Mafeteng	793	991	1,127	1,315	1,331	1,336	1,331
Maseru	2,040	2,549	2,898	3,381	3,422	3,435	3,422
Mohale's Hoek	708	885	1,006	1,174	1,188	1,193	1,188
Mokhotlong	368	460	523	611	618	620	618
Qacha's Nek	263	329	374	437	442	444	442
Quthing	482	602	684	798	808	811	808
Thaba-Tseka	453	567	644	751	760	763	760
Total	**7,600**	**9,500**	**10,800**	**12,600**	**12,750**	**12,800**	**12,750**
PMTCT Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	336	338	361	383	392	406	428
Berea	1,039	1,045	1,115	1,185	1,213	1,255	1,324
Leribe	1,314	1,322	1,410	1,499	1,534	1,587	1,675
Mafeteng	856	861	918	976	999	1,033	1,091
Maseru	2,201	2,214	2,362	2,509	2,568	2,657	2,804
Mohale's Hoek	764	769	820	871	892	922	974
Mokhotlong	397	400	426	453	464	480	506
Qacha's Nek	284	286	305	324	332	343	362
Quthing	520	523	558	592	606	627	662
Thaba-Tseka	489	492	525	558	571	590	623
Total	**8,200**	**8,250**	**8,800**	**9,350**	**9,570**	**9,900**	**10,450**

TABLE 11: ANNEX 4: 2014-2020 NATIONAL AND DISTRICT TARGETS

DNA PCR Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	428	428	428	428	428	428	428
Berea	1,324	1,324	1,324	1,324	1,324	1,324	1,324
Leribe	1,675	1,675	1,675	1,675	1,675	1,675	1,675
Mafeteng	1,091	1,091	1,091	1,091	1,091	1,091	1,091
Maseru	2,804	2,804	2,804	2,804	2,804	2,804	2,804
Mohale's Hoek	974	974	974	974	974	974	974
Mokhotlong	506	506	506	506	506	506	506
Qacha's Nek	362	362	362	362	362	362	362
Quthing	662	662	662	662	662	662	662
Thaba-Tseka	623	623	623	623	623	623	623
Total	**10,450**	**10,450**	**10,450**	**10,450**	**10,450**	**10,450**	**10,450**

TB/HIV Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	205	219	298	324	347	366	362
Berea	634	677	923	1,002	1,072	1,132	1,120
Leribe	801	856	1,167	1,267	1,356	1,431	1,416
Mafeteng	522	557	760	825	883	932	922
Maseru	1,342	1,433	1,954	2,121	2,270	2,396	2,371
Mohale's Hoek	466	498	678	737	788	832	823
Mokhotlong	242	259	353	383	410	433	428
Qacha's Nek	173	185	252	274	293	310	306
Quthing	317	338	461	501	536	566	560
Thaba-Tseka	298	318	434	471	505	533	527
Total	**5,000**	**5,340**	**7,280**	**7,905**	**8,460**	**8,930**	**8,835**

TABLE 12: ANNEX 4: 2014-2020 NATIONAL AND DISTRICT TARGETS

IPT Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	2,665	2,493	2,493	2,493	2,493	2,493	2,493
Berea	8,237	7,705	7,705	7,705	7,705	7,705	7,705
Leribe	10,417	9,744	9,744	9,744	9,744	9,744	9,744
Mafeteng	6,783	6,345	6,345	6,345	6,345	6,345	6,345
Maseru	17,443	16,316	16,316	16,316	16,316	16,316	16,316
Mohale's Hoek	6,057	5,665	5,665	5,665	5,665	5,665	5,665
Mokhotlong	3,149	2,946	2,946	2,946	2,946	2,946	2,946
Qacha's Nek	2,253	2,107	2,107	2,107	2,107	2,107	2,107
Quthing	4,119	3,852	3,852	3,852	3,852	3,852	3,852
Thaba-Tseka	3,876	3,626	3,626	3,626	3,626	3,626	3,626
Total	**65,000**	**60,800**	**60,800**	**60,800**	**60,800**	**60,800**	**60,800**

VMMC Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	
Butha-Buthe	7,000	7,700	8,400	8,400	8,400	8,400	
Berea	3,000	3,300	3,600	3,600	3,600	3,600	
Leribe	8,000	8,800	9,600	9,600	9,600	9,600	
Mafeteng	5,500	6,050	6,600	6,600	6,600	6,600	
Maseru	12,500	13,750	15,000	15,000	15,000	15,000	
Mohale's Hoek	5,000	5,500	6,000	6,000	6,000	6,000	
Mokhotlong	2,000	2,200	2,400	2,400	2,400	2,400	
Qacha's Nek	1,500	1,650	1,800	1,800	1,800	1,800	
Quthing	2,500	2,750	3,000	3,000	3,000	3,000	
Thaba-Tseka	3,000	3,300	3,600	3,600	3,600	3,600	
Total	**50,000**	**25,966**	**60,000**	**60,000**	**45,000**	**25,000**	

TABLE 13: ANNEX 4: 2014-2020 NATIONAL AND DISTRICT TARGETS

HTC Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	46,940	58,166	70,832	77,955	85,212	92,706	100,451
Berea	79,108	98,028	119,374	131,379	143,608	156,238	169,291
Leribe	91,459	113,333	138,011	151,890	166,028	180,631	195,722
Mafeteng	73,127	90,616	110,348	121,445	132,750	144,425	156,491
Maseru	146,747	181,844	221,441	243,710	266,394	289,825	314,038
Mohale's Hoek	52,796	65,423	79,669	87,680	95,842	104,271	112,983
Mokhotlong	27,603	34,205	41,653	45,842	50,109	54,516	59,071
Qacha's Nek	20,471	25,367	30,891	33,997	37,162	40,431	43,808
Quthing	30,988	38,399	46,761	51,464	56,254	61,202	66,315
Thaba-Tseka	30,762	38,120	46,421	51,089	55,844	60,756	65,832
Total	**600,000**	**743,500**	**905,400**	**996,450**	**1,089,200**	**1,185,000**	**1,284,000**

Female Condom Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	81,142	95,632	98,530	104,326	110,121	110,121	115,917
Berea	80,220	94,545	97,410	103,140	108,870	108,870	114,600
Leribe	187,343	220,797	227,488	240,869	254,251	254,251	267,633
Mafeteng	206,650	243,552	250,932	265,693	280,453	280,453	295,214
Maseru	652,263	768,739	792,034	838,624	885,214	885,214	931,805
Mohale's Hoek	67,109	79,093	81,490	86,283	91,077	91,077	95,870
Mokhotlong	15,512	18,283	18,837	19,945	21,053	21,053	22,161
Qacha's Nek	14,319	16,876	17,388	18,410	19,433	19,433	20,456
Quthing	45,344	53,441	55,061	58,300	61,538	61,538	64,777
Thaba-Tseka	50,117	59,067	60,857	64,436	68,016	68,016	71,596
Total	**1,400,000**	**1,650,000**	**1,700,000**	**1,800,000**	**1,900,000**	**1,900,000**	**2,000,000**

National and District Targets

Male Condom Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	1,231,433	1,286,848	1,325,843	1,403,834	1,481,825	1,481,825	1,559,816
Berea	2,271,431	2,373,645	2,445,574	2,589,431	2,733,288	2,733,288	2,877,146
Leribe	4,490,293	4,692,356	4,834,549	5,118,934	5,403,319	5,403,319	5,687,705
Mafeteng	3,532,573	3,691,538	3,803,403	4,027,133	4,250,863	4,250,863	4,474,592
Maseru	13,772,100	14,391,845	14,827,961	15,700,194	16,572,427	16,572,427	17,444,660
Mohale's Hoek	1,960,154	2,048,361	2,110,432	2,234,575	2,358,718	2,358,718	2,482,861
Mokhotlong	493,551	515,760	531,390	562,648	593,906	593,906	625,164
Qacha's Nek	292,140	305,286	314,537	333,039	351,541	351,541	370,044
Quthing	1,283,313	1,341,062	1,381,701	1,462,977	1,544,254	1,544,254	1,625,530
Thaba-Tseka	673,013	703,298	724,610	767,234	809,858	809,858	852,483
Total	**30,000,000**	**31,350,000**	**32,300,000**	**34,200,000**	**36,100,000**	**36,100,000**	**38,000,000**

SBCC Adult Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	33,562	33,875	34,188	34,344	34,344	34,345	34,345
Berea	58,013	58,554	59,094	59,365	59,365	59,365	59,365
Leribe	67,070	67,695	68,320	68,633	68,633	68,633	68,634
Mafeteng	43,486	43,892	44,297	44,500	44,500	44,500	44,500
Maseru	107,614	108,618	109,621	110,123	110,123	110,123	110,123
Mohale's Hoek	38,717	39,078	39,439	39,619	39,619	39,619	39,620
Mokhotlong	20,242	20,431	20,620	20,714	20,714	20,714	20,714
Qacha's Nek	15,012	15,152	15,292	15,362	15,362	15,362	15,362
Quthing	22,725	22,937	23,148	23,254	23,254	23,254	23,255
Thaba-Tseka	22,559	22,770	22,980	23,085	23,085	23,085	23,085
Total	**429,000**	**433,000**	**437,000**	**439,000**	**439,001**	**439,002**	**439,003**

National and District Targets

SBCC Young People Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	6,093	8,181	9,082	9,953	10,807	11,664	12,498
Berea	11,753	15,780	17,518	19,198	20,845	22,499	24,107
Leribe	13,149	17,655	19,599	21,479	23,322	25,173	26,971
Mafeteng	7,379	9,908	10,999	12,054	13,088	14,127	15,136
Maseru	13,801	18,530	20,571	22,544	24,478	26,421	28,308
Mohale's Hoek	8,065	10,829	12,022	13,174	14,305	15,440	16,543
Mokhotlong	5,921	7,950	8,826	9,673	10,502	11,336	12,146
Qacha's Nek	12,581	16,891	18,752	20,550	22,313	24,084	25,805
Quthing	9,900	13,292	14,756	16,172	17,559	18,953	20,307
Thaba-Tseka	7,940	10,661	11,835	12,970	14,083	15,201	16,286
Total	**129,000**	**173,200**	**192,280**	**210,720**	**228,800**	**246,960**	**264,600**

Sex Workers Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	86	90	112	133	159	178	204
Berea	200	210	260	309	369	415	474
Leribe	237	249	308	365	436	490	560
Mafeteng	153	161	199	236	282	317	362
Maseru	354	372	461	546	652	734	839
Mohale's Hoek	139	146	181	215	257	289	330
Mokhotlong	77	80	100	118	141	159	181
Qacha's Nek	95	100	124	147	176	198	226
Quthing	58	61	76	90	107	121	138
Thaba-Tseka	100	105	129	153	183	206	236
Total	**1,500**	**1,575**	**1,950**	**2,310**	**2,760**	**3,105**	**3,550**

National and District Targets

Men who have sex with men (MSM) Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	148	169	206	246	289	333	376
Berea	335	381	466	557	653	753	850
Leribe	399	455	555	665	779	898	1,014
Mafeteng	264	301	367	440	515	594	670
Maseru	566	645	788	943	1,105	1,274	1,438
Mohale's Hoek	235	268	327	391	458	528	596
Mokhotlong	130	148	181	217	254	293	330
Qacha's Nek	158	180	220	263	308	355	401
Quthing	94	108	132	157	184	213	240
Thaba-Tseka	171	195	239	285	334	386	435
Total	**2,500**	**2,850**	**3,480**	**4,165**	**4,880**	**5,625**	**6,350**

Factory/Migrant Workers Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	1,005	1,005	1,226	1,430	1,662	1,899	2,144
Berea	60	60	73	85	99	113	128
Leribe	3,255	3,255	3,971	4,633	5,382	6,152	6,944
Mafeteng	1,020	1,020	1,244	1,452	1,686	1,928	2,176
Maseru	7,500	7,500	9,150	10,675	12,400	14,175	16,000
Mohale's Hoek	450	450	549	641	744	851	960
Mokhotlong	255	255	311	363	422	482	544
Qacha's Nek	1,350	1,350	1,647	1,922	2,232	2,552	2,880
Quthing	75	75	92	107	124	142	160
Thaba-Tseka	30	30	37	43	50	57	64
Total	**15,000**	**15,000**	**18,300**	**21,350**	**24,800**	**28,350**	**32,000**

National and District Targets

Inmates Targets							
District	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Butha-Buthe	54	55	60	65	73	81	86
Berea	86	88	96	104	116	129	137
Leribe	164	167	182	197	221	245	262
Mafeteng	36	37	40	43	48	54	57
Maseru	582	595	649	703	786	873	931
Mohale's Hoek	268	274	299	324	362	402	429
Mokhotlong	28	29	32	34	38	43	45
Qacha's Nek	42	43	47	51	57	63	67
Quthing	58	60	65	71	79	88	94
Thaba-Tseka	82	84	91	99	110	123	131
Total	**1,400**	**1,430**	**1,560**	**1,690**	**1,890**	**2,100**	**2,240**

[i] MOHSW (2009): Lesotho Demographic and Health Survey, Ministry of Health and Social Welfare, Lesotho
[ii] GOL (2006): Population and Housing Census, Government of Lesotho
[iii] UNDP (2013): Human Development Report, (Global)
[iv]Moleli-Habi, M. and Liphapang-Sefako M. (2011): Population Dynamics and HIV and AIDS: Situation Analysis in the Context of National Development Planning in Lesotho – Government of Lesotho
[v] UNDP (2010): Human Development Report – The Real Wealth of Nations
[vi] UNDP (2013): Human Development Report, (Global)
[vii] GOL (2010): Bureau of Statistics, Government of Lesotho.
[viii]GOL. 2008. Statistical Yearbook. Maseru, LS: MOFDP/BOS.
[ix] MOHSW (2009) Lesotho Demographic and Health Survey
[x] MOHSW (2012) Lesotho Global AIDS Response Country Progress Report, January 2010-December 2011
[xi]MOHSW (2009): Lesotho Demographic and Health Survey 2009, Table 13.3 pg. 203, ICF Macro, USA
[xii] MOHSW (2009): Lesotho Demographic and Health Survey 2009, Table 13.3 pg. 203, ICF Macro, USA
[xiii] MOHSW (2009) – Lesotho Demographic and Health Survey,
[xiv] Modes of Transmission report 2009
[xv] Modes of Transmission report (2009).