2017 Sustainability Index Dashboard Summary: Lesotho

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 89 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Dark Green Score (8.50-10 points) **(sustainable and requires no additional investment at this time)**
Light Green Score (7.00-8.49 points) **(approaching sustainability and requires little or no investment)**
Yellow Score (3.50-6.99 points) **(emerging sustainability and needs some investment)**
Red Score (<3.50 points) **(unsustainable and requires significant investment)**

Lesotho Overview: Lesotho has made significant progress is addressing the HIV/AIDS epidemic in the last few years. The recently released Lesotho Population Based HIV/AIDS Impact Assessment shows that for adults 15-59 in Lesotho the country is making real progress towards the UNAIDS 90/90/90 targets. In Lesotho, 77% of PLHIV know their status, 90% of those who know their status are on ART, and 88% of those on ART are virally suppressed. Moving forward, Lesotho will continue to focus efforts on strengthening data quality, identifying priority populations (including adolescents and men), and addressing gaps in the national response. The Government of Lesotho continues to be a strong partner in the HIV/AIDS response.

SID Process: On November 8th, PEPFAR and UNAIDS co-convened a one-day SID stakeholders workshop. The workshop included participants from the Ministry of Health, Cabinet sub-committee on HIV/AIDS, Ministry of Social Development, UNAIDS, the National AIDS Commission, Global Fund principal recipients, civil society organizations, and other development partners. After introductory remarks from both PEPFAR and UNAIDS, the participants broke off into four domain subgroups to discuss and complete the SID tool. The full group then reconvened for a report back session where each domain presented the key findings. Each domain was allowed to continue discussions and data collection over email in the week following the stakeholders meeting. The chairperson of each domain then submitted the final domain to PEPFAR on November 15th. The PEPFAR Coordinator compiled the tool into one final submission.

Sustainability Strengths:

- **Planning and Coordination (9.07, dark green):** Lesotho scored highly in the area of planning and coordination. In Lesotho, technical working groups and stakeholder forums for various health areas exist and are active (examples include HIV Testing Services TWG, Treatment TWG, and quarterly PEPFAR POART stakeholder meetings). The AIDS Development Partners meeting, which is co-chaired by PEPFAR and UNAIDS, meets monthly to review progress and ensure program harmonization. The current National Coordination Framework was developed in 2013 when the current National Strategic Plan (NSP) was developed. The NSP is currently being

reviewed and the national coordination framework will be reviewed alongside it. Lastly, a variety of donors usually engage with the Ministry of Health in a resource mapping activity that helps to analyze and address areas of duplication.

- **Policies and Governance (7.97, light green):** The next highest score for Lesotho was in policies and governance. The Ministry of Health in Lesotho has been very proactive in developing and implementing updated policies to ensure the highest impact and work towards epidemic control. For example, Lesotho was the first country in sub-Saharan Africa to adopt Test and Treat and the Ministry was very quick to include PrEP and self-testing in their updated guidelines. However, Lesotho was not able to score a dark green in this section because a number of policies were still in draft form and the laws were not key population friendly.

Sustainability Vulnerabilities:

- **Commodity Security and Supply Chain (3.56, yellow):** This is the element where the score dropped the most from SID 2.0 to SID 3.0. The MOH Supply Chain Strategic plan draft (2013/14-2016/17) has expired. However, there is a plan to develop a follow-on strategy in 2018. The creation of the MOH Supply Chain Coordination Unit and support from USAID projects improved the standardization and reliability of national quantifications. But, there is still the absence of a fully functional national drug regulatory agency. There is a working quantification working group for the MoH that carries out annual quantifications to inform government budgeting cycle and procurements, and bi-annual quantification reviews to inform procurements. In Lesotho there is still no adequate system for monitoring and reporting of stock level at facility level in the country that creates gaps in adequately knowing national stock level picture for all the products beyond National Drug Supply Organization level. Additionally, the multiplicity of formulations and pack sizes of same medicines at facility level creates confusion among health workers at time of reporting and ordering. There is also a significant delay in release of funds for procurement of medicines and health supplies and the amounts released are further affected by procurement issues within Ministry of Finance.
- **Laboratory (3.75, yellow):** Another area where Lesotho saw a drop from SID 2.0 to SID 3.0 was in laboratory. There is no laboratory strategy in place in Lesotho. In addition, the human resources for the country's laboratories are mostly donor funded (Global Fund and PEPFAR). According to the Human Resource Plan for 2017, 60% of laboratory positions are vacant and the workload for the current staff is very high. Lastly, many of the laboratory services are donor finances. Viral testing, Genexpert cartridges, and TB Drug resistance tests are financed by Global fund, World Bank and PEPFAR. Routine lab tests like FBC, Chemistries are financed by the Government of Lesotho.

Additional Observations: Lesotho had no red scores in the Sustainability Index Dashboard. For the areas that saw a drop in score from SID 2.0 to SID 3.0, there are a number of comments to help explain the reasons for the current score. It is also important to remember that much of the scoring is subjective and the stakeholders engaged and general approach to scoring for this SID 3.0 can also play a role in these perceived decreases.

Contact: For questions or further information about PEPFAR's efforts to support sustainability of the HIV response in Lesotho, please contact Dr. Robert Manda at rmanda@usaid.gov.

Sustainability Analysis for Epidemic Control: Lesotho

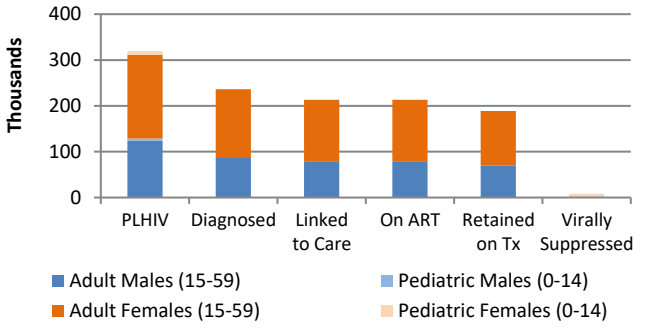
Epidemic Type: Generalized
Income Level: Lower middle income
PEPFAR Categorization: Long-term Strategy
PEPFAR COP 17 Planning Level: $67,871,405

SUSTAINABILITY DOMAINS and ELEMENTS

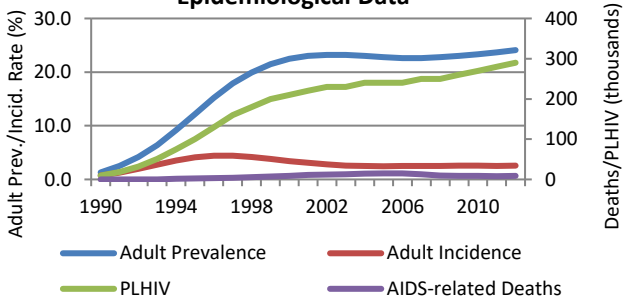
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	8.00	9.07		
2. Policies and Governance	5.01	7.97		
3. Civil Society Engagement	6.50	7.17		
4. Private Sector Engagement	3.80	4.13		
5. Public Access to Information	9.00	6.00		
National Health System and Service Delivery				
6. Service Delivery	4.81	6.06		
7. Human Resources for Health	5.75	6.50		
8. Commodity Security and Supply Chain	6.32	3.56		
9. Quality Management	5.48	4.24		
10. Laboratory	4.17	3.75		
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	5.00	4.13		
12. Technical and Allocative Efficiencies	5.47	6.33		
Strategic Information				
13. Epidemiological and Health Data	6.01	4.60		
14. Financial/Expenditure Data	3.75	5.83		
15. Performance Data	4.71	6.51		

CONTEXTUAL DATA

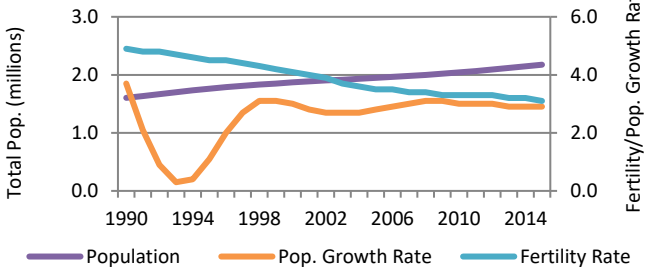
National Clinical Cascade



Epidemiological Data

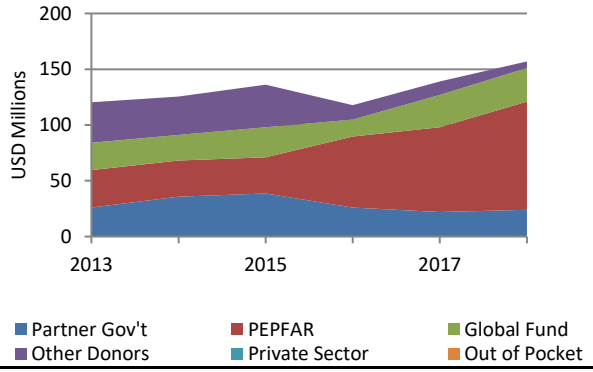


Population and Fertility

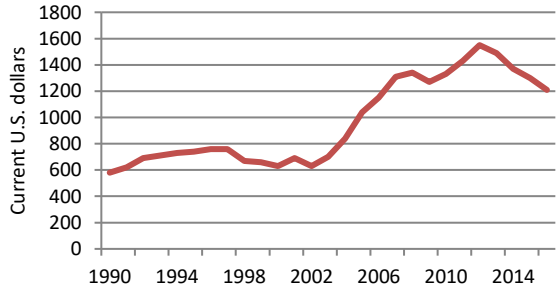


CONTEXTUAL DATA

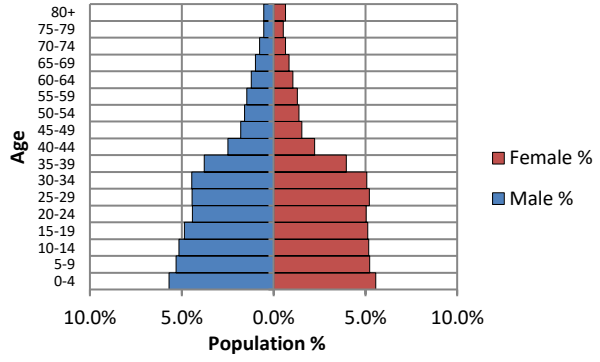
Financing the HIV Response



GNI Per Capita (Atlas Method)



Population Pyramid (2017)



Domain A. Governance, Leadership, and Accountability

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, provides accurate information and education on HIV/AIDS, and supports mechanisms for eliciting feedback. Relevant government entities take actions to create an enabling policy and legal environment, ensure good stewardship of HIV/AIDS resources, create space for and promote participation of the private sector, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

1. Planning and Coordination: Host country develops, implements, and oversees a costed multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector.			**Data Source**	**Notes/Comments**
1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. There is no national strategy for HIV/AIDS ◉ B. There is a multiyear national strategy. Check all that apply: ☑ It is costed ☑ It has measurable targets. ☑ It is updated at least every five years ☐ Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics) ☐ Strategy includes explicit plans and activities to address the needs of key populations. ☑ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children ☑ Strategy (or separate document) includes considerations and activities related to sustainability	1.1 Score: 2.07	National HIV/AIDS Strategic Plan 2011/12 - 2017/18	1. Country does not currently have the VMMC 'catchup'plan in the current document. 2. MoH is still working on the Key Populations plan, curretly there is no finalised plan. 3. There needs to be a transition plan from the emergency response to a sustainable one. The Lesotho Investment Case (2014) still needs endorsement and review.
1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?	○ A. There is no national strategy for HIV/AIDS ◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply): ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy ☑ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy ☐ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR) ☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy	1.2 Score: 2.00	National HIV/AIDS Strategic Plan 2011/12 - 2017/18	1. CSOs participated but there was no active participation, however CSOs are actively involved in implementation. 2. Businesses and the corporate sector are most of the time not participating.

1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Check all that apply: ☑ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc. ☑ The host country government routinely tracks and maps HIV/AIDS activities of: ☑ civil society organizations ☑ private sector (including health care providers and/or other private sector partners) ☑ donors ☑ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes. ☑ Joint operational plans are developed that include key activities of implementing organizations. ☑ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 2.50	1. National Coordination Framework. 2. LOMSHA. 3. Terms of Reference for various TWGs. 4. National AIDS ACT and Policy.	1. Technical Working Groups and Stakeholder forums for various thematic areas exists and are active. 2. AIDS Development Partners meetings are held regularly to review progress. 3. The current plan was developed in 2013 when the NSP was developed. 4. Different donors usually engage in a resource mapping activity to analyse and adress duplications.
1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for either checkbox under option B)	○ A. There is no formal link between the national plan and sub-national service delivery. ◉ B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.) ☐ Sub-national units have performance targets that contribute to aggregate national goals or targets. ☑ The central government is responsible for service delivery at the sub-national level.	1.4 Score: 2.50	NSP and National M&E Plan	
	Planning and Coordination Score:	**9.07**		

2. Policies and Governance: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Data Source**	**Notes/Comments**
2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current WHO guidelines for initiation of ART, i.e. Test and START for all populations?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines for each of the following: A. Adults (>19 years) ☑ Yes ☐ No B. Pregnant and Breastfeeding Mothers ☑ Yes ☐ No C. Adolescents (10-19 years) ☑ Yes ☐ No D. Children (<10 years) ☑ Yes ☐ No	2.1 Score: 1.11	MOH ART Guidelines 2016	

2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery? Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.	Check all that apply: ☑ A national public health services act that includes the control of HIV ☑ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☐ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits ☑ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) ☑ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) ☑ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☑ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS ☑ Policies that permit HIV self-testing ☑ Policies that permit pre-exposure prophylaxis (PrEP) ☑ Policies that permit post-exposure prophylaxis (PEP) ☑ Policies that allow HIV testing without parental consent for adolescents, starting at age 15 ☐ Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent	2.2 Score: 0.93	HIV/AIDS Policy 2007; NAC 2005 (ammendment Bill 2015); Public Health Act 1970; MoH ART Guidelines 2016; NSP; OVC Policy 2011-2016/17; Self Testing Policy; HIV Testing Services Policy (Draft)	1.HIV/AIDS Policy is outdated and needs revision urgently; 2. Draft VHW policy is available; 3. HTS for adolescents without parental consent starts at 12 years, treatment at 18 years

2.3 Data Protection: Does the country have policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS?	The country has policies in place that (check all that apply): ☑ Govern the collection of patient-level data for public health purposes, including surveillance ☐ Govern the collection and use of unique identifiers such as national ID for health records ☑ Govern the privacy and confidentiality of health outcomes matched with personally identifiable information ☑ Govern the use of patient-level data, including protection against its use in crimincal cases	2.3 Score: 0.83	M&E Tools; LOMSHA; HTS Policy; Integrated Disease Surveilence Response (IDSR) Guidelines; Public Health Law;	Director Planning/Policy at the MOH to provide policy document for last point on criminal cases.
2.4 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?	Check all that apply: Transgender people (TG): ☑ Constitutional prohibition of discrimination based on gender diversity ☑ Prohibitions of discrimination in employment based on gender diversity ☐ A third gender is legally recognized ☐ Other non-discrimination provisions specifying gender diversity (note in comments) Men who have sex with men (MSM): ☑ Constitutional prohibition of discrimination based on sexual orientation ☐ Hate crimes based on sexual orientation are considered an aggravating circumstance ☐ Incitement to hatred based on sexual orientation prohibited ☐ Prohibition of discrimiation in employment based on sexual orientation ☐ Other non-discrimination provisions specifying sexual orientation Female sex workers (FSW): ☑ Constitutional prohibition of discrimination based on occupation ☐ Sex work is recognized as work ☐ Other non-discrimination protections specifying sex work (note in comments)	2.4 Score: 0.39	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. Data Source: Constitution of Lesotho	1. Constitiution of Lesotho is silent on KP issues; 2. Penal code does not allow for sodomy

	People who inject drugs (PWID): ☐ Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments) ☐ Explicit supportive reference to harm reduction in national policies ☐ Policies that address the specific needs of women who inject drugs			
2.5 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?	The country has the following to protect key populations and people living with HIV (PLHIV) from violence: ☑ General criminal laws prohibiting violence ☑ Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population ☑ Programs to address intimate partner violence ☐ Programs to address workplace violence ☑ Interventions to address police abuse ☐ Interventions to address torture and ill treatment in prisons ☑ A national plan or strategy to address gender-based violence and violence against women that includes HIV ☑ Legislation on domestic violence ☑ Criminal penalties for domestic violence ☑ Criminal penalties for violence against children	2.5 Score: 0.89	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. Data Source: Police Art 1998; National Action Plan 2012; Sexual Offences Act; OVC Policy	1. GBV services provided in two districts (Berea and Maseru), otherwise we have pockets of such programs here and there. There is a need to develop a national program on IPV and GBV. 2. Police act covers abuse by police and establishment of the Police Complaints Directorate. 3. Matrix capacitates police

2.6 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services?	**For each question, select the most appropriate option:** Are transgender people criminalized and/or prosecuted in the country? ☑ Both criminalized and prosecuted ☐ Criminalized ☐ Prosecuted ☐ Neither criminalized nor prosecuted Is cross-dressing criminalized in the country? ☐ Yes ☐ Yes, only in parts of the country ☐ Yes, only under certain circumstances ☑ No Is sex work criminalized in your country? ☑ Selling and buying sexual services is criminalized ☐ Selling sexual services is criminalized ☐ Buying sexual services is criminalized ☐ Partial criminalization of sex work ☐ Other punitive regulation of sex work ☐ Sex work is not subject to punitive regulations or is not criminalized. ☐ Issue is determined/differs at subnational level	2.6 Score: 0.76	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. Data Source: Sexual Offences Act	Legal expertise is needed in this section.

Does the country have laws criminalizing same-sex sexual acts?

- [ ] Yes, death penalty
- [ ] Yes, imprisonment (14 years - life)
- [ ] Yes, imprisonment (up to 14 years)
- [x] No penalty specified
- [ ] No specific legislation
- [ ] Laws penalizing same-sex sexual acts have been decriminalized or never existed

Does the country maintain the death penalty in law for people convicted of drug-related offenses?

- [ ] Yes, with high application (sentencing of people convicted of drug offenses to death and/or carrying out executions are a routine and mainstreamed part of the criminal justice system)
- [ ] Yes, with low application (executions for drug offenses may have been carried out in recent years, but in practice such penalties are relatively rare)
- [ ] Yes, with symbolic application (the death penalty for drug offenses is included in legislation, but executions are not carried out)
- [x] No

Does the country have laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission?

- [ ] Yes
- [x] No, but prosecutions exist based on general criminal laws
- [ ] No

Does the country have policies restricting the entry, stay, and residence of people living with HIV (PLHIV)?

- [ ] Yes
- [x] No

	Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people? ☐ Yes, promotion ("propaganda") laws ☐ Yes, morality laws or religious norms that limit LGBTI freedom of expression and association ☑ No			
2.7 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	There are host country government efforts in place as follows (check all that apply): ☑ To educate PLHIV about their legal rights in terms of access to HIV services ☑ To educate key populations about their legal rights in terms of access to HIV services ☑ National law exists regarding health care privacy and confidentiality protections ☐ Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	2.7 Score: 0.83	Patient Charter	No laws but all health facilities have patient charters displayed for everyone's awareness.
2.8 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?	○ A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. ○ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. ◉ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.	2.8 Score: 1.11	There is one Joint External Review of TB/HIV/Hepatitis and Modes of Trasmission currently being conducted	
2.9 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?	○ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. ○ B. The host country government does respond to audit findings by implementing changes as a result of the audit. ◉ C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.	2.9 Score: 1.11	There is one Joint External Review of TB/HIV/Hepatitis and Modes of Trasmission currently being conducted	
	Policies and Governance Score:	**7.97**		

3. Civil Society Engagement: Local civil society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.			**Data Source**	**Notes/Comments**
3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. ○ B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen. ◉ C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.	3.1 Score: 1.67	CSO membership on CCM and CCM oversight committee. CSO engagement and participation in AIDS Development Partner Forum and PEPFAR COP development.	
3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. There are no formal channels or opportunities. ○ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. ◉ C. There are functional formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☑ During strategic and annual planning ☑ In joint annual program reviews ☑ For policy development ☑ As members of technical working groups ☑ Involvement on government HIV/AIDS program evaluation teams ☑ Involvement in surveys/studies ☑ Collecting and reporting on client feedback ☑ Service delivery	3.2 Score: 1.67	PEPFAR COP planning stakeholder engagement, PEPFAR COP planning civil society engagement, AIDS Development Partner Meetings, MOH TWGs	

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply): ☑ In policy design ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☐ In HIV/AIDS basket or national health financing decisions	3.3 Score: 1.33	PEPFAR COP planning stakeholder engagement, PEPFAR COP planning civil society engagement, AIDS Development Partner Meetings, MOH TWGs. CSOs do service delivery for both PEPFAR and GF activities.	
3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)	○ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources. ○ B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ◉ D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients).	3.4 Score: 2.50	CSO mapping by NAC	
3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)? Note: This sometimes referred to as "social contracting" or "social procurement."	◉ A. There is no law, policy, ore rgulation which permits CSOs to be funded from a government budget for HIV Services through open competition (not to include Global Fund or other donor funding to government that goes to CSOs). ○ B. There is a law, policy or regulation which permits CSOs to be funded from a government budget for HIV services. Check all that apply: ☐ Competition is open and transparent (notices of opportunities are made public) ☐ Opportunities for CSO funding are made on an annual basis ☐ Awards are made in a timely manner (within 6-12 months of announcements) ☐ Payments are made to CSOs on time for provision of services	3.5 Score: 0.00	CSOs are funded by PEPFAR, Global Fund, and other donors.	
		Civil Society Engagement Score:	**7.17**	

4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.			**Data Source**	**Notes/Comments**
4.1 Government Channels and Opportunities for Private Sector Engagement: Does the host country government have formal channels and opportunities for diverse private sector entities (including service delivery, corporations, and private training institutions) to engage and provide feedback on its HIV/AIDS policies, programs, and services? (If option B is true, check all subsequent boxes that apply.)	○ A. There are no formal channels or opportunities for private sector engagement. ◉ B. There are formal channels or opportunities for private sector engagement. i. The following private sector stakeholders formally contribute input into national or sub-national processes for HIV/AIDS planning and strategic development (check all that apply): ☐ Corporations ☑ Employers ☑ Private training institutions ☑ Private health service delivery providers ii. Stakeholders contribute in the following ways (check all that apply): ☑ The private sector contributes technical expertise into HIV program planning ☐ Data and strategic input into supply chain management for HIV commodities ☐ Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning ☐ Data on staffing in private health service delivery providers ☑ Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning ☐ For technical advisory on best practices and delivery solutions	4.1 Score: 0.90	Private Practicioners and private corporations are active in the HIV program in Lesotho. The CCM has membership from private sector and the Ministry of Health works with private practicioners on the HIV response.	

	iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply): ☐ The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response. ☐ A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan ☐ The government and private sector effectively coordinates and executes a total market approach for HIV service delivery, which accounts for whether people are able and/or willing to pay for HIV services.			
4.2 Enabling Environment for Private Corporate Contributions to HIV/AIDS Programming: Does the host country government have systems and policies in place that allow for private corporate contributions to HIV/AIDS programming?	Check all that apply: ☐ Tax policies and incentives are designed to encourage corporate social responsibility efforts from companies who are contributing financial commitments and/or non-financial resources (including, but not limited to, product donations, expertise, and employee staff time). ☐ The host country government has in-house expertise in contracting services to private sector corporations when appropriate and necessary (e.g., transportation and waste management). ☐ The host country government has standards for reporting and sharing data across public and private sectors. ☑ Regulations help ensure that workplace programs align with the national HIV/AIDS program (e.g., medical leave policies, on-site testing, on-site prevention and education, anti-discrimination policies). ☑ There are strong linkage and referral networks between on-site workplace programs and public health care facilities.	4.2 Score: 1.00	While workplace prgrams are limited, HIV testing and counseling has been rolled out in many of the large factories in Lesotho which employee large numbers of people. These programs put a strong focus on linking HIV positive patients to care and treatment.	Workplace programs are limited in scope

4.3 Enabling Environment for Private Health Service Delivery: Does the host country government have systems and policies in place that allow for private health service delivery? Note: Full score possible without checking all boxes.	○ A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services. ○ B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years. ◉ C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply): ☑ Policies are in place to ensure that private providers receive, understand, and adhere to national guidelines/protocols for ART, and appropriate quality standards and certifications. ☑ Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting. ☑ Joint (i.e., public-private) supervision and quality oversight of private facilities. ☐ The government offers tax deductions for private facilities delivering HIV/AIDS services. ☐ The government offers tax deductions for private training institutions. ☑ The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores ☑ The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services. ☐ HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes ☑ There are open competitions for private health care providers to compete for government service contracts ☐ There is a systematic and timely process for private company registration and/or testing of new health products (e.g., drugs, diagnostic kits, medical devices, etc.) that support HIV/AIDS programming ☑ The government effectively regulates the flow of subsidized commodities into the private sector.	4.3 Score: 2.22	Private Practicioners and private corporations are active in the HIV program in Lesotho. The CCM has membership from private sector and the Ministry of Health works with private practicioners on the HIV response.	

4.4 Private Sector Capability and Interest: Does the private sector possess the capability to support HIV/AIDS services, and do private sector stakeholders demonstrate interest in supporting the national HIV/AIDS response?	◉ A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response. ○ B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response. ○ C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply): ☐ Market opportunities that align with and support the national HIV/AIDS response ☐ Opportunities to contribute financial and/or non-financial resources to the national response (including business skills, market research, logistics, communication, research and development, product design, brand awareness, and innovation)	4.4 Score: 0.00	While the private sector is engaged in aspects of the HIV response, the reviewers felt that the host country government did not fully leverage the skill sets of the private sector.	
		Private Sector Engagement Score:	**4.13**	

5. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards , etc.) related to HIV/AIDS. Program and audit reports are published publically. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.			**Source of Data**	**Notes/Comments**
5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data and analyses are made available to stakeholders and general public in a timely and useful way?	○ A. The host country government does not make HIV/AIDS surveillance and survey data available to stakeholders and the general public, or they are made available more than one year after the date of collection. ○ B. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within 6-12 months. ◉ C. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within six months.	5.1 Score: 2.00	Timeline of LePHIA release	
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data available to stakeholders and the public in a timely and useful way?	○ A. The host country government does not track HIV/AIDS expenditures. ○ B. The host country government does not make HIV/AIDS expenditure data available to stakeholders and the general public, or they are made available more than one year after the date of expenditures. ◉ C. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within 6-12 months after date of expenditures. ○ D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures.	5.2 Score: 1.00	Annual Joint Review (AJR)	
5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data available to stakeholders and the public in a timely and useful way?	○ A. The host country government does not make HIV/AIDS program performance and service delivery data available to stakeholders and the general public or they are made available more than one year after the date of programming. ◉ B. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within 6-12 months after date of programming. ○ C. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within six months after date of programming .	5.3 Score: 1.00	DHIS 2 and LOMSHA	NAC is currently training stakeholders on LOMSHA.

5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. The host country government does not make any HIV/AIDS procurements. ◉ B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ○ C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ○ D. The host country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score: 0.00	The Government of Lesotho procures HIV/AIDS commodities. However the details of these procurements are not publicly available.	
5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for providing scientifically accurate education to the public about HIV/AIDS?	○ A. There is no government institution that is responsible for this function and no other groups provide education. ○ B. There is no government institution that is responsible for this function but at least one of the following provides education: ☐ Civil society ☐ Media ☐ Private sector ◉ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.	5.5 Score: 2.00	Ministry of Education and Training Website http://www.gov.ls/education/	Listed as sector objectives for the Ministry of Education and Training
	Public Access to Information Score:	**6.00**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving prevention, treatment, and care services and interventions. There is a high demand for HIV/AIDS services, which are accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and/or are affected by the HIV/AIDS epidemic.

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.			**Data Source**	**Notes/Comments**
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	☑ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) ☑ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☑ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 1.11	MOH DHS II and DATIM (PEPFAR) reports	At least 70% of sites are covered. It should be sustained and scaled up in other areas. VHL are charged with demand creation. Service flexibility to address demand of services: Extra staff is still a challenge in some health centres to meet the demand for services. There is a need to sustain direct service delivery where it is happening and to scale-up where there is a gap. Labs provide extra hour shifts to increase sample processing. Donor support for additional staffing to meet the demand for services. Demand from mobile clinics is higher than the available mobile clinics, and needs to be scaled up. Demand Creation: Health care workers at the public facilities not actively engaged in demand creation. Noted that Community health care workers and Village health care workers actively included in demand creation in the community, but do not cover all areas. However, VHW need additional support to increase demand for services from partners e.g. PSI, EGPAF, M2M, JHPIEGO, SolidaMed, LENASO, etc.
	The host country has standardized the following design and implementation components of community-based HIV/AIDS services through (check all that apply): ☐ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services ☑ National guidelines detailing how to operationalize HIV/AIDS services in communities ☑ Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities ☑ Providing financial support for community-based services	6.2 Score: 0.74	MOH Community Health Workers training manuals ; MOH budget/MOH payroll	No formalized mechanism for coordination of communities in service delivery and oversight. The NAC conducted a consultative process with all community providers to define areas of coordination. Need to finalize that process in developing a coordination framework. At the MOH, there is a staffing gap with the Community Manager, which has not been filled for the last year. NAC has launched LOMSHA to enable community providers

6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.)	☑ Providing supply chain support for community-based services ☐ Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness)			to report M&E at the national level. The next step is to implement it. Supply Chain for community based services is different for different districts. There is a strucutre for accessing commodities, with a few challenges. All community providers pick from a designated health facility. Condoms are not adequately getting in to the communities. Formalized bi-directional referral between facility-community: varied based on implementing partner who are using different tools for referrals. Good efforts through partners, and there is a need to strengthen it further by having a formal national system for monitoring the completed bi-directional referrrals and linkages.
6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services (i.e. excluding any external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services ◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services	6.3 Score: 0.83	CHAI resource mapping ; COP 17 SDS and current Global Fund TB/HIV concept	GOL provides the ARVs, essential drugs, HRH, VHWs, and infrastructure for HIV/AIDS services.

6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services without external technical assistance from donors?	○ A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.	6.4 Score: 0.37	COP 17 SDS, Global Fund TB/HIV concept	PEPFAR suppported partners providing direct service delivery staff in the scale-up districts (highest burden to support the scale-up ART services and attain epidemic control)
6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations (i.e. without external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations. ◉ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations. ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.	6.5 Score: 0.42	COP 17 SDS, Global Fund TB/HIV concept	GOL provides resources for all PLHIV in need of services. No desiganted funding allocation for KPs. They access services by default e.g. ARVs, Condoms, Lubricants. There are challenges of KP accessing health care in public health units due to stigma and legal framework. Key population focus activities implemented by organization like MANTSOPA-SW; MATRIX-MSM; PSI are all donor funded (PEPFAR and Global Fund) Stigma may prevent some key populations from seeking health care services
6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations without external technical assistance from donors?	○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.37	COP 17 SDS, Global Fund TB/HIV concept	GOL provides resources for all PLHIV in need of services. No desiganted funding allocation for KPs. They access services by default e.g. ARVs, Condoms, Lubricants. There are challenges of KP accessing health care in public health units due to stigma and legal framework. Key population focus activities implemented by organization like MANTSOPA-SW; MATRIX-MSM; PSI are all donor funded (PEPFAR and Global Fund) Stigma may prevent some key populations from seeking health care services
6.7 National Service Delivery Capacity: Do national health authorities have the capacity to	National health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations.	6.7 Score: 1.11	National Health Sector Strategic Plan 2012-2017	Lack of a HIV Program Manager at national level to manage the programme, coordinate partner support, and mobilize adequate resources for the programme for all ART sites both in scale-up and sustained

effectively plan and manage HIV services?	☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engage with civil society in program planning and evaluation of services. ☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.			

6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Sub-national health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☑ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☑ Effectively engage with civil society in program planning and evaluation of services. ☑ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.8 Score:	1.11	National Health Sector Strategic Plan 2012-2017	Lack of appropriate HIV Focal Coordinators at DHMT level to support HIV care providers at hospital and facility levels. The current HIV focal persons lack clinical background and skills and therefore, unable to fully execute their role There are challenges with performance management plans, training and mentorship capacity in some districts. This may affect program transitioning in future.
		Service Delivery Score	**6.06**		

7. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Data Source**	**Notes/Comments**
7.1 HRH Supply: To what extent is the clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level?	Check all that apply: ☑ The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers ☐ The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☐ The country has developed retention schemes that address clinical health worker vacancy or attrition in high HIV burden areas ☑ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children	7.1 Score: 0.56	Lesotho National Council , Lesotho Nurses training institutions, NEPI Program	Adequately qualified nurses but not adequately deployed. No retention schemes
7.2 Role of Community-based Health Workers (CHWs): To what extent are community-based health workers' roles and responsibilities specified for HIV/AIDS service delivery?	Check all that apply: ☑ There is a national community-based health worker (CHW) cadre that has a defined role in HIV/AIDS service delivery (e.g., through a national strategy or task-sharing framework/guidelines). ☐ Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors. ☑ The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services.	7.2 Score: 0.74	MOH-Directorate of Human resource	For the VHW the list is available
7.3 HRH transition: What is the status of transitioning PEPFAR and/or other donor supported HIV/AIDS health worker salaries to local financing/compensation? Note in comments column which donors have transition plans in place.	○ A. There is no inventory or plan for transition of donor-supported health workers ◉ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support ○ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented ○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	7.3 Score: 0.28	PEPFAR and GF Inventory, NGO inventory	Currently there is no retention strategy for and absorption plan for HRH funded by PEPFAR or Global fund (Counselors, Nurses, Microscopist, community focal persons).

7.4 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) health worker salaries ○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries ○ C. Host country institutions provide some (approx. 10-49%) health worker salaries ◉ D. Host country institutions provide most (approx. 50-89%) health worker salaries ○ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries	7.4 Score: 2.50	MOH-Directorate of Human resource	HRH MOH database
7.5 Pre-service: Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years? Note: List applicable cadres in the comments column.	○ A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years) ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☑ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☑ Institutions maintain process for continuously updating content, including HIV/AIDS content ☑ Updated curricula contain training related to stigma & discrimination of PLHIV ☑ Institutions track student employment after graduation to inform planning	7.5 Score: 1.11	Lesotho National Council, Lesotho Nurses training institutions, NEPI Program	Affected Cadres mainly include Nurses and Lab Technologists.
7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (if exact or approximate percentage known, please note in Comments column)	Check all that apply among A, B, C, D: ☑ A. The host country government provides the following support for in-service training in the country (check ONE): ☐ Host country government implements no (0%) HIV/AIDS related in-service training ☑ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training ☐ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training ☐ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training ☐ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training ☐ B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS ☑ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians ☑ D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)	7.6 Score: 0.63	MOH Training reports, Partners Training reports	Developmental partners providing support for the trainings.

7.7 HR Data Collection and Use: Does the country systematically collect and use health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?	○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management ○ B. There is no HRIS in country, but some data is collected for planning and management ☐ Registration and re-licensure data for key professionals is collected and used for planning and management ☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used ☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites ◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: ☑ The HRIS is primarily financed and managed by host country institutions ☐ There is a national strategy or approach to interoperability for HRIS ☐ The government produces HR data from the system at least annually ☐ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)	7.7 Score: 0.69	MOH Directorate of Human resource	
		Human Resources for Health Score	**6.50**	

8. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, diagnosis and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.			**Data Source**	**Notes/Comments**
8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○A. This information is not known. ○B. No (0%) funding from domestic sources ○C. Minimal (approx. 1-9%) funding from domestic sources ○D. Some (approx. 10-49%) funded from domestic sources ◉E. Most (approx. 50 – 89%) funded from domestic sources ○F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.63	MOH Budget, Global TB/HIV concept documents	The government of Lesotho progressively moved to finance 70% of all required ARV medicines as per FY2017/2018 budget.
8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○A. This information is not known ○B. No (0%) funding from domestic sources ○C. Minimal (approx. 1-9%) funding from domestic sources ◉D. Some (approx. 10-49%) funded from domestic sources ○E. Most (approx. 50-89%) funded from domestic sources ○F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.42	MOH Budget, Global TB/HIV concept documents	The government of Lesotho progressively moved to finance 70% of all required ARV medicines as per FY2017/2018 budget.
8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs. (if exact or approximate percentage known, please note in Comments column)	○A. This information is not known ○B. No (0%) funding from domestic sources ○C. Minimal (approx. 1-9%) funding from domestic sources ◉D. Some (approx. 10-49%) funded from domestic sources ○E. Most (approx. 50-89%) funded from domestic sources ○F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.42	CHAI Resource mapping, Global Fund TB/HIV and PSI	Government of Lesotho budgets for Condoms but in recent years condoms are supported by Global fund . There is no condom coordination structure within MOH; Current Condom procurement is donor dependent and thus the underutilization of MOH budget.

8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	◉ A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). ○ B. There is a plan/SOP that includes the following components (check all that apply): ☐ Human resources ☐ Training ☐ Warehousing ☐ Distribution ☐ Reverse Logistics ☐ Waste management ☐ Information system ☐ Procurement ☐ Forecasting ☐ Supply planning and supervision ☐ Site supervision	8.4 Score: 0.00	MOH Supply Chain Unit; 2017 TB /HIV program review reports.	The MOH Supply Chain Strategic plan draft (2013/14-2016/17) has expired. There is a plan to develop a follow-on in 2018. Creation of the MOH Supply Chain Coordination Unit (SCCU) and support from USAID projects improved the standardisation and reliability of national quantifications. There is a working quantification group for the MoH that carries out annual quantifications to inform government budgeting cycle and procurements, and bi-annual quantification reviews to inform procurements. The MoH was able to adopt and use standard tools for quantification of HIV and TB medicines namely Quantimed™ and QuanTB™ respectively. Challenges: Inadequate system for monitoring and reporting of stock level at facility level in the country creates gaps in adequately knowing national stock level picture for all the products beyond NDSO level; absence of a fully functional national drug regulatory agency; multiplicity of formulations and pack sizes of same medicines at facility level creating confusion among health workers at time of reporting and ordering in addition to rational use challenges at patient level; significant delay in release of funds for procurement of medicines and health supplies and the amounts released are further affected by limits determined by quarterly release warrants from Ministry of finance.
8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)? (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not available. ○ B. No (0%) funding from domestic sources. ○ C. Minimal (approx. 1-9%) funding from domestic sources. ○ D. Some (approx. 10-49%) funding from domestic sources. ◉ E. Most (approx. 50-89%) funding from domestic sources. ○ F. All or almost all (approx. 90%+) funding from domestic sources.	8.5 Score: 0.63	CHAI Resource mapping , Global Fund TB/HIV and COP17 SDS	This estimate is based on different grant budgets and MOH as there is currently no costed supply chain plan

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Check all that apply: ☐ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities ☑ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time ☑ MOH or other host government personnel make re-supply decisions with minimal external assistance: ☑ Decision makers are not seconded or implementing partner staff ☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects ☑ Team that conducts analysis of facility data is at least 50% host government	8.6 Score: 1.48	MOH Stock status reports	although no plan, quantification is provide by the different MOH progams (TB, HIV, Lab etc.)
8.7 Assessment: Was an overall score of above 80% achieved on the National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years? (if exact or approximate percentage known, please note in Comments column)	◉ A. A comprehensive assessment has not been done within the last three years. ○ B. A comprehensive assessment has been done within the last three years but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments ○ C. A comprehensive assessment has been done within the last three years and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score: 0.00		Last National Supply chain assessment was done in 2013.
	Commodity Security and Supply Chain Score:	**3.56**		

9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			**Data Source**	**Notes/Comments**
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	○ A. The host country government does not have structures or resources to support site-level continuous quality improvement ◉ B. The host country government: ☑ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement ☐ Has a budget line item for the QM program ☐ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions	9.1 Score: 0.67	MOH QA/QI unit	The structure is there but it is not functional
9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)	○ A. There is no HIV/AIDS-related QM/QI strategy ◉ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not utilized ○ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized. ○ D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.	9.2 Score: 0.67	Current QI/QA plan is under review.	QI/QA plan is under review.
9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?	○ A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. ◉ B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): ☑ The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement ☑ There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities ☐ There is documentation of results of QI activities and demonstration of national HIV program improvement through sharing and implementation of best practices across HIV/AIDS sites at all levels	9.3 Score: 1.33	PHC meeting minutes from the different districts	It works in the district and site levels

9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?	○ A. There is no training or recognition offered to build health workforce competency in QI. ◉ B. There is health workforce competency-building in QI, including: ☐ Pre-service institutions incorporate modern quality improvement methods in curricula ☑ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 1.00	Slide package from HCW training.	Sites have their own QI initiatives as a result of training.
9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?	The national-level QM structure: ☐ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convenes meetings that include health services consumers ☐ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convene meetings that includes health services consumers ☐ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 0.57	Refer DHMTs and IP Reports	
		Quality Management Score: **4.24**		

10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.			**Data Source**	**Notes/Comments**
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	◉ A. There is no national laboratory strategic plan ○ B. National laboratory strategic plan is under development ○ C. National laboratory strategic plan has been developed, but not approved ○ D. National laboratory strategic plan has been developed and approved ○ E. National laboratory plan has been developed, approved, and costed ○ F. National laboratory strategic plan has been developed, approved, costed, and implemented	10.1 Score: 0.00	MOH -LAB directorate records	NO LAB Strategic plan in place. The laboratory network in Lesotho is organized in a tiered system with the NRL director providing oversight to the regional laboratories. National Reference Laboratory (NRL) provides high complexity testing and referral services to lower tiered laboratories. The regional laboratories provide referral services to district laboratories and/or health centers. The specific services offered at each level are specified detailed in the laboratory handbook. External laboratories in South Africa (NICD) and Uganda (NTBRL) serve as reference labs for HIV and TB, respectively. Sample transport system, supported by riders for health (R4H), across the tiered laboratory network
10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)	○ A. Regulations do not exist to monitor minimum quality of laboratories in the country. ○ B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). ○ C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated). ○ D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). ◉ E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). ○ F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).	10.2 Score: 1.25	MOH -LAB directorate records	Laboratory Proficiency Testing_Continuous Quality Improvement is avaialable for 87% of the POCT. In 2017 the pass rate was 96%
10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?	◉ A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control ○ B. There are adequate qualified laboratory personnel to perform the following key functions: ☐ HIV diagnosis by rapid testing and point-of-care testing ☐ Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria ☐ Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays ☐ TB diagnosis	10.3 Score: 0.00	Based on Current funding from Global fund and COP 17 SDS. Human resource plan 2017	HR specifically Lay counselors for HIV testing and Microscopists for TB diagnosis are mostly donor-funded (Global Fund and PEPFAR). World Bank is funding some of the staff at the National TB reference lab. According to the Human resource plan for 2017, 60% of laboratory positions are vacant as a result; the workload for current staff in facilities is high.

10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	○A. There is not sufficient infrastructure to test for viral load. ◉B. There is sufficient infrastructure to test for viral load, including: ☑ Sufficient HIV viral load instruments ☑ All HIV viral load laboratories have an instrument maintenance program ☐ Sufficient supply chain system is in place to prevent stock outs ☐ Adequate specimen transport system and timely return of results	10.4 Score: 0.83	MOH -LAB directorate	The Lesotho National Strategy and Implementation Plan for Scaling up HIV Viral Load Testing for 2015/16 – 2017/18 outlines plans to roll out and ensure routine access to viral load testing for diagnosis and monitoring of treatment failure in people living with HIV (PLHIV) on antiretroviral treatment (ART) by2020. Lab equipment for Viral load is leased from Roche. There are infracture challenges-strctural adjustments needed in some labs to accomodate all the equipment. There are challenges with reagent supply contract--very supplier friendly
10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)? (if exact or approximate percentage known, please note in Comments column)	○A. No (0%) laboratory services are financed by domestic resources. ○B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources. ◉C. Some (approx. 10-49%) laboratory services are financed by domestic resources. ○D. Most (approx. 50-89%) laboratory services are financed by domestic resources. ○E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.	10.5 Score: 1.67	Resource mapping exercise.	Viral testing and Genexpert catridges and TB Drug resistance tests are financed by Global fund, World Bank and PEPFAR. Routine lab tests like FBC, Chemistries are financed by the GOL .
	Laboratory Score:	**3.75**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Investments, Efficiency, and Sustainable Financing

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

Fiscal Context for Health and HIV/AIDS This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.			**Data Source**	**Notes/Comments**
1. What percentage of general government expenditures goes to health?	11%		11% (1.943 bln) 2015-2016 AJR MOH	
2. What is the per capita health expenditure all sources?	$105		www.knoema.com,2014;	276 USD, WHO 2016
3. What is the total health care expenditure all sources as a percent of GDP?	10.60%		www.knoema.com,2014;	
4. What percent of total health expenditures is financed by external resources?	52%		2014,www.worldbank.org	
5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?	15.10%		2014,www.worldbank.org	

11. Domestic Resource Mobilization: The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability.			**Data Source**	**Notes/Comments**
11.1 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?	Check all that apply: ☑ A. Yes, there is a universal, comprehensive financing scheme that integrates social health insurance, public subsidies, and national budget provisions for public health aspects (e.g., disease surveillance). It includes the following (check all that apply): ☑ ARVs are covered ☑ Non-ARV care and treatment is covered ☑ Prevention services are covered ☐ B. Yes, there is an affordable health insurance scheme available (check one of the following). ☐ It covers 25% or less of the population. ☐ It covers 26 to 50% of the population. ☐ It covers 51 to 75% of the population. ☐ It covers more than 75% of the population. ☐ C. The affordable health insurance scheme in (B.) includes the following (check all that apply): ☐ ARVs are covered. ☐ Non-ARV care and treatment services are covered. ☐ Prevention services are covered. ☐ It includes public subsidies for the affordability of care.	11.1 Score: 0.32	Program Data/report	There is no integrated social insurance

11.2 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?	○ A. There is no explicit funding for HIV/AIDS in the national budget. ◉ B. There is explicit HIV/AIDS funding within the national budget. ☑ The HIV/AIDS budget is program-based across ministries ☐ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals ☐ The budget includes specific HIV/AIDS service delivery targets ☑ National budget reflects all sources of funding for HIV, including from external donors	11.2 Score: 0.71	There is MTR of domestic investments, reprogramming implemented, but not based on data. There is an HIV/AIDS cost center in the budget, but it focuses fully on the purchasing of ARVs.	There is no information on line ministries compliance to 2% allocation for HIV/AIDS, only key major donors are accounted for at national level
11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?	○ A. There are no HIV/AIDS goals/targets articulated in the national budget ◉ B. There are HIV/AIDS goals/targets articulated in the national budget. ☐ The goals/targets are measurable. ☐ Budget items/programs are linked to goals/targets. ☐ The goals/targets are routinely monitored during budget execution. ☐ The goals/targets are routinely monitored during the development of the budget.	11.3 Score: 0.48	National Budget Speech 2017/18, for example targets are Test & Treat and LePhiA	
11.4 HIV/AIDS Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level? (If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)	◉ A. There is no HIV/AIDS budget, or information is not available. ○ B. 0-49% of budget executed ○ C. 50-69% of budget executed ○ D. 70-89% of budget executed ○ E. 90% or greater of budget executed	11.4 Score: 0.00	Information on execution rate is not available yet	

11.5 Donor Spending: Does the Ministry of Health or Ministry of Finance routinely, and at least on an annual basis, collect all donor spending in the health sector or for HIV/AIDS-specific services?	◉ A. Neither the Ministry of Health nor the Ministry of Finance routinely collects all donor spending in the health sector or for HIV/AIDS-specific services. ○ B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services. ○ C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.	11.5 Score: 0.00	Resource mapping data, MoH Q-ter and AR on capital budget. (CHAI is no longer supporting resource mapping. It is currently owned by the MoH but there is uncertainty if it will be carried out again)	
11.6 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding? (Domestic funding excludes out-of-pocket, Global Fund grants, and other donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. None (0%) is financed with domestic funding. ○ B. Very liitle (approx. 1-9%) is financed with domestic funding. ◉ C. Some (approx. 10-49%) is financed with domestic funding. ○ D. Most (approx. 50-89%) is financed with domestic funding. ○ E. All or almost all (approx. 90%+) is financed with domestic funding.	11.6 Score: 1.67	UNAIDS data book 2014 (out of pocket under). This is unknown.	
11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?	○ A. There is no budget for health or no money was allocated. ○ B. 0-49% of budget executed. ○ C. 50-69% of budget executed. ○ D. 70-89% of budget executed. ◉ E. 90% or greater of budget executed.	11.7 Score: 0.95	- 91.7% (allocation 1.75bln ; exp 1.61bln), AJR 2016. - -95%, 2017 WB Public Expenditure Review (PER)	
11.8 Data-Driven Reprogramming: Do host country government policies/systems allow for reprograming domestic investments based on new or updated program data during the government funding cycle?	◉ A. There is no system for funding cycle reprogramming. ○ B. There is a policy/system that allows for funding cycle reprogramming, but is seldom used. ○ C. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, but not based on data. ○ D. There is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy, and is based on data.	11.8 Score: 0.00	there is MTR of domestic investments,reprogramming, implemented, but not based on data	
	Domestic Resource Mobilization Score:	**4.13**		

12. Technical and Allocative Efficiencies: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).			**Data Source**	**Notes/Comments**
12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources? If yes, please note in the comments section when the model was last used and for what purpose (e.g., for Global Fund concept note development) (note: full score achieved by selecting one checkbox)	◉ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources. ○ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply): ☐ Optima ☐ Spectrum (including EPP and Goals) ☐ AIDS Epidemic Model (AEM) ☐ Modes of Transmission (MOT) Model ☐ Other recognized process or model (specify in notes column)	12.1 Score: 0.00		
12.2 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)? (if exact or approximate percentage known, please note in Comments column)	○ A. Information not available. ○ B. No resources (0%) are targeting the highest burden geographic areas. ○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas. ◉ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas. ○ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas. ○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.	12.2 Score: 1.00	All geographic areas received resources. Maseru is receiving the majority of funding, as it also has the highest disease burden. The specifics are not known but this is an estimate.	

12.3 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	○ A. The host country government does not have/use recent expenditure data or cost analysis to estimate unit costs ◉ B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply): ☑ HIV Testing ☑ Laboratory services ☑ ART ☑ PMTCT ☑ VMMC ☑ OVC Service Package ☐ Key population Interventions	12.3 Score: 2.00	NSP, donor program	
12.4 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?	Check all that apply: ☐ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies ☐ Reduced overhead costs by streamlining management ☑ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. ☑ Improved procurement competition ☐ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) ☑ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) ☑ Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years) ☑ Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years) ☑ Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)	12.4 Score: 1.33	T&T, CAG, MC, MMD, EH, MOC, same date ART	

12.5 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)	○ A. Partner government did not pay for any ARVs using domestic resources in the previous year. ○ B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen. ○ C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen. ○ D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen. ◉ E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.	12.5 Score:	2.00	check the source (NDSO)	
Technical and Allocative Efficiencies Score:			**6.33**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

What Success Looks Like: Using local and national systems, the host country government collects, analyzes and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

13.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.			**Data Source**	**Notes/Comments**
13.1 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies	13.1 Score: 0.48	Protocols for DHS, LEPHIA, ANC, Cohort Analysis	DHS/Sentinel/PHIA-coordinate, provides leadership, planning by Ministry with financial support and technical input from partners
13.2 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ◉ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ○ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies	13.2 Score: 0.24	ToR for Currrent IBBS developed by PACT. Report for previous study done in 2015.	Key pop survey done by PSI in 2015, PACT is currently planning the next survey. Government in the technical committee but not planned by Government. PACT planning and financing
13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	13.3 Score: 0.42	Protocols/Budgets	PHIA/ANC Sentinel completely funded by partners. The proportion fluctuates, for DHIS for example. However Government plays role in terms of human resources. The government budgeting process is done in line with partner's budgets to avoid duplication. Government provides technical assistance and management.

13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (approx. 90% +) is provided by the host country government	13.4 Score: 0.42	Protocols/Budgets	All supported by PSI (2015), PACT (current) - governments contributon is staff time (human resource)
13.5 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below. (A.) refers to prevalence data. (B.) refers to incidence data: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☐ Age (at coarse disaggregates) ☑ Age (at fine disaggregates) ☑ Sex ☑ Key populations (FSW, PWID, MSM, TG, prisoners) ☑ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ Sub-national units ☑ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☑ Age (at coarse disaggregates) ☐ Age (at fine disaggregates) ☑ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☐ Sub-national units	13.5 Score: 0.67	DHIS2, Specific surveys, Priority populations (only AGYW) sample six large enough to extrapolate to populations unlike other priority populations.	For priority population only at AGYW, clients of sex workers. Key populations study was done only at 2 districts Maseru and Leribe. Need for national prevalence study for key populations. The current study conducted by PACT in 4 districts Berea, Mafeteng, Leribe and Maputose. LDHS Incidence was not for key populations, not disaggregated by age, districts. Only for the general populations and it was disaggregated by sex. LEPHIA has incidence by age groups, sex, subnational. Incidence has not been measured for key populations.

13.6 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage known, please note in Comments column)	○ A. The host country government does not collect/report viral load data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load data (answer both subsections below): According to the following disaggregates (check ALL that apply): ☑ Age ☑ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) For what proportion of PLHIV (select ONE of the following): ☐ Less than 25% ☐ 25-50% ☑ 50-75% ☐ More than 75%	13.6 Score: 0.60	DHIS2	LMIS data disaggregated by age and sex.
13.7 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.) Please note most recent survey dates in comments section.	○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM, TG, prisoners) or priority populations (Military, etc.). ◉ B. The host country government conducts (answer both subsections below): IBBS for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☐ Transgender (TG) ☐ People who inject drugs (PWID) ☑ Prisoners ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☐ Transgender (TG) ☑ People who inject drugs (PWID) ☑ Prisoners ☐ Priority populations (AGYW, clients of sex workers, miliitary, mobile populations, non-injecting drug users)	13.7 Score: 0.83	DHS 2014	There is no national study that has been conducted. Only few districts. Mathematical extrapolation for the national size estimation in the 2015 study. For AGYW can use the census data. IBBS only planned for key pops. No IBBS specifically planned for priority pops; further analysis can be done from DHIS data. Mathematical extrapolation for the districts not Maseru and Leribe. For prisoners - data is available from census/prison records- same for AGYW(census)

13.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?	○ A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys ◉ B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups ○ C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups	13.8 Score: 0.48	Research agendas, M&E plan for health and HIV, health strategy	
13.9 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply): ☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data ☐ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance ☐ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection ☑ An in-country internal review board (IRB) exists and reviews all protocols.	13.9 Score: 0.48	Research unit at MOH, NAC	
		Epidemiological and Health Data Score:	**4.60**	

14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.			**Data Source**	**Notes/Comments**
14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	○A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ○B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions ◉C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance ○D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance ○E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	14.1 Score: 1.67	Resource tracking tool	
14.2 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?	○A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ◉B. HIV/AIDS expenditure data are collected (check all that apply): ☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening ☑ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel ☐ Sub-nationally	14.2 Score: 2.50	PSHER: Public Health Sector Expenditire Review 2017 conducted by CHAI	
14.3 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	○A. No HIV/AIDS expenditure data are collected ○B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago ◉C. HIV/AIDS expenditure data were collected at least once in the past 3 years ○D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures ○E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	14.3 Score: 1.67	PSHER: Public Health Sector Expenditire Review 2017 conducted by CHAI	Available from planning unit: Can pull out HIV expenditure from the government public health expenditure.
	Financial/Expenditure Data Score:	**5.83**		

15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.			**Data Source**	**Notes/Comments**
15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?	○A. No system exists for routine collection of HIV/AIDS service delivery data ◉B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions ○C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution ○D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution ○E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government	15.1 Score: 0.33	One primary data collection tool but data flows through different channels thereafter HIV M&E Framework National HIV paper based tools National Data Warehouse	Need for data alignment. The primary data collection is the same however different partners have their own service delivery tool. Need to have clear similar definitions for targets. The national HIV/AIDS program has standardized paper based M&E tools (patient level, registers and reports) the standardized reporting tools are incorporated into the national electronic information system (data warehouse-DHIS 2)
15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)	○A. No routine collection of HIV/AIDS service delivery data exists ○B. No financing (0%) is provided by the host country government ○C. Minimal financing (approx. 1-9%) is provided by the host country government ◉D. Some financing (approx. 10-49%) is provided by the host country government ○E. Most financing (approx. 50-89%) is provided by the host country government ○F. All or almost all financing (90% +) is provided by the host country government	15.2 Score: 1.67	Marjority of staff costs for collection of primary clinical data are supported by the government. Data clerks supported by external agencies	Majority of staff costs for collection of primary clinical data are supported by the government. Nurses/Doctors do Bukana; nurse do care card; data clerk do registers; nurse/ data clerk do tallying; data clerk do report; data clerk do DHIS Data clerks supported by external agencies Recommend finer bands for percentages

15.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government routinely collects & reports service delivery data for: ☑ HIV Testing ☑ PMTCT ☑ Adult Care and Support ☑ Adult Treatment ☑ Pediatric Care and Support ☑ Orphans and Vulnerable Children ☑ Voluntary Medical Male Circumcision ☑ HIV Prevention ☐ AIDS-related mortality ☑ B. Service delivery data are being collected: ☐ By key population (FSW, PWID, MSM, TG, prisoners) ☐ By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ By age & sex ☑ From all facility sites (public, private, faith-based, etc.) ☐ From all community sites (public, private, faith-based, etc.)	15.3 Score: 1.11	National TB and HIV strategic plan HIV M&E Framework	OVC data at Min of Planning and development AIDS related mortality not collected HIV/AIDS service delivery data is collected by age and sex, from all facility and community sites.

15.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?	○ A. The host country government does not routinely collect/report HIV/AIDS service delivery data ○ B. The host country government collects & reports service delivery data annually ○ C. The host country government collects & reports service delivery data semi-annually ◉ D. The host country government collects & reports service delivery data at least quarterly	15.4 Score: 1.33	National TB and HIV strategic plan HIV M&E Framework	Health facilities collect and report HIV/AIDS service delivery data on a monthly basis
15.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	○ A. The host country government does not routinely analyze service delivery data to measure program performance ◉ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply): ☑ Continuum of care cascade for each identified priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users), including HIV testing, linkage to care, treatment, adherence and retention ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention ☑ Results against targets ☑ Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.) ☑ Site-specific yield for HIV testing (HTC and PMTCT) ☐ AIDS-related mortality rates ☑ Variations in performance by sub-national unit ☑ Creation of maps to facilitate geographic analysis	15.5 Score: 1.00	Annual Joint Review National Data ware house- DHIS 2	On monthly basis performance on the National indicators are analysed and displayed on DHIS 2 dashboard; provide performance/results by all the checked options Additionally DHIS 2 dashboard provides care cascades for HIV Care and Treatment, PMTCT, TB and TB/HIV
15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☐ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☑ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government ☑ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☑ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☑ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans	15.6 Score: 1.07	The national M&E framework and the National RDQA tools	The national M&E framework exist and guide on routine data quality assurance (RDQA); outlines the responsibilties and the frequency at which RDQA should be conducted. Observation is that RDQA is not conducted at the expected frequency. It was ususually conducted annually (just before compiling results for AJR). Recently DHMTS have decided to conduct RDQA on quarterly basis and the first RDQA was done in October 2017
		Performance Data Score: **6.51**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D