

PRICEWATERHOUSECOOPERS 



# FINAL REPORT ON 2003 DATA QUALITY AUDIT

## KINGDOM OF LESOTHO

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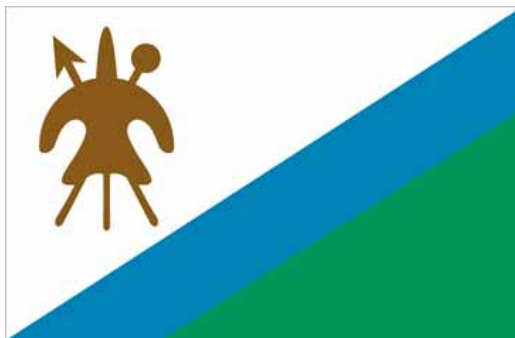
**AUGUST 2004**





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## 1 Executive Summary



The overall conclusion of the DQA team is that Lesotho has a good system in place for reporting immunization information. This system requires a few improvements rather than a major overhaul.

We have highlighted below some of the key issues that require management attention. We have categorised them under system design, denominators, monitoring and

evaluation, data processing and vaccine store management.

### System Design

There is no official written regulation regarding the reporting of immunization data from the health centre through to the national level, and covering frequency of reporting, where to report, reporting deadlines, etc. We understand that the Government of the Kingdom of Lesotho has a draft policy document addressing these matters that is awaiting cabinet approval.

*The Government of the Kingdom of Lesotho should finalise and implement the policy document.*

### Denominators

Currently there are three denominators in use for surviving infants: 1996 Census (64,428), World Bank 2002 Study

(53,614) and Ministry of Health - Health planning and statistics unit – (47,920). The denominator used in the JRF is 64,428. However all tabulations, charts or tables in the country use the 47,920 figure, which was reported to be the most realistic.

*The correct denominator should be agreed upon and utilised at all levels for purposes of consistency.*

### **Monitoring and evaluation**

There is a need to monitor core indicators such as drop-out rates and immunisation coverage at all levels.

### **Data Processing**

There is a need to train EPI Central data processing staff on the use of the EPI Info Data Management system in place. EPI also need to be empowered to produce conclusive reports through appropriate liaison with relevant Ministry of Health departments.

### **Vaccine Store Management**

Staff at all levels need to be trained on proper record keeping of vaccines and syringes. Staff at the National level should also be trained on the use of the computerised Vaccine Stock Management System in place.

Computation of vaccine wastage should take into account both closed and open vial wastage. Currently, only open vial wastage is monitored.

## 2 Introduction

The DQA is a tool developed by WHO to evaluate the quality and precision of vaccination reporting, monitoring and evaluation systems and vaccination data (but not the quality of medical service delivery) and also, to calculate indicators relating to performance in the design and implementation of immunisation data reporting in particular the verification factor and the quality of system index. The main objectives of the DQA are to:

- Assess the quality, accuracy and completeness of administrative immunisation reporting systems,
- Audit the number of DTP3<1 doses given to infants in a specific calendar year and then estimate the national verification factor (VF, recounted/reported vaccinations) for use in the allocation of vaccine fund shares,
- Provide practical feedback to health staff on the quality of reported data.

The DQA was undertaken in the Kingdom of Lesotho from 28 July 2004 to 13 August 2004 by external auditors Dickson Lihanda and Emmah Mathu accompanied by national auditors Pulane Hlalele (EPI Central Data Officer) and Rahaba Musenene (Officer, Family Health Division). There are nineteen Health Service Areas “HSAs” (equivalent to districts) in the Kingdom of Lesotho. Out of these, thirteen were eligible for sampling while six were ineligible on the basis that they had less than six health centers. The four randomly selected HSAs were:

- Butha – Buthe,
- Mafeteng,
- Q.E.II, and
- Scott

Butha - Buthe HSA served as a replacement for Lesotho Flying Doctors Service (L.F.D.S), which had originally been sampled.

L.F.D.S HSA is served by flying doctors who conduct immunisation in mountainous areas that are generally inaccessible by other modes of transport. We understand from discussions with the nurses at the flying doctors headquarters that the clinics covered are not mobile and

that immunisation records (i.e. tally sheets and registers) are kept at the respective health centers. However, monthly reporting is performed, as in other health centers, using the MCH/FP report forms, which are submitted to the EPI Central Office. It was therefore not possible to count tally sheets at the National level. The DQA was carried out during winter, when snowy conditions made the health centers served by L.F.D.S. difficult to access and the only practical solution would have resulted in auditing one health center per day based on unpredictable flight schedules. This would have considerably slowed down the DQA exercise. L.F.D.S. was therefore replaced by Butha-Buthe, also randomly sampled, after making appropriate consultations with World Health Organisation (WHO). There were no other logistical problems and all the 24 randomly selected health centers in the four HSAs were visited without having to use a reserve.

A debriefing meeting was held on Friday, 13 August 2004 at the Ministry of Health headquarters with the members of the Interagency Coordinating Committee (ICC). The meeting was chaired by the Honourable Minister of Health of the Kingdom of Lesotho, Dr M Phooko. A

comprehensive list of persons met during the DQA including those present in the debriefing session is included in Annex I of this report. The conclusions of the discussion during the debrief meeting are summarised as follows:

- There is a working EPI system in the country, which requires improvements in certain key areas.
- The main areas requiring management attention are recording practices, training of EPI personnel and strengthening of the HSA level to give adequate support to the EPI Central Office.

## 2.1 Background

The Kingdom of Lesotho, through the EPI programme, serves an under-five population of 240,756 (1996 Population census projections). The health care delivery system is divided into nineteen (19) Health Service Areas which together comprise twenty hospitals and two-hundred health centers.

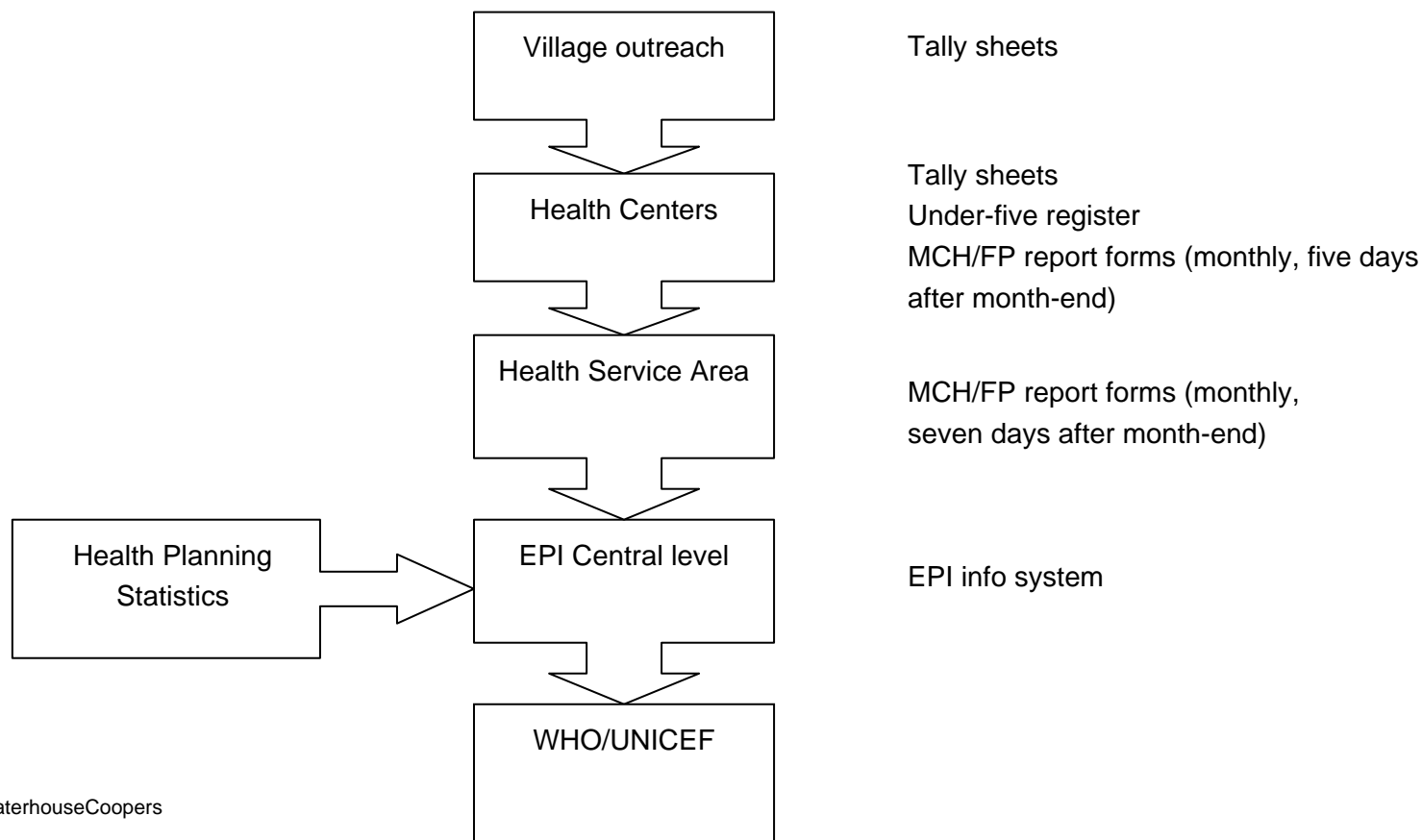


The country carries out its immunisation program using fixed and outreach strategies. Tally sheets and under-five child registers are the primary immunisation records used for both strategies.

Immunisation performance reports are included in the monthly Mother & Child/Family Planning (MCH/FP) report forms, which are prepared by the health centers based on the tally sheets and under-five register records and submitted to the Public Health Nurses (PHNs) who are the administrative heads at the HSA level. The PHNs, in turn, forward all the MCH/FP report forms collected to the EPI central office. Data processing and analysis is done at the Central level.

The Flow of information in the EPI program is shown in the diagram overleaf:

**Information/Data Flow and organisation of EPI in the Kingdom of Lesotho**





### 3 Data Accuracy – Findings

#### 3.1 Verification Factor

In simple terms the verification factor is a quantification of the accuracy of reported data. Its basic formula is:

Immunisations recounted

Immunisations reported

The Kingdom of Lesotho achieved a verification factor of 77.5% placing it below the 80% threshold at which an immunisation reporting system is deemed to be reliable. The main causes of errors in reporting that may have negatively affected the national verification factor can be broadly classified as follows:

#### Missing Information

Most of the health centers visited did not retain some or all of the tally sheets from previous reporting periods. They were either destroyed or used for other purposes. As such

the recounted figures were in most cases lower than the reported figures.

In addition, the alternative immunisation records available, i.e. the under-five registers, were not regularly updated and in particular did not capture information on children vaccinated during outreach sessions. Hence, where registers were used, the recounted figure was also lower than the reported figure.

#### Transcription errors

There were minimal transcription errors noted in the reporting process, which resulted in differences between the national tabulation and reports found at the HSA and health center level.

#### Over reporting

No examples of over-reporting were observed, nor did anything come to our attention, which would suggest that immunisation data was deliberately over-reported.

### 3.2 Other Critical points

#### 3.2.1 Differences between the JRF and National Tabulation

The latest national tabulation provided to the auditors shows the number of DTP3<1 doses administered as 39,466 while the JRF figure is 39,781- hence a difference of 315 doses. This seems to be because the “latest” national tabulation available was produced earlier than the JRF tabulation although these tabulations are not dated hence not possible to tell which had been done earlier.. in Addition, the JRF tabulation and the intended latest tabulation could not be reproduced from an archive file.

#### 3.2.2 Comparison of health center reports found at the district and district tabulation

There is no formal tabulation done at the HSA level. However, all public health nurses prepare an informal tabulation which is not submitted to the national level. Differences between these tabulations and the health center reports found at the HSA are mainly attributed to transcription errors as the system is manual.

District	Tabulation	Reports at HSA	Variance
Butha - Buthe	1,918	1,918	-
Mafeteng	2,817	2,819	2
Q.E.II	7,074	7,234	160
Scott	2,945	2,945	-

#### 3.2.3 Comparison DTP3/ Other Antigens

Other antigens are reported using the same forms as those of DTP3<1 hence the problems associated with recording practices for DTP3 are applicable to all other antigens. The audit team noted differences in other antigens where they were recounted (see the various health unit worksheets in the excel workbook).

#### 3.2.4 Inflation/fraud statement

There was no evidence in any case of inflated or “creative” reporting that came to our attention.

## 4 National Level – Findings and Recommendations

### 4.1 System Design

- 4.1.1 There is no official written regulation regarding the reporting of immunization data from health centres, covering frequency of reporting, where to report, reporting deadlines, etc

*Recommendation 1:*

*We understand that there is a draft policy addressing these matters awaiting Cabinet approval. EPI Central Level should set up a formal written regulation regarding the reporting system from health centre.*

*If not already done, the country should consider circulating the current draft to focal points at HAS and HU level for their comments on the feasibility*

*and reasonableness of policy and its implementation. This recommendation also applies to late reporting policy.*

#### Management Comments

*Please note: At the time this report was finalised, PricewaterhouseCoopers had not received comments from the Expanded Programme on Immunisation of the Kingdom of Lesotho.*

- 4.1.2 There is no policy on Adverse Events Following Immunisation (AEFI). See details and recommendations under section 7 on core indicators.
- 4.1.3 Computation of System and Global Wastage of vaccines does not take into account closed (unopened) vials.

*Recommendation 2:*

*In addition to administered wastage, unopened vials (damaged, discarded, expired, etc) should be monitored, recorded and reported.*

#### **Management Comments**

### **4.2 Denominators**

4.2.1 Currently there are three denominators in use for surviving infants: 1996 Census (64,428), World Bank 2002 Study (53,614) and MOHSW Health Planning and Statistics Unit (47,920).

*Recommendation 3:*

*The issue of denominators needs to be resolved at National level by the relevant departments and communicated to the HSAs and Health Centers to*

*facilitate planning and monitoring of core indicators.*

#### **Management Comments**

4.2.2 The process of target setting (children and pregnant women) is deficient. The proportion of infants per strategy type (fixed, outreach, mobile) is not set at national level nor is it cascaded down to HSAs and Health Unit levels.

*Recommendation 4:*

*There is a need to determine the number of infants per strategy type for planning purposes. Individual HSAs and health units should also be encouraged to monitor the same.*

#### **Management Comments**

### 4.3 Monitoring and Evaluation

4.3.1 An up-to-date monitoring chart or table of drop-out rates was not displayed anywhere in the EPI Central Office, nor in the four selected HSA offices or the 24 health centers visited. In 12 out of the 24 health centers visited, the staff could not recall how to calculate the drop-out rate.

*Recommendation 5:*

*Charts or tables on drop-out rates should be prepared and displayed in the relevant EPI offices at all levels as well as at the health centers. Health center staff should be refreshed on the importance of monitoring drop-out rates.*

#### Management Comments

4.3.2 The numerators reported to WHO/UNICEF on the Joint Reporting Form for 2003 cannot be reproduced from an archive file. Additionally the latest national tabulation provided to the auditors shows the number of DTP3<1 doses administered as 39,466 – which is lower than the JRF figure of 39,781.<sup>1</sup>

*Recommendations 6 i-iv:*

i) *In future, the reported immunisation figures should be supported by detailed analysis and reports. Such reports and analysis should be stored for reference purposes.*

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<sup>1</sup> The lower figure is based on an earlier tabulation than the JRF. Due to late reports coming in at the national level, the JRF figure is higher than the tabulation. However since tabulations are not dated, the audit team could not tell when this tabulation was produced.

- ii) *There is a need to train EPI Central data processing staff on the EPI Info Data Management System in place.*
- iii) *EPI need to be empowered to produce conclusive reports through appropriate liaison with relevant MOH departments.*
- iv) *The difference between the JRF and latest national tabulation figure for DTP3<1 made available to the auditors needs to be investigated.*

#### **Management Comments**

- 4.3.3 There is no map of the country on display at the EPI Central Office showing performance per HSA i.e. coverage, drop-out and population not immunized.

#### *Recommendation 7:*

*Such a map should be developed to include performance details for purposes of planning and monitoring. It should also be distributed to the various HSAs for purposes of performance comparison.*

#### **Management Comments**

#### 4.4 Data Processing

- 4.4.1 There is no written procedure within the EPI programme for dealing with late reporting (cf. 4.1.1).

*Recommendation 8:*

*A written procedure for late reporting should be put in place and implemented.*

#### Management Comments

- 4.4.2 There is no written backup procedure and backups are done on an ad hoc basis. This has been attributed to lack of appropriate storage media.

*Recommendations 9 i-ii:*

- i) A backup policy should be developed and documented.*
- ii) Appropriate storage devices with large storage capacity should be procured e.g. backup tapes, CD ROMs.*

#### Management Comments

- 4.4.3 In addition to the observation made under 4.3.2, tabulations produced at the EPI Central office were not dated. It is therefore difficult to determine the sequence of preparation and the latest updates of any tabulation.

*Recommendation 10:*

*All tabulations should be dated.*

#### **Management Comments**

#### **4.5 Vaccine Store**

There is a computerised vaccine management system at the EPI Central office. However, the current logistician and the cold chain technician are not trained on its use.

*Recommendation 11:*

*There is a need to train the Vaccine Store staff on the use of the computerised vaccine management system.*

#### **Management Comments**



#### 4.6 Quality Index

The quality of system index at national level (cf. Annexe III) was on overall 75% with the specific areas having scored as follows:

System Design – 3.75/5.00

Recording Practices – 5.00/5.00

Storing/Reporting – 3.00/5.00

Monitoring and evaluation – 3.61/5.00

Denominators – 3.5/5.00

## 5 Health Service Area – Findings and Recommendations

### 5.1 Denominators

- 5.1.1 There was no target number of children and pregnant women that some of the selected HSAs strive to vaccinate during a calendar year (cf. 4.2.2). This may be attributed to the diverging views on the most appropriate denominator to use in target setting and the failure of the National level to advise on what denominators to use. This was observed in Mafeteng (pregnant women), Scott, Butha – Buthe (pregnant women) and Q.E.II (pregnant women).

*Recommendation 12:*

*Targets need to be set for each year and compared to actuals for the previous year for reasonableness.*

### Management Comments

- 5.1.2 The proportions of infants per strategy type was not known for all the HSAs selected (cf. 4.2.2 and 5.1.1).

*Recommendation 13:*

*Having the number of infants per strategy type helps in resource allocation and for other planning purposes. These proportions therefore need to be determined and utilised.*

### Management Comments

- 5.1.3 There were no maps showing catchment areas and immunisation strategies in all selected HSAs, However, as described below (6.2.2) most HU (8/24) did display maps.

*Recommendation 14:*

*These maps should be prepared (possibly based on information gathered from Hus) and should ideally include denominator, targets and strategy type.*

#### **Management Comments**

#### **5.2 Monitoring and Evaluation**

- 5.2.1 There were no updated charts/tables of the current year immunization coverage and drop-out rate of DTP3<1 year displayed in Scott, Mafeteng (drop-out), Butha Buthe (drop out) and Q.E.II (drop-out).

*Recommendation 15:*

*An up-to-date chart/table of the current year immunization coverage and drop-out rate of DTP3<1 should be displayed to facilitate proper monitoring of the status of vaccination program.*

#### **Management Comments**

- 5.2.2 There was no routine feedback format provided by the HSAs to the health centers in all the selected HSAs.

*Recommendation 16:*

*There is a need to provide feedback in the form of written summaries or analysis of immunisation data to the health centers. This feedback should be routine (not ad hoc).*

#### **Management Comments**

### **5.3 Data Processing**

- 5.3.1 All selected HSA offices do not stamp or write the date on all reports received from the Health Centers.

*Recommendation 17:*

*Monthly Health Center reports should be stamped or dated when received by the HSA to monitor the*

*completeness and timeliness of reports. A monthly tracking form can be introduced to monitor the timeliness and completeness of reports.*

#### **Management Comments**

- 5.3.2 There is no system for monitoring the receipt/issuing of injection supplies (syringes).

*Recommendation 18:*

*All syringe stocks should be monitored through a stock ledger, which should be regularly updated and reconciled to physical stocks.*

#### **Management Comments**

- 5.3.3 Although all the HSAs and health centers are aware of the reporting deadlines, there is no procedure/system for dealing with late reporting (cf. 4.1.1).

*Recommendation 19:*

*National guidelines should be developed for dealing with late reporting, With the input and support of the HSA level.*

#### **Management Comments**

- 5.3.4 All the selected HSA offices visited were equipped with computers. However none of these were being utilised for data processing and analysis.

*Recommendation 20:*

*HSAs should be encouraged to provide some primary form of data analysis to be submitted to EPI Central together with the MCH/FP report forms. This would reduce workload at the central level. The analysis could also be utilised as part of the routine feedback process.*

#### **Management Comments**

#### 5.4 Vaccine Store

In Butha Buthe HSA, vaccine receipts and issues were not recorded in a vaccine ledger book. As such it was difficult to determine the stock levels for all vaccines.

*Recommendation 21:*

*A vaccine ledger book should be opened and updated regularly with all receipts and issues of vaccines.*

#### Management Comments

## 6 Health Centers – Findings and Recommendations

### 6.1 Recording Practices

- 6.1.1 All the health centers visited did not have an updated under-five register. In addition entries for children immunised during outreach sessions were not made.

*Recommendation 22:*

*Child registers need to be updated immediately after immunisation takes place so that a child's vaccination history can be easily and rapidly retrieved, and to facilitate scheduling of vaccines due and tracking of defaulters.*

#### Management Comments

- 6.1.2 13 out of 24 health centers visited did not keep track in a register of the vaccination history of pregnant mothers.

*Recommendation 23:*

*Ante Natal registers need to be updated immediately following immunisation so that a woman's vaccination history can be easily and rapidly retrieved. This will also ensure easy monitoring against targets.*

#### Management Comments

- 6.1.3 In 4 out of 24 health centers visited there was no clear ownership of record keeping. This was attributed to regular rotation of nurses.

*Recommendation 24:*

*In health centers where rotation is practiced, responsibility for storage and reporting of health data should be assigned to the appropriate permanent member of staff.*

*Alternatively the responsibility of storage and reporting should be included in the handover procedures as the nurses rotate.*

**Management Comments**

- 6.1.4 In general filing of EPI records is poor. 18 out of 24 health units do not retain some or all of the tally sheets from previous reporting periods. They are either destroyed, misfiled or used for other purposes. Where tally sheets were used for other purposes, this was partly attributed to lack of adequate stationery.

*Recommendations 25 i-ii:*

- i. An appropriate filing system for health center records should be developed and inspected during routine supervisory visits.*
- ii. The central level should ensure that adequate stationery is provided to the health centers for capturing EPI data.*

**Management Comments**



## 6.2 Monitoring and Evaluation practices

- 6.2.1 In all health centers visited, staff were not aware of the target number of infants and pregnant women that they were striving to vaccinate during the audit year (cf. 4.2.2 and 5.1.1).

*Recommendation 26:*

*Health center staff should be involved in the setting of targets since they are the basic level of interaction with the community and where targets are set at different levels this should be communicated. There is also need to encourage health center involvement in planning.*

### Management Comments

- 6.2.2 In 8 out of 24 health centers visited there were no maps showing the catchment areas including the outreach villages.

*Recommendation 27:*

*All health centers should strive to maintain maps of their catchment areas. Ideally the health centers should plot the strategy type for the various locations on these maps.*

### Management Comments

- 6.2.3 There were no updated charts or tables showing coverage on display in all health centers visited.

*Recommendation 28:*

*Staff should be encouraged to calculate coverage and display the same on a chart/table at the health centers for purposes of monitoring performance.*

#### **Management Comments**

*damaged and discarded vaccines should be monitored through these ledgers. Information in these ledgers should form the basis of reconciling the physical stocks to the book stocks periodically.*

#### **Management Comments**

### **6.3 Vaccine Store**

14 out of 24 health centers visited did not have vaccine and syringe ledger books to monitor stocks.

*Recommendation 29:*

*Vaccine and syringe ledgers should be acquired and updated with all receipts and issues. Additionally expiry dates, batch numbers,*

## 7 Core Indicators

### 7.1 Safety

#### 7.1.1 Surveillance of adverse events

There is no written procedure/process for submission of aggregate reports of Adverse Events Following Immunization (AEFI) from the Health Center to HSA to Central Level.

*Recommendation 30:*

*EPI Central should design a standard form to be submitted together with the MCH/FP report form. Zero reporting should be encouraged where there are no cases to be reported.*

#### Management Comments

#### 7.1.2 Monitoring of Syringe Supply

EPI Central monitors the receipts and issues of syringe supplies. However, there was no system in place for monitoring these supplies at all the HSAs and health centers visited

*Recommendation 31:*

*Each HSA and health center should monitor syringe supplies. This can be done in the same ledger book as that of vaccine store supplies.*

#### Management Comments

## 7.2 Wastage

### 7.2.1 Global Wastage

Health centers compute wastage based on open vial. However not all the centers visited monitored and reported this wastage. In addition most of the health centers did not keep track of receipts and issues of vaccine supplies. This appeared to be a problem of lack of stationery and poor recording practices. It was therefore not possible to estimate the global wastage rate at health center level.<sup>2</sup>

*Recommendations 32 i-ii:*

- i) *EPI Central should ensure that adequate stationery supplies are made to both HSAs*

<sup>2</sup> Where it was possible, the following rates were calculated:

Health Unit	District	Wastage
Emmanuel	Butha Buthe	27.5%
Qoaling	Butha Buthe	-44.80%

*and health centers. Where stocks run out improvisation should be encouraged.*

- ii) *There is a need to train the center staff on the calculation of wastage and maintenance of vaccine stock ledgers.*

### Management Comments

#### 7.2.2 System Wastage

Wastage occurring within the vaccine store due to losses of un-opened vials could not be estimated. This can be attributed to lack of complete data on vaccine stocks at both the Central and HSA level.

The wastage reported in the 2003 JRF of 18%<sup>3</sup> takes into account only the open vial wastage

<sup>3</sup> Based on the formula: wasted doses/used doses, where:

reported from the Health centers. It therefore does not accurately reflect the real wastage in the country.

*Recommendation 33:*

*There is a need to keep accurate records on vaccine stocks at both the HSA and Central level.*

### **Management Comments**

#### **7.3 Completeness of reporting**

The structure of reporting in Lesotho is such that the health centers prepare and submit MCH/FP report forms containing immunisation data to the

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“wasted doses” is based on the cumulative open vial wastage reported by the health units in the MCH/FP report forms; and “used doses” is based on the issues from the national/district vaccine stores.

HSA on a monthly basis. The HSAs pass on these forms to the national level with no additional intervention i.e. no report is prepared giving an analysis or summary of the reports collected from the health centers. As such, whenever a HSA submits the health center reports collected to the national level, it is considered to have reported. Based on this, the completeness of HSA reports received at national level is 100%. However, in analysing the completeness of all reports received at the national level from the various health centers, the average completeness of reporting is 92% (i.e. 8% of health centers did not submit their reports). This is partly attributed to:

- i) Lack of official regulations regarding the reporting of immunisation data
- ii) In clinics where rotation is practiced, there is likelihood of loss of trail in reporting especially where there are no clear handover procedures with regard to reporting.

## 8 Immediate Recommendations

HSA Level

### 8.1 Recording Practices

The need to maintain tally sheets and updated registers (under-fives and ante natal) at the health center level should be emphasised.

There is a need to equip the Public Health Nurses and other HSA staff with computer skills which will enable them to perform some form of primary data analysis at their level and provide appropriate feedback to both the central and health center levels. In addition, understaffing currently limits the PHNs' capacity to perform such analyses.

### 8.2 Training

Central Level

There is a need to train the EPI Central data processing staff on the EPI Info Management System in place to enable timely and efficient synthesis of data.

The cold chain and vaccine store staff should also be trained on the use of the computerised vaccine stock management system in place.

### 8.3 Supervision

Supervision of the health centers at the HSA level needs to be strengthened to ensure that the EPI system is working. This may require additional staff support to the Public Health Nurses.

### 8.4 Changes from last DQA

Being the first year of DQA in the Kingdom of Lesotho, there were no prior year recommendations.

## APPENDIX I - LIST OF PEOPLE MET

Name	Designation
<b>ICC Introduction and Briefing Meeting</b>	
Dr M Phooko	Hon Minister of Health
T.J.Ramot'soari	Permanent Secretary Ministry of Health
Dr Y Masholongu	Health Planning (MOHSW)
Dr N Letsie	Head Family health Division
Anne Petlane	EPI Manager
Dr Angela Benson	WHO AI
T. Ramateapeng	
Dr B Desmouguni	UNICEF Rep

Name	Designation
Dr A Munyiri	UNICEF Rep
Dr Samuel Sackey	WHO Rep
T Kittch	FHP
G.P.Nchee	CHAL
B Thokoane	EPI Surveillance Officer
<b>Central Level</b>	
Pulane Hlalele	EPI Data officer
Willy Matela	Vaccine Store manager
Sam R Nchee	Cold Chain Logistician
<b>Butha – Buthe District</b>	



Name	Designation
Mary Letsie	Public Health Nurse
Same Nchee	Cold Chain/Vaccine Store Manager
Mamohale Hlasoa	Acting Matron
Matiisetso Fekefeke	Nursing Sister
<b>Mafeteng HSA</b>	
Mathebane Tsoako	Public Health Nurse
<b>Q.E.II HSA</b>	
Madonna Thakholi	Public Health Nurse
<b>Scott HSA</b>	
Ella M Ramatla	Health Center Coordinator

## APPENDIX II - CORE INDICATORS TABLE

### NATIONAL LEVEL

Indicator	JRF	REPORTED AT THE TIME OF AUDIT	Comments on Differences
Districts with DTP3 coverage $\geq 80\%$	4	6	Based on the 4 <sup>th</sup> quarterly report for immunisation 2003 6 districts reported a coverage of over 80% for DPT3. These were LFDS, Mokhotlong, QEII, Quthing, Leribe and Paray. One of the reasons why the JRF figure could be different is due to incoming late reports. However since tabulations are not dated and the JRF figure cannot be reproduced from an archive file, this is difficult to ascertain
Districts with Measles coverage $\geq 90\%$	2	4	Based on the 4 <sup>th</sup> quarterly report for immunisation 2003 6 districts reported a coverage of over 80% for DPT3. These were LFDS, Mokhotlong, QEII and Quthing. One of the reasons why the JRF

Indicator	JRF	REPORTED AT THE TIME OF AUDIT	Comments on Differences
			figure could be different is due to incoming late reports. However since tabulations are not dated and the JRF figure cannot be reproduced from an archive file, this is difficult to ascertain.
Districts with DOR <10%	4	4	
Types of syringes used in the country	AD	AD and Non AD disposable	Based on quality questions asked at District and Health Unit level, it came through that Non AD disposable syringes were also in use in the country. It is not clear why the country reported that they only use the AD syringes in the HAS.
Districts with AD syringes	ALL	ALL	
Introduction of Hepatitis B	Partly in some HSAs in October 2003	ALL	By the time of the audit all HSAs had introduced Hepatitis B. However by the time of reporting the JRF only some of the

Indicator	JRF	REPORTED AT THE TIME OF AUDIT	Comments on Differences
			HSA's had introduced this vaccine.
Introduction of Hib	NO	NO	
Country wastage of DTP	18%	18%	
Country wastage of Hep B vaccine	8%	8%	
Wastage rate Hib	NA	NA	
Interruption in vaccine supply 2003	None	None	
Number of districts with interruption in vaccine supply 2003	None	None	
% district surveillance reports	NA	NA	

Indicator	JRF	REPORTED AT THE TIME OF AUDIT	Comments on Differences
received at national level*			
% of coverage reports received at national level compared to number of reports expected*	NA	NA	
% of coverage reports received on time at national level compared to the number of reports expected*	NA	NA	
Number of Districts supervised at least once in 2003	ALL	ALL	
Number of districts which have supervised all Hus during the audit year	Not reported in the JRF	ALL	Based on discussions with the National auditor and a review of the supervision schedule for 2003 at national level all HSAs had been supervised. It is not clear why the country did not report this in the

Indicator	JRF	REPORTED AT THE TIME OF AUDIT	Comments on Differences
			JRF.
Number of districts with Microplans including routine immunisation	ALL 19	ALL 19	.

- The Health Service Areas (HSAs) do not send any reports to the Central level. All data aggregation and analysis is done from the EPI central level

## SCOTT

Indicator	Information at the National Level	Information at the District Level
District DPT3 Coverage (Latest tabulation available)	76%	Information not available
District Measles Coverage(Latest tabulation available)	81%	Information not available
District Drop out (DTP 1 –3)	Not calculated	Not Calculated
No of Syringes supplied in 2003 to the district	Information not available	Information not available
Total immunisations given in 2003(less OPV)	15,566	Information not available
No of district coverage reports received/sent	N/A	N/A
No of district coverage reports received/ sent on time	N/A	N/A
No district disease reports sent (regular VPD reporting)	N/A	N/A

Indicator	Information at the National Level	Information at the District Level
No HU coverage reports received/sent		Completeness not monitored
No HU coverage reports received/sent on time		Timeliness not monitored
Any district vaccine stock out	No	No
If yes specify vaccine and duration	N/a	N/a
Has the district been supervised by a higher level in 2002	Yes	Yes
Has the district been able to supervise all Hus in 2002	Yes	Yes
Did the District have a microplan for 2003?	Yes	Yes



**BUTHA BUTHE**

Indicator	Information at the National Level	Information at the District Level
District DPT3 Coverage (Latest tabulation available)	77%	77%
District Measles Coverage(Latest tabulation available)	77%	77%
District Drop out (DTP 1 –3)	Not calculated	Not Calculated
No of Syringes supplied in 2003 to the district	Information not available	No records available
Total immunisations given in 2003(less OPV)	9,070	Information not available
No of district coverage reports received/sent	N/A	N/A
No of district coverage reports received/ sent on time	N/A	N/A
No district disease reports sent (regular VPD reporting)	N/A	N/A

Indicator	Information at the National Level	Information at the District Level
No HU coverage reports received/sent		Completeness not monitored
No HU coverage reports received/sent on time		Timeliness not monitored
Any district vaccine stock out	No	No
If yes specify vaccine and duration	N/a	
Has the district been supervised by a higher level in 2002	Yes	Yes
Has the district been able to supervise all Hus in 2002	Yes	Yes
Did the District have a microplan for 2003?	Yes	Yes

**QEII**

Indicator	Information at the National Level	Information at the District Level
District DPT3 Coverage (Latest tabulation available)	79%	118%
District Measles Coverage(Latest tabulation available)	93%	94.5%
District Drop out (DTP 1 –3)	Not computed	Not computed
No of Syringes supplied in 2003 to the district	Information not available	Information not available
Total immunisations given in 2003(less OPV)	34,058	Information not available
No of district coverage reports received/sent	N/A	N/A
No of district coverage reports received/ sent on time	N/A	N/A
No district disease reports sent (regular VPD reporting)	N/A	N/A

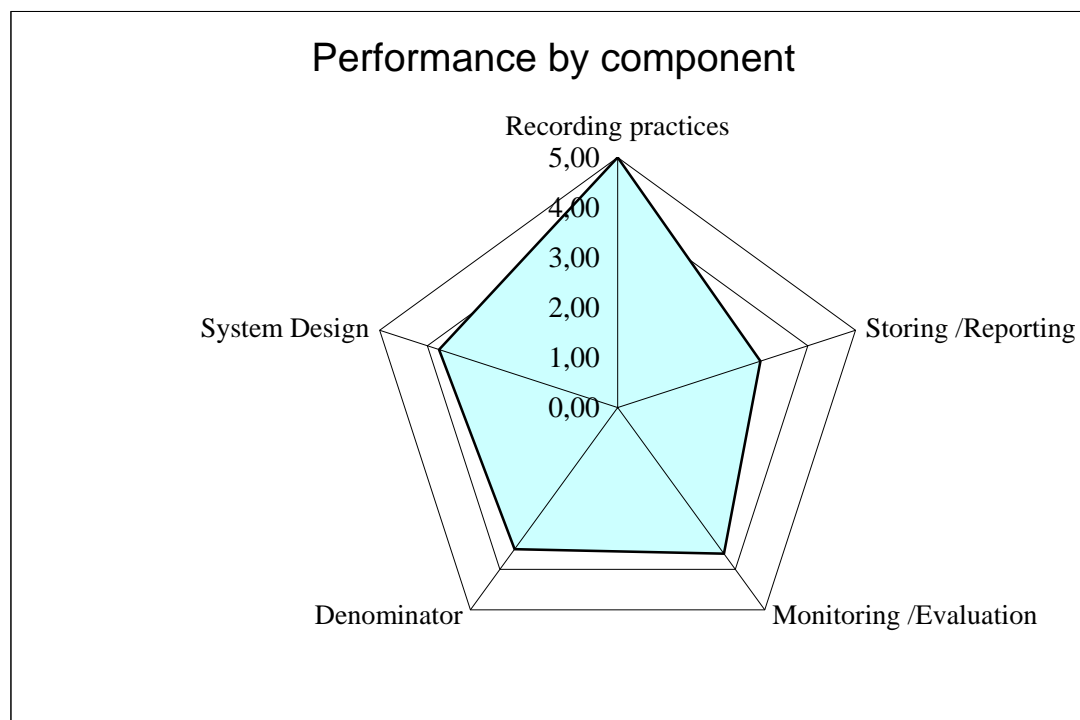
Indicator	Information at the National Level	Information at the District Level
No HU coverage reports received/sent		Completeness not monitored
No HU coverage reports received/sent on time		Timeliness not monitored
Any district vaccine stock out	No	No
If yes specify vaccine and duration	N/a	N/a
Has the district been supervised by a higher level in 2002	Yes	No
Has the district been able to supervise all Hus in 2002	Yes	Yes
Did the District have a microplan for 2003?	Yes	No

## MAFETENG

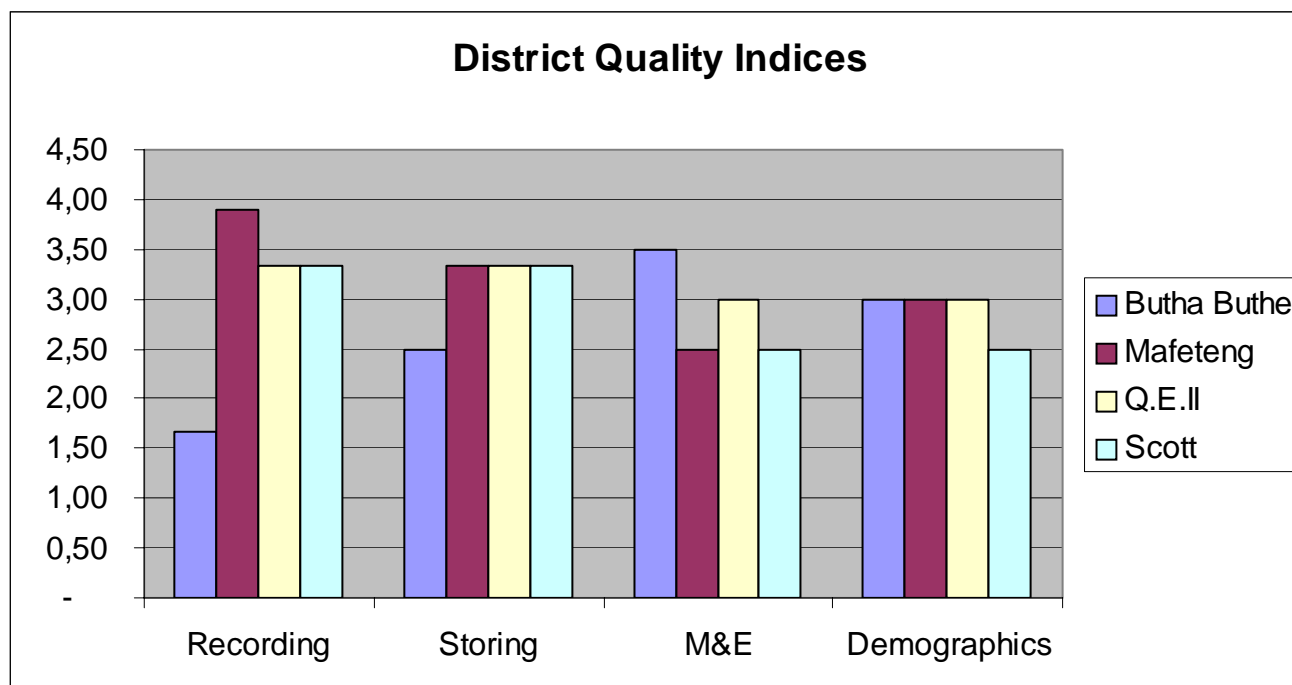
Indicator	Information at the National Level	Information at the District Level
District DPT3 Coverage (Latest tabulation available)	53%	Information not available
District Measles Coverage(Latest tabulation available)	66%	Information not available
District Drop out (DTP 1 –3)	Not computed	Not computed
No of Syringes supplied in 2003 to the district	Information not available	Information not available
Total immunisations given in 2003(less OPV)	13,982	Information not available
No of district coverage reports received/sent	N/A	N/A
No of district coverage reports received/ sent on time	N/A	N/A
No district disease reports sent (regular VPD reporting)	N/A	N/A

Indicator	Information at the National Level	Information at the District Level
No HU coverage reports received/sent		Completeness not monitored
No HU coverage reports received/sent on time		Timeliness not monitored
Any district vaccine stock out	No	Yes DTP
If yes specify vaccine and duration	N/a	1 week due to expiry of vaccine at the District Store
Has the district been supervised by a higher level in 2002	Yes	Yes
Has the district been able to supervise all Hus in 2002	Yes	Yes
Did the District have a microplan for 2003?	Yes	Yes

### APPENDIX III – NATIONAL PERFORMANCE INDICATORS



**APPENDIX IV – DISTRICT QUALITY INDICES**





**APPENDIX V - HEALTH CENTER QUALITY INDICES AVERAGE**

