Lesotho

Operational Plan Report

FY 2013

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.

Operating Unit Overview

OU Executive Summary

1. Country Context

The Kingdom of Lesotho, located in the eastern part of Southern Africa, covers an area of 30,350 km2 and has a population of 1,876,633 million. Largely mountainous, 23% of the population lives in urban areas clustered along the flatter north-western borders. The remaining 77% live in rural and difficult to access areas. Less than 20% of the population has salaried employment and 77% of households in Lesotho depend on subsistence agricultural as their main source of food. Employment in Lesotho is limited; 43% of the population lives on less than $1.25 per day and the Lesotho workforce depend on migration to the Republic of South Africa for work opportunities such as mining, agriculture, construction, and domestic work.

Health indicators are poor; maternal mortality has increased to 1,155 deaths per 100,000 live births and population growth declined to 0.08%. The impact of the HIV epidemic has been identified as a major factor in the decline in population growth and is linked to broader health and development challenges for Lesotho.

1.1. Epidemiology

Lesotho has the third highest HIV prevalence in the world: approximately one in four people in the country are living with HIV. Since 2005 there has been no significant change in Lesotho's national adult HIV prevalence. Of those infected with HIV, over half are women, 41,000 are children and 42% of people who need treatment are not accessing it. In 2011 there were 26,000 new HIV infections and 14,000 people died from AIDS. The prevalence of tuberculosis in Lesotho is among the highest in the world: 80% of patients identified with TB are co-infected with HIV.

The generalized HIV epidemic in Lesotho is driven by behavioral and structural factors. The primary behavioral drivers include: multiple and concurrent sexual partnerships, inadequate levels of HIV-testing, low frequency of condom use and high rates of alcohol use. The primary structural drivers include: poverty and food insecurity and barriers to access to health care services, including insufficient Human Resources for Health (HRH) to appropriately staff existing health facilities. Although limited data exists on self and social stigma and discrimination against people infected and/or affected by HIV in Lesotho, anecdotal evidence suggests stigma as a barrier to accessing prevention, care and treatment services.

1.2. Status of National Response

Lesotho’s National HIV and AIDS Strategic Plan 2011/12-2015/16 was launched on December 1, 2011 by His Majesty King Letsie III. The priorities going forward for the multi-sectoral response to the HIV

epidemic are as follows: to accelerate and intensify HIV prevention in order to reduce new annual HIV infections by 50%; to scale up universal access to comprehensive and quality-assured care, treatment, and support; to strengthen coping mechanisms for vulnerable individuals, groups, and households; and to improve the efficiency and effectiveness of coordination of the national multi-sectoral HIV and AIDS response. The Ministry of Health (MoH) launched its male circumcision program in February 2012 and accomplished 10,000 circumcisions in the first twelve months of operations. The MOH is implementing its plan to scale up Voluntary Medical Male Circumcision (VMMC) services and as of May 2013, Lesotho will adopt Option B+ for HIV positive pregnant women.

1.3. USG contribution to the national response

Based on the principles of country ownership, the response of PEPFAR Lesotho has been guided by the National Strategic Plan. For prevention, PEPFAR has committed to supporting the government in its implementation of a national behavior change and risk reduction program, full support for community-based HIV Testing and Counseling (HTC) services and as a new activity, PEPFAR will support Provider-Initiated Testing and Counseling (PITC) services. PEPFAR co-funds the implementation of the VMMC national scale up and national blood transfusion programs.

In order to support the newly-created Ministry of Social Development, PEPFAR supports the implementation of the recently-enacted Child Protection Law through its Orphans and Vulnerable Children (OVC) program. Our program provides extensive technical assistance to the national Prevention of Mother-to-Child Transmission (PMTCT), HIV/TB, and treatment programs. PEPFAR also supports the MoH in addressing key weaknesses in the health system in the areas of laboratory services, Strategic Information (SI), HRH, and supply chain management.

1.4. Coordination and other development partners

The Global Fund (GFATM) is the second largest donor in the HIV sector in Lesotho, following PEPFAR, having disbursed $24 million in 2012. Other donors include the European Union, the Joint UN Program on AIDS, the African Development Bank, the World Bank, Irish AID, and the German Agency for International Cooperation (GIZ). Development partner coordination is largely accomplished through participation in in-country coordinating mechanisms at various technical and political levels. PEPFAR co-chairs the Health Development Partner's Forum and is a member of the Country Coordinating Mechanism of GFATM. In addition, PEPFAR liaises with the GFATM Portfolio Manager to ensure that GFATM is aware of PEPFAR resource allocations and programmatic direction. In the absence of a National AIDS Committee, close dialogue with senior management at the MoH and other line ministries ensures coordination with the Government of Lesotho (GoL).

2. PEPFAR Focus in FY 2013

2.1. Priorities

The PEPFAR Lesotho team has applied a Continuum of Response (COR) lens to the portfolio in line with the COP13 funding memo and national priorities. Building upon the existing programs and partners, the COP13 plan aims to improve the linkages between HTC and Care and Treatment, keeping a high percentage of individuals identified HIV-infected through the continuum of services. The primary priorities for PEPFAR Lesotho in COP13 include: expansion of VMMC services; continuation of the accelerated PMTCT program, including (Nutrition Assessment, Counseling, and Support) NACS activities; increasing the number of newly-initiated clients on ART; and improvement in retention. Supporting priorities in these activity areas includes a continued emphasis on HRH and supply chain management.

2.2. Change

In order to achieve the targets communicated in the COP13 funding memo, PEPFAR Lesotho will realign its existing portfolio to include: a more targeted approach to HTC (adding a PITC component); a national scale up of VMMC services; the maintenance of the accelerated plan for PMTCT; and a commitment to enroll ~20,000 new clients on ART.

Health Systems Strengthening (HSS) remains crucial to the portfolio; however, budget challenges this year have translated into many of our HSS activities remaining unfunded priorities. Because we recognize the importance of functional supply chains for the national health system, we have increased funding for supply chain management activities. HRH-related activities in COP13 will support the national Health Care Workers database and core recruitment and retention activities will be maintained.

2.3. COP13 Funding memo priorities

Achieving the VMMC, PMTCT, and treatment targets as identified in the COP13 funding memo, as well as the COR linkages, have meant reductions in other budget codes. For example, the behavioral prevention portfolio has been reduced significantly, which will have an impact on the national HIV prevention revitalization initiative. OVC services, local capacity building, SI, laboratory services, and HSS activities have all been cut back significantly. These complimentary and supportive activities have been reduced and potentially render the Lesotho portfolio vulnerable.

3. Progress and Future

3.1. PF/PFIP/Country Strategy Monitoring

The U.S. Government (USG) signed its Partnership Framework (PF) with the GoL in 2009 and finalized the Implementation Plan in 2010. The most ambitious goal set in the PF was to reduce HIV incidence in Lesotho by 35% by 2014, a goal developed with the expectation that the GoL would rapidly scale up

VMMC. VMMC services were launched in February 2012, with national scale up planned in COP 2013. Given the nascence of VMMC service provision in Lesotho, it is not clear if this activity will result in the ambitious reduction of HIV incidence in Lesotho as stated in the PF.

The USG will review the PF internally in May 2013 and then engage the GoL to evaluate where the PF requires revision in order to ensure that the document remains relevant to the current context.

3.2. Country Ownership

The GoL currently plays a pivotal role in providing political leadership in the delivery of HIV/ AIDS and other health services. The national response to HIV service delivery in Lesotho was the mandate of the National AIDS Commission (NAC). However, since being disbanded in 2011, a replacement structure has not yet been established. The USG team will continue to work closely with the Office of the Prime Minister and development partners to ensure that the new NAC structure will provide national guidance to the HIV response in Lesotho. In the interim, PEPFAR Lesotho will continue to implement in line with the National HIV Strategy 2011-2015, as per the technical assistance model implemented by PEPFAR Lesotho since 2006.

PEPFAR implementing partners working in the health sector design their annual work plans within the framework of GoL priorities. The MoH Director General reviews/approves all work plans before partners begin implementation.

The platforms described above provide an environment that is conducive to country ownership and partnership. While there are ample opportunities to liaise with the GoL and the GoL drives the agenda for health in Lesotho, at times the GoL has been challenged in leading on some key policy issues such as human resources for health, health information systems, and supply chain management. The USG continues to advocate for and provide support through partners to make progress on these issues.

3.3. Trajectory FY 2014 and beyond

Lesotho has been identified by OGAC as a long-term strategy country and band 1: low income, high burden country by the GFATM, it will require ongoing technical assistance for the medium term. The GoL has allocated 14% of its budget to health and the HIV program in the MOH received $38 million of public funding, so financial commitment to the response is good. The technical assistance approach of PEPFAR has been well received and should be continued into the foreseeable future.

Through partnership with the GOL, policy development and shifts have been realized that have fostered an increasingly conducive environment to HIV/AIDS programming. This partnership, codified in the PF, strengthened by the development partner relationships, provides a platform for joint planning and execution that has the GoL in control.

The PEPFAR Lesotho team envisages this relationship continuing with increasing responsibility for strategic development being shouldered by the GoL. Working with all actors, through a timely and transparent process, the development partners and government will define priorities, strategies and targets that are evidence based and allocate funding accordingly. As this is realized, the GoL will be enabled to take more financial planning decisions in guiding the PEPFAR support. And in turn, the PEPFAR program will be able to focus increasingly on discreet programmatic technical assistance projects to improve the quality, effectiveness and efficiency of the national response.

4. Program Overview

4.1. HTC

In an attempt to increase the identification of people who are HIV-infected, population targeting of HTC activities has been updated. Existing Community-Based HTC (CBHTC) programs targeting men in transport corridors are currently identifying only 8% HIV-infected within the context of a national male prevalence of ~18%. In order to increase the number of HIV-infected persons identified within the CBHTC program, shifts will be made to better target higher-risk men.

According to the Demographic Health Survey 2009, to reach more HIV-positive men with HTC, the program needs to target men with more education (secondary+) and incomplete primary education as well as those that are employed. In COP 11 and 12 PEPFAR used a male-centered approached of 'Test for Your Team' as one of the principle activities to reach men. While this approach was effective at increasing numbers of men tested it did not reach our primary target (men aged 25-35) and did not increase our yield of HIV-positive clients. Other mobile strategies did a much better job of reaching the target audience but were also not very successful at increasing significantly our yield of HIV-positive men.

In order to improve our targeting and increase our yield of HIV positive men, in COP 13 we plan to collaborate with construction companies to reach manual laborers which will assist with the more intensified effort to reach employed men with incomplete primary education. We plan to collaborate with more "professional" workplaces to reach employed men with secondary+ education. PEPFAR's HTC program currently works with corporate partners to offer HTC services, but the uptake has been limited because they were offered in a cost-share model. For COP 13 we will continue to pursue such partnerships but will offer the HTC services for free as an added incentive for corporate partners.

We will move our door-to-door HCT strategy into urban areas. In COP 12 we've focused more on rural and peri-urban areas but transitioning to urban areas could be more effective at reaching men and HIV-positive clients. Additional plans for active referrals from CHHTC to VMMC sites will be initiated

through the implementation of an electronic medical records module consistent between the two services.

A new activity in COP 2013 will be direct support to the MoH sites for PITC; this is expected to greatly increase the yield of HIV-infected persons linking to care and treatment services. HTC counselors will be placed at four district hospitals and at filter clinics for the tertiary referral hospital in Maseru. These counselors will be based in the out-patient departments and target especially clients served through the TB and STI services. The program will also train staff at the hospital to initiate testing with all clients, especially those in targeted services, and provide them with on-going support. This site-base approach should increase dramatically the yield of positives identified, we well as increase the direct linkages of the positives identified into care and treatment services.

4.2. VMMC

PEPFAR and UNAIDS estimate that scaling up VMMC to reach 80 percent of males aged 15 to 49 years in Lesotho in 5 years (2012 to 2016) would avert more than 106,000 (or 36.6 percent) new adult infections in the next 15 years. Given the potential of VMMC to change the course of the epidemic in Lesotho, PEPFAR Lesotho is rapidly scaling up VMMC services to all 10 districts of Lesotho, while maintaining the MoH's vision of integrated facility-based services. In COP13, services will expand from eight to sixteen sites, including three high-volume sites in Maseru. The expected number of VMMCs performed with COP13 funds is estimated at 34,500.

Program activities will focus on ensuring that supply is matched with demand, and that VMMC service provision is as efficient as possible. Implementation to date demonstrates that currently there is a very high demand for VMMC services, which exceeds supply. However, experience from other countries shows that there is a need for a phased-approach to demand creation. The team recognizes that demand creation will have an important role in the VMMC program in Lesotho; particularly as existing demand tapers off. The MoH has clearly stated its reluctance to engage in a mass media-style demand creation campaign in the short-term. The approach to demand creation will include: development of a demand creation and communication strategy, continual assessment of supply-demand ratios and use of Interpersonal Communication (IPC). A whole facility approach will be undertaken to ensure that all departments in hospitals and health facilities understand the VMMC service approach, and can refer clients to VMMC and EIMC services as well as actively linked to care and treatment services within the integrated clinical site.

Demand creation will also need to sensitively address the issue of men who have been partially circumcised. Reaching these potential clients presents a special challenge. The programs will work closely with the MoH to develop a strategy for reaching these men, in a manner that does not discredit traditional beliefs and practices.

As noted earlier, at this point the MoH wants VMMC services to be conducted in facilities, and is wary of demand creation activities as well as VMMC provision at community health facilities. The forthcoming facility-based outreach pilot will shed additional light on the capacities in-country to conduct outreach, and gauge the willingness of the MoH to conduct future community outreach and mass media style demand creation activities. The MoH has, however, demonstrated willingness and communicated several ideas about how to implement a successful but subtle demand creation approach, which is appropriate for the Lesotho context.

Though not yet realized, funding for comprehensive VMMC program is available from the GFATM round 8 HIV grant, now in phase 2. A catch-up and revised PSM plan has been developed with $520,000 of funding for VMMC consumables and kits to compliment the sensitization of public and private health care providers, community leaders and the public on male circumcision as a component of HIV prevention; training providers from both public and private sectors to deliver MC services and conducting formative operational research on uptake and impact activities. The USG will work closely with the Global Fund Coordination Unit in the MOFED and MOH to leverage these resources in a systematic manner that builds upon the earlier success. However, given the historic delays in implementation of the VMMC activities under the grant, the primary focus remains as above.

4.3. PMTCT

PEPFAR Lesotho will continue to support the Lesotho PMTCT program, as the country transitions to Option B+ in May of 2013. The transition to Option B+ comes with a whole cascade of activities to strengthen the national, district and local health systems in quality improvement, strategic information, pharmacovigilance, surveillance, PITC, improved (evidence based and measurable) community based approaches and human resources for health. PEPFAR is working to identify innovative approaches that can be implemented to ensure linkage to care and pre ART health services, initiation on ART in Ante-Natal Clinics and Maternal, Neonatal, and Child Health (MNCH) settings, and retention on ART in the post-natal period.

Mother-Baby pairs need to be closely monitored to ensure HIV Free Survival of HIV exposed infants. Many of these activities will leverage on already-existing services supported by PEPFAR through existing COP and PMTCT acceleration activities. Services will be provided on various integrated platforms (with MNCH, Nutrition, ART, Sexually-Transmitted Infections (STI) clinics) and will be expanded to include community-based services for PMTCT. The implementation of the Lesotho Village Health Worker strategy will be supported in COP13.

To ensure we have evidence base for the effectiveness of prior and proposed interventions, the National PMTCT Effectiveness study will be conducted this FY, with the establishment of a national cohort for

mother- infant pairs which will extend into 2015. In order to mitigate for the effects of stock outs on the national PMTCT program (as experienced in the past), PEPFAR will support the establishment of a three month emergency test kit buffer system, should there be any unprecedented challenges with the supply of test kits or reagents. All these, in addition to the established activities in eMTCT and introduction of two more partners into PMTCT for community based PMTCT and expanded quality improvement, will strengthen the national program to increase access to an accurate monitoring of the program development.

4.4. Treatment

Budget allocations for adult and pediatric treatment have increased in COP13 because of additional support we will be providing as we move to Option B+ and national coverage for treatment services increases. In adult treatment, PEPFAR Lesotho will scale up district and facility level quality improvement of services. Also, capacity building at these levels for treatment will be strengthened with the secondment of an additional five nurse clinicians to ART clinics in 5 more district hospitals. Trainings and rotations for HIV resistance diagnosis and management will be established at a high-volume Maseru site while central support for early diagnosis of HIV resistance will be provided.

In pediatric treatment, COP13 funds will support four additional pediatric HIV management satellite centers of excellence. PEPFAR Lesotho will support clinical cohorts for mother-baby pairs to monitor HIV free survival and proportion of children still on treatment after twenty-four months (Phase 2 of the PMTCT Effectiveness Study) as part of our efforts to provide evidence base and eliminate pediatric HIV.

4.5. Positive Health, Dignity and Prevention (PHDP)

PHDP activities focus on keeping People Living with HIV (PLHIV) physi¬cally and psychologically healthy; preventing transmission of HIV, and involving PLHIV in HIV prevention activities, program design, implementation and monitoring, leadership, and advocacy. Previous concerns around specifically targeting PLWHA due to increasing stigma have been ameliorated with improving legal protection and greater access to HIV services. As a result, many more infections are occurring in serodiscordant couples, but rates of disclosure and condom use remain low. In Lesotho, 50% of HIV infected people are in a sero-discordant relationship.

Evidence shows that HTC in serodiscordant couples (whether individual or couple testing) are more likely to use condoms. Therefore, the program, working through community-based PLWHA associations will deliver a package of services to PLWHA that includes condoms, risk reduction counseling, education and referral for services adherence support. The evidence for the latter is not robust but provided as a wrap-around to services is expected to support the increase in retention and adherence targeted in the COR assessment.

Through our MNCH and STI/ ART linkage nurses, the program supports counseling for sero-discordant couples, counseling on sero-conversion in pregnancy, counseling on safer sex negotiation skills, and male partner testing and counseling. However, these services have not been expressly provided in one package at all health facilities. With PMTCT acceleration funds, we will increase efforts to provide these services. Similarly, PEPFAR will work with MoH and implementing partners to develop a strategy for PHDP and improve the quality of services provided.

4.6. Human Resources for Health

The lack of human resources for health is a critical limitation to the functioning of Lesotho's health system. Effective health systems depend on a trained and motivated workforce that can carry out the tasks and build the systems needed. Defined as an HRH crisis country by the WHO, Lesotho has distinct challenges which place it at a disadvantage even as compared to other African countries. As a result, there is a high level of misdistribution of the health workforce within the country; with urban areas absorbing much of the labor pool.

The MoH takes these challenges seriously, and has taken steps to address them. The MoH has developed several Sector policies and strategies, including a Human Resource Development Strategic Plan (2005-2025). Since the plan's development, the MoH, with the support of various partners, has been implementing components of this strategy. An area that has received particular attention includes pre-service training, with an emphasis on increasing the nursing cadre. Lesotho is also preparing to open its first School of Medicine in partnership with the University of Zimbabwe, where PEPFAR Lesotho is continuing to leverage support from the Medical Education Partnership Initiative. A policy dialogue was also initiated toward improving recruitment, deployment and retention mechanisms for critical health professionals.

In COP 2013, the focus is on the continuing the activities that were successful in COP 2012, most notably the Auxiliary Social Work training program, and accelerating efforts in initiatives critical to the MOH's efforts to strengthen human resources for health.

The programs will intensify efforts to enhance the implementation capacity of the HRH Directorate and will finalize implementation plans for strengthening the recruitment and retention systems. Revamped technical assistance, will improve progress in the refinement and roll-out of the HRIS as part of the structures for a decentralized workforce. The Council for Higher Education will be supported to further take up their authority for oversight of health training institutions. And finally, to support the sustainability of technical assistance to the MoH for strengthening human resources for health, programs will implement some program activities through local organizations. This selection of activities is expected to maximize

the impact of the efforts made in COP 2012, and create a firm foundation for the MoH to continue strengthening its human resource for health systems in subsequent years.

4.7. Supply Chain Management

The main challenge in Lesotho's pharmaceutical sector is the unreliable supply of essential medicines. This is caused by a number of reasons, including weaknesses in policy implementation and legislative frameworks; inefficiencies within the supply chain system, specifically weak information management; chronic under-spending of health resources as well as inefficiencies in allocation of health resources; and chronic challenges with pharmaceutical human resource capacity at all levels.

The weak information management capacity within the ART program has resulted in the GFATM setting a condition precedent which the Principal Recipient (PR) has to address to qualify for further disbursement of Round 8, Phase 2 funds. The GFATM has requested that the PR put in place a robust, functional management information system for the ART program. This has been evidenced by over-stocking of some ARVs and stock-outs of rapid HIV test kits and laboratory reagents in the recent past.

The strategic focus will therefore be on improving pharmaceutical management by strengthening the central pharmaceutical directorate to provide strategic direction in pharmaceutical issues in the country, and building capacity at facilities to enable them to improve commodity management and patient care. Particular focus will be placed on building information management capacity among healthcare workers, both at the central level as well as the districts and facilities. The program activities are based not only on the need to strengthen systems, but also on the immediate needs identified locally, including the need to satisfy the GFATM's condition precedent for further Round 8 disbursements.

Direct USG participation and partner engagement will be strengthened in the national Supply Chain Technical Working Group (SCTWG) to facilitate coordination between partners and program units in the MoH. The program will initially focus on supporting the TWG to function effectively, and for the chair to collect and release supply chain data on a routine basis for informed forecasting, planning and decision making. Parallel to the governance support, the program will continue the support to the HMIS systems in order for more accurate consumption data can be used for PSM.

5. GHI, Integration, Central Initiatives and other considerations

Although the USG's health and development funding in Lesotho is largely focused on HIV/AIDS, we believe that applying Global Health Initiative (GHI) principles to both existing and future investments will produce a greater impact on Lesotho's broader health and development outcomes. In partnership with the GoL, the USG in Lesotho will coordinate and improve existing health initiatives under the GHI

Strategy by integrating gender considerations in all programs (informed by PEPFAR Lesotho's Gender Assessment and Strategy completed in July 2012), strengthening health systems for service delivery, and continuing to integrate primary prevention and supporting improvements in governance.

To most strategically achieve these goals, USG will implement integrated and efficient programs that benefit the formal and informal health sectors in ways that have a significant and sustainable impact. USG will make a concentrated effort to improve cross-cutting areas of health systems strengthening that improve access to integrated services. In Lesotho, these areas have been identified as critical limits on development, and improvement to these will lead to an improvement in overall health outcomes as above and beyond those that are specific to HIV/AIDS and TB.

As an example of such integration and leveraging funding from the broader health presence in Lesotho, the PEPFAR program will support the sustainability of the accomplishments of the Millennium Challenge Corporation (MCC) which has renovated 137 health centers and out-patient departments in Lesotho's District Hospitals. Such contributions will help to preserve the strong relationship between USG agencies and the GoL. PEPFAR strives to integrate services in other ways by supporting activities such as Public-Private Partnerships for HRH retention (through a centrally-funded DCA) and reform and laboratory technical assistance to strengthen site operational and strategic information systems.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	280,000	2011	AIDS Info, UNAIDS, 2013			
Adults 15-49 HIV Prevalence Rate	23	2011	AIDS Info, UNAIDS, 2013			
Children 0-14 living with HIV	41,000	2011	AIDS Info, UNAIDS, 2013			
Deaths due to HIV/AIDS	14,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among adults	22,000	2011	AIDS Info, UNAIDS, 2013			
Estimated new HIV infections among	26,000	2011	AIDS Info, UNAIDS, 2013			

adults and children						
Estimated number of pregnant women in the last 12 months	60,000	2010	UNICEF State of the World's Children 2009. Used "Annual number of births (thousands) as a proxy for number of pregnant women.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	16,000	2011	WHO			
Number of people living with HIV/AIDS	320,000	2011	AIDS Info, UNAIDS, 2013			
Orphans 0-17 due to HIV/AIDS	140,000	2011	AIDS Info, UNAIDS, 2013			
The estimated number of adults and children with advanced HIV infection (in need of ART)	145,346	2011	WHO			
Women 15+ living with HIV	170,000	2011	AIDS Info, UNAIDS, 2013			

Partnership Framework (PF)/Strategy - Goals and Objectives

Number	Goal / Objective Description	Associated Indicator Numbers	Associated Indicator Labels
1	HIV incidence in Lesotho is reduced 35 percent by 2014.		
1.1	80 percent of people aged 15-49 years are reached with comprehensive social	P12.3.D	P12.3.D Number of people reached by an individual,

	and behavior change interventions.		small-group, or community-level intervention or service that explicitly addresses the legal rights and protection of women and girls impacted by HIV/AIDS
1.2	80 percent of most at risk populations are reached with HIV prevention programs	P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required
1.3	The percentage of HIV+ positive children born to HIV+ mothers is reduced by at least 40 percent	C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth
1.4	Increased access and availability of HTC services in all health facilities (should be in all community councils)	P11.1.D	P11.1.D Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results
2	To reduce morbidity and mortality and provide essential support to Basotho people living with or affected by HIV and AIDS through expanding access to high quality treatment, care adn OVC services by 2014.		
2.1	40% of all eligible individuals of all age groups access a continuum of pre-ART and ART services including TB/HIV screening and treatment.	C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting
		C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment

2.2	100% of health facilities to offer routine testing for HIV and referral to other services.	P11.1.D	P11.1.D Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results
2.3	People who are infected and affected by HIV, access quality care and support services by community home-base care providers in 60% of community councils.	P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions
		C1.1.D	C1.1.D Number of eligible adults and children provided with a minimum of one care service
2.4	20% of OVC have received comprehensive care and support services (at least 3 types of free services from external source - health, educational, psycosocial, financial support, food packages, clothing/household shelter and legal services.	C1.1.D	C1.1.D Number of eligible adults and children provided with a minimum of one care service
3	The human resource capacity for HIV service delivery is improved and increased in 3 key areas (retention, training and quality improvement) by 2014.		
3.1	40% of HIV and AIDS service delivery staff (including volunteers) have been retained for at least 3 years.	H2.3.D	H2.3.D Number of health care workers who successfully completed an in-service training program within the reporting period
3.2	An increased proportion of HIV and AIDS service providers are trained in relevant technical skills.	H2.1.D	H2.1.D Number of new health care workers who graduated from a pre-service training institution within the reporting period

		H2.3.D	H2.3.D Number of health care workers who successfully completed an in-service training program within the reporting period
3.3	The efficiency and effectiveness of the health service delivery systems to provide high quality work for all cadres is improved as defined by meeting the following benchmarks: a) instituting career ladders b) implementing task shifting c) implementing posting and deployment policy d) implementing supervision of all staff.	H2.3.D	H2.3.D Number of health care workers who successfully completed an in-service training program within the reporting period
4	Health Systems are strengthened in 4 key areas (HMIS, lab systems, organizational capacity, and supply chain) to support the prevention, care, treatement and support goals by 2014.		
4.1	An integrated HMIS that encompasses vital registration, all diseases, service delivery, human and financial resource data is developed and functional.	H2.3.D	H2.3.D Number of health care workers who successfully completed an in-service training program within the reporting period
4.2	The laboratory system is able to effectively provide quality services to 100% of clinical sites.	H1.2.D	H1.2.D Number of testing facilities (laboratories) that are accredited according to national or international standards
4.3	The organizational capacity of civil society organizations is strenghthened to improve the provision of quality HIV and AIDS services.	H2.3.D	H2.3.D Number of health care workers who successfully completed an in-service training program within the reporting period
4.4	Funtional and effective national health supply chain management system is in	H2.3.D	H2.3.D Number of health care workers who successfully

	place by 2012.		completed an in-service training program within the reporting period
4.5	A functional health finance system is in place that provides effective management of GOL and donor financing.	H3.1.N	H3.1.N Domestic and international AIDS spending by categories and financing sources

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

How is the USG providing support for Global Fund grant proposal development?
Lesotho has requested for an extension to the Civil Society and PMTCT Single Stream Grant up to March 2014. The TB and Round 8 HIV/AIDS grants are just starting phase two so will run for another two years. Performance of the grants has been B1/B2 with notable under spend of funds, so it is unlikely that Lesotho will submit a new application in FY2013.

However, the USG PEPFAR team will examine with UNAIDS and the CCM ways to support the development of an Investment Case to support the National Strategy in light of the new funding model. Use of the UNAIDS Investment Framework model will be examined for use as a common tool.

The USG will also work with the Government of Lesotho and development partners to strengthen the epidemiological information available to the country in order to make an investment framework. The Global Fund has invested in MDR-TB and TB prevalence surveys that USG technical assistance has also supported. Funding is available to conduct a behavioral and size estimation survey of MARPs from both the Global Fund and USG, so discussions are ongoing on how to achieve synergies and cover more behaviorally distinct populations.

Technical assistance has and will, continue to be provided in reprogramming, phase two proposal developments and other grant processes.

Are any existing HIV grants approaching the end of their agreement (Phase 1, Phase 2, NSA, CoS, or RCC) in the coming 12 months?
Yes

If yes, please indicate which round and how this may impact USG programming. Please also

describe any actions the USG, with country counterparts, is taking to inform renewal programming or to enable continuation of successful programming financed through this grant(s).

Rd 8 HIV, Grant: LSO-809-G07-H with PR-LCN/MoF. There was a significant delay in grant signing, though there was a fixed retroactive start date of 1 March 2012 and delays in changing the PR from LCN to MoF led to further delays. As a result TGF is examining the possibility of a 1 year no-cost extension up to March 2014.

Single Stream Funding, Grant: LSO-H-MoFDP with PR-MoF. Original phase 1 ended on March 31, 2013 but extension to March 31, 2014 has recently been given.

Redacted

To date, have you identified any areas of substantial duplication or disparity between PEPFAR and Global Fund financed programs? Have you been able to achieve other efficiencies by increasing coordination between stakeholders?

Yes

If yes, how have these areas been addressed? If not, what are the barriers that you face?

Redacted

Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
2011 APR	Improving HCW retention through personal and housing loans	13983:Human Resources Alliance for Africa - HRAA	Standard Bank			Proposal to improve HCW retention through personal & housing loans was approved for $500,000 &

						included in COP 12. Initial work began on identifying potential private partners (banks, housing development companies). Since the project has the potential to multiply the US$500,000 contribution ten-fold (to US$5, 000,000), more infrastructural activities have been added including construction of dormitories and classrooms for pre-service schools. A Dutch NGO is currently assessing if experience in building similar low cost housing and infrastructure projects in South Africa will work in Lesotho.

						In COP 2012 the PEPFAR team plans to allocate the PPP funding to ECSA-HC led Human Resources Alliance for Africa (HRAA), an already existing implementing mechanism that will carry-out the initial Development Credit Authority work and M&E responsibilities. Although we have listed Standard Bank as the private sector partner, we are still in negotiations with them, so this is not yet confirmed.
2013 COP	Integrated public-private partnership to improve and strengthen linkages to and retention in TB	13987:STRENGTHENING TB/HIV COLLABORATION IN THE KINGDOM	TBD	Redacted	Redacted	The proposed project is an integrated public-private partnership to improve and strengthen

	and HIV care and support services for migrant mineworkers in Lesotho and across borders.	OF LESOTHO				linkages to and retention in TB and HIV care and support services for migrant mineworkers in Lesotho and across borders by partnering with largest mineworker recruitment and management company in southern Africa and using strategic health information systems and existing community based initiatives.
2012 APR	Partnership for Management Development	10459:Strengthening Clinical Services (SCS) Project	Johnson and Johnson			PEPFAR (USAID), Johnson and Johnson (J&J), Elizabeth Glaser Pediatrics AIDS Foundation and University of Cape Town Graduate School of Business (UCT) are partners in this high level PPP.

						The PPP is designed t enhance the management and leadership skills of national and district MOH managers and supporting NGOs for PMTCT and ART service delivery in Lesotho. The PPP intends to catalyze improvement in resource management skills of the health managers. With the global goal of eliminating pediatric HIV by 2015, such an activity is essential in order to increase the effectiveness, coverage and quality of PMTCT and HIV services in the country.

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
Survey	ANC Sentinel Surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Planning	12/01/2013
Surveillance	ANC surveillance	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Planning	10/01/2013
Surveillance	ART Cohort Estimation (1-Year)	AIDS/HIV Case Surveillance	Other	Implementation	06/01/2013
Survey	ART Cohort Outcomes Study (5-year Cohort)	HIV-mortality surveillance	Other	Planning	09/01/2013
Surveillance	Comparison of ANC Sentinel Survey to PMTCT Surveillance	Evaluation of ANC and PMTCT transition	Pregnant Women	Development	09/01/2013
Survey	Demographic and Health Survey	Population-based Behavioral Surveys	General Population	Planning	09/01/2013
Surveillance	Drug resistance survey	HIV Drug Resistance	Pregnant Women, Other	Planning	10/01/2013
Survey	KAB Survey for TB among Migrant Mine Workers	Behavioral Surveillance among MARPS	Migrant Workers	Planning	03/01/2013
Survey	KAP Assessment Study of Health Workers	Evaluation	Other	Planning	09/01/2013
Survey	National PMTCT effectiveness study	Other	General Population	Development	02/01/2015

Survey	OVC Situational Analysis	Other	Other	Other	08/01/2013
Survey	PSI factory program process evaluation	Evaluation	General Population	Planning	12/01/2013
Survey	Risk factors for un-favorable outcomes of TB treatment	Other	Other	Implementation	11/01/2013
Survey	SCS Midterm Evaluation	Evaluation	General Population	Planning	12/01/2013
Survey	Size Estimation & Behavioral Surveillance Survey among Commercial Sex Workers in Lesotho	Behavioral Surveillance among MARPS	Other	Planning	09/01/2013
Surveillance	Spectrum Modeling Exercise	Modeling Infections Averted	Other	Implementation	09/01/2013
Survey	Tracking Results Continuously (TRAC) behavioral survey	Population-based Behavioral Surveys	General Population	Data Review	01/01/2013
Survey	Tuberculsis Drug Resistance survey (DRS)	Other	Other	Planning	09/01/2013

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source			Total
	GAP	GHP-State	GHP-USAID	
DOD		891,000		**891,000**
HHS/CDC	1,035,376	11,265,948		**12,301,324**
PC		606,134		**606,134**
State		157,285		**157,285**
State/AF		175,000		**175,000**
USAID		13,669,257	6,400,000	**20,069,257**
Total	**1,035,376**	**26,764,624**	**6,400,000**	**34,200,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency							Total
	State	DOD	HHS/CDC	PC	State/AF	USAID	AllOther	
CIRC		404,500	9,144			4,266,043		**4,679,687**
HBHC		50,000			75,000	1,010,944		**1,135,944**
HKID		2,250		246,736	100,000	2,181,259		**2,530,245**
HLAB		40,000	1,773,718			54,173		**1,867,891**
HMBL			763,718			47,401		**811,119**
HMIN			9,144			6,772		**15,916**
HTXS		79,500				1,260,944		**1,340,444**
HVAB						54,173		**54,173**
HVCT		60,500	3,407,007			13,543		**3,481,050**
HVMS	157,285	30,000	952,842	112,661		985,827		**2,238,615**
HVOP		69,500	9,144	246,737		2,128,660		**2,454,041**
HVSI		40,000	1,188,625			1,393,543		**2,622,168**
HVTB		76,750	3,854,822			227,086		**4,158,658**
MTCT		26,750				3,067,716		**3,094,466**
OHSS		6,750	333,160			1,939,914		**2,279,824**

PDCS		2,250				397,401		**399,651**
PDTX		2,250				1,033,858		**1,036,108**
	157,285	**891,000**	**12,301,324**	**606,134**	**175,000**	**20,069,257**	**0**	**34,200,000**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

Policy Area: Access to high-quality, low-cost medications						
Policy: Medicines Controls Bill						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	March 2012	December 2012	Varies	TBD
Narrative	n/a	n/a	External Stakeholders Consultation Process for Draft Medicine Bill	Adiditional consultation with stakeholders as necessary (04-2012) . MOH submits Bill to Cabinet for Approval (04-2012) . MOH presents Bill to Parliament (06-2012) . Portfolio Committee review and public consultation (07-2012) . Parliament enact Medicines Control Bill to establish Drug	MOH establishes Drug Regulatory Board, pursuant to enactment of MCB (03-2013) . Recruitment of staff (03-2013) . Training of staff (03-2013) . Draft Regulations or standards to implement Act, as necessary, e.g., Medicines Register; Classifications of	

				Regulatory Board (12-2012)	Medicines (to publish in Gazette); Pharmaceutical Code of Ethics regarding marketing policies; Prescribe fees for registration of pharmaceutical providers	
Completion Date						
Narrative						

Policy Area: Gender						
Policy: Male Circumcision Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			ongoing	ongoing	1/2011	ongoing
Narrative		MOH conducts facility assessment of clinical readiness to carry out neonatal MC (round 2) [2-2012]		• MOHSW finalizes AMMC Strategy. [11-2011] • MOHSW begins phased-in		

				implementation of MC. [4-2012] • MOHSW carries out HR and capacity building; • Obtain financial support for development of training modules and manuals.		
Completion Date	10-2008		2-2009	6-2010	varies	
Narrative	MOHSW completed Situational Analysis, with consulation of community and professionals to inform the policy, operational plans and guidelines regarding	Facility assessment (round 1) of clinical readiness to carry out adult MC completed. [2009]	• MOHSW developed and finalized ministerial policy with the purpose of providing a framework for policy makers to support scale-up of safe, culturally-	• MOHSW adopted National Health Sector Policy on Comprehensive HIV Prevention, which provides for MC as a biomedical component. [Approved by Cabinet,	• MOHSW finalized Health Sector Operational Guidelines. [Approved by Ministry, 7-2010] • MOHSW finalized Neonatal and Adult Operational Plan and	

	the scale up of MC in Lesotho.		and socially-acceptable, accessible, affordable, and sustainable MC as an integral component of the HIV prevention strategy in Lesotho. MC services provide to males between the ages of 15-49.	6-2010] • MOHSW engages traditional practitioners regarding scale-up of adult medical MC upon capacity strengthening. [5-2011]	Strategy [7-2011] • MOHSW obtained stakeholder input & presented to Minister. [11-2010] • MOHSW finalized HIV Prevention BCC Manual. [11-2010] • Surgical guidelines and training packages developed [5-2011] • Guidelines approved [7-2011]	

Policy Area: Human Resources for Health (HRH)						
Policy: Lesotho Health Sector Retention Strategy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	n/a	n/a	December 2010	December 2010	Varies	TBD
Narrative	n/a	n/a	Complted	MOH	. MOH	Measurable

			with MCA support	Senior Management adopts revised Retention Strategy	develops Costed Retention Strategy (completed Dec - 2012) . MOH adopts Action Plan to implement strategy (June 2013) . MOH develops guidelines for increasing and/or equalizing salaries, and establishing housing and security measures (December 2013)	indicators and targets developed as part of Action Plan (completed December 2012) . Mid term evaluation earmarked for December 2014
Completion Date						
Narrative						

Policy Area: Human Resources for Health (HRH)						
Policy: Retention Strategy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion	n/a	n/a	December	December	Varies	TBD

Date			2010	2010		
Narrative	n/a	n/a	Complted with MCA support	MOH Senior Management adopts revised Retention Strategy	. MOH develops Costed Retention Strategy (completed Dec - 2012) . MOH adopts Action Plan to implement strategy (June 2013) . MOH develops guidelines for increasing and/or equalizing salaries, and establishing housing and security measures (December 2013)	Measurable indicators and targets developed as part of Action Plan (completed December 2012) . Mid term evaluation earmarked for December 2014
Completion Date			9-2010	02-2010	7-2004	
Narrative			• MOHSW finalized the National	• MOHSW adopts Retention	• MOHSW finalized HR Developme	

			Health and Social Welfare Policy, which is the basis for the health sector retention strategy. [2004] • MOHSW developed (revised) Retention Strategy. [9-2010]	Strategy with focus on financial incentives. [2-2010]	nt and Strategic Plan, 2005-2025. [7-2004] • Plan is costed. [7-2010]	

Policy Area: Laboratory Accreditation						
Policy: Medical Laboratory Regulatory Board						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date	01/24/2011	01/24/2011	Varies	Varies	Ongoing	Not yet done
Narrative	No regulatory body for accreditation.There is a lack of regulatory body to enforce to enforce quality of services	The MOHSW has recognized this and recommends for the establishment of a Regulatory Authority, to regulate	MOHSW approves strategic Plan for Laboratory Regulatory Body (03-2011) The Medical Laboratory Policy,	MOHSW submits bill to Cabinet for approval (10-2012) Parliament enacts Bill to establish Laboratory Regularity Board	MOHSW approves strategic Plan (11-2011) MOHSW draft regulation and/or standards to	The Medical laboratory Regulatory Body policy has not been approved by GOL. So no evaluation is planned

	clinical laboratory service through licensure and accreditation of laboratory services and professionals in the country	medical laboratory practice including registration of personnel, setting standards and licensing facilities and development and enforcement of professional code of conduct. The establishment of a Medical Laboratory Regulatory Boards necessary to regulate quality medical laboratory services	MOHSW (04-2011) MOHSW approves Policy (12-2011) MOHSW submits the legislative policy proposal and request to draft legislative to the cabinet MOHSW drafts legislative drafting instructions (6-20-2012)	(Pending for 04-2013)	implement Act (02-25-2013)	until approved and implemented. Thus it should be "TBD'
Completion Date						
Narrative						

Policy Area: Orphans and Other Vulnerable Children						
Policy: National OVC Policy						
Stages:	**Stage 1**	**Stage 2**	**Stage 3**	**Stage 4**	**Stage 5**	**Stage 6**
Estimated Completion Date			varies	varies	varies	Varies
Narrative			MOHSW in process of implementing and disseminating bill and developing guidelines [ongoing]	• MOHSW approves the newest revision of OVC Strategic Plan [in process] • MOET Trains school administrators, teachers and public. Training expanded to include early childhood development [ongoing as of 10-2010]	• MOHSW disseminates OVC Situational Analysis final report [11-2011] and uses findings to inform the implementation of NPOVC. [in process]	• MOHSW completes OVC Situational Analysis to inform implementation of NPOVC. [1-2011]
Completion Date	varies	varies	varies	varies	varies	
Narrative	• Rapid Assessment, Analysis and Action Planning	• LLRC engaged stakeholder consultative process and	• LLRC drafted Children's Protection and Welfare	• MOHSW adopted National Policy on OVC	• Final Situational analysis for	

	(RAAAP) exercise completed. [2004] • MOHSW developed National Action Plan for OVC. [2004] • Lesotho Law Reform Commission (LLRC) launched Child Law Reform Project. [2001]	identified shortcomings of existing legislation and need to address vulnerable children. [2001-2004]	Bill. [2004] • Education Act has been enacted by MOET. [FY-2010] • Child Welfare Act implemented [6-2010]	(NPOVC). [2006] • Parliament enacted Education Act. [3-2010] • MOHSW presented CPWB to Parliament (First Reading). [5-2010] • National Assembly passed CPWB (Third Reading). [10-2010] • MOHSW approved and gazetted Education Act regulations [5-2010] • Parliament enacted CPWB ? MOHSW	MOET Strategic Plan completed [2010] • Phases of implementation of CPWB by MOHSW prioritized [On-going] • Registration of OVC by Bureau of Statistics completed and final report disseminated [7-2011]	

				approved CPWB (Act) regulations • Regulations gazetted [6-2011]		

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	1,135,944	0
HKID	2,530,245	0
HVTB	4,158,658	0
PDCS	399,651	0
Total Technical Area Planned Funding:	**8,224,498**	**0**

Summary:

Major Accomplishments: In FY 2011 PEPFAR actively engaged with MOHSW and other stakeholders to develop the National Pediatric HIV Elimination Strategy (2012–2016). Enhanced direct service provision was achieved by seconding doctors, technical advisors, district coordinators and nurses, to GOL facilities for MNCH, PMTCT/ANC and ART clinics, fostering integration of services and the development of the 'one stop shop' approach to provision of health services which is now being scaled up in all health facilities.

In the area of nutrition, PEPFAR has contributed towards establishing and strengthening the national nutrition technical working group which ensured that nutrition interventions were prominent in ensuring that NACS was fully integrated within the new National Strategy for the Elimination of MTCT and Pediatric HIV. PEPFAR also supported the establishment of nutrition corners in all hospitals which provide nutrition education, counseling, and assessment services to all mothers and their children. A new innovation that combines play therapy and psycho-stimulation with nutrition feeding for severely malnourished children and their care givers has been successfully piloted at Queen Elizabeth II Hospital and is now being rolled out to other hospitals.

The proposal for cervical cancer screening and diagnosis project at Senkatana HIV center has been approved by the MOHSW and an assessment of the site has been conducted.

In FY 2011, PEPFAR's engagement with government and non-governmental stakeholders in Lesotho increased significantly under the leadership of the OVC and Community Based Care Specialist. PEPFAR intensified its efforts to increase the number of local partnerships. Management Sciences for Health/Building Local Capacity (MSH/BLC) was awarded in FY 2011 and Pact increased the number of local partners received sub-grants MSH/BLC's ongoing support in systems strengthening of the Social Welfare workforce in leadership and management; increase in the number of local CBOs and network organizations whose technical, organizational and financial capacity have been enhanced. PEPFAR in partnership with EU, Global Fund, UNICEF and AusAID jointly funded the National OVC situation analysis study. Coordinated support and advocacy from OVC stakeholders, including PEPFAR, resulted in the enactment of the Children Welfare and Protection Act (2011).

PEPFAR lead the revitalization of the TB/HIV Technical Advisory Committee. Main accomplishments include the development of national guidelines for the implementation of the 3 I's (national guideline for Intensive case finding, for INH preventive therapy and for TB Infection Control), joint planning and programming between the National TB Program (NTP) and the HIV/AIDS directorate. Another major accomplishment was the revision of the national TB and HIV recording and reporting tools to effectively monitor and evaluate the implementation of the 3 I's . The revision of the TB/HIV referral guidelines in order to strengthen the integration of TB and HIV services as well as the referral system between TB and HIV services, among facilities and between facilities and the community is

another key success. The revision of the TB/HIV referral guidelines has been based on the actual implementation and success of various models of integrated TB/HIV services (1 Stop services) in various districts with the support from Columbia University (ICAP). USG has supported capacity building of health care workers to screen for TB among HIV infected, screening for HIV among TB patients as well as TB/HIV co-infection management. Other support has been in harmonization of the TB and ART policies and revision of the National ART guidelines based on the WHO rapid advice for early initiation of ART for all people with HIV and TB co-infection. USG and its partners have played a key role in the Midterm National TB strategy review with WHO and other agencies. USG has supported the implementation of electronic TB register at district level in all the 10 districts. USG and its implementing partners have supported the TB program gap analysis and review and design of acceleration plans for previous Global Fund rounds 6 and 8. USG and its partners are currently supporting the country with writing the Round 11 proposal based on the identified gaps.

Key priorities and major goals: PEPFAR will continue to support the achievement of GOL national priorities and goals. In adult and pediatric care and support, PEPFAR, in partnership with MOSHW will contribute towards the GOL's goal to reach 100% coverage of PMTCT. Through the clinical and community partners, PEPFAR will scale up infant, adolescent and adult care programs. With PMTCT Acceleration funds, PEPFAR will support scale up of nutrition, assessment, counseling and support (NACS) activities in two districts. Activities will cover the entire district including primary healthcare and community/household levels. In addition, SCS will support MOHSW to scale up nutrition corners and nutrition services to health centers in the two pilot NACS districts and communities within their catchment areas. Play therapy and psycho- stimulation activities will be scaled up to more health facilities.

The HIV clinical care program will also focus on provider initiated testing and counseling (PITC) services within an integrated clinical setting; availability of quality clinical care services, improved supply chain systems for CTX and other OI drugs. PEPFAR and the MOHSW have prioritize the establishment of a center for cervical cancer screening and HIV referral center. Studies have shown that highest mortality rates due to malignancies in PLHIV are due to cervical cancer and breast cancer, hence this center will be actively staffed and engaged to provide screening for both malignancies.

PEPFAR will also focus on strengthening community outreach for HIV, facility-based delivery and PMTCT. Emphasis will be placed on monitoring ART adherence of pregnant women on prophylaxis, tracking defaulted HIV positive or exposed mother-baby pairs and tracking of defaulted HIV exposed children. This will be achieved through activities such as Family Health Days, Mobile Clinic Outreach, capacity building and support to FBOs and community based groups to provide ongoing psychosocial support to school age children, adolescents, teenagers and women/mothers. The PMTCT Acceleration plan includes strategies to increase involvement of male partners and mothers-in-law in PMTCT as a way of improving the uptake of PMTCT services, adherence to ART and reducing defaulter and lost-to-follow-up rates. There will be an increased focus on community level M&E by development and piloting of reporting tools and conducting DQAs for monitoring community activities.

PEPFAR will focus on the following key priorities in OVC: Systems strengthening to enhance the capacity of GOL, specifically the Department of Social Welfare and the National OVC Coordinating Committee (NOCC) to provide coordinated leadership in Lesotho's response to addressing OVC issues; Scaling up of quality OVC service delivery and; Capacity strengthening of local NGOs and community based organizations. The two OVC implementing partners MSH/BLC and Pact will increase the number of sub-grantees and build their capacity in technical and organizational skills. The portfolio will foster linkages with prevention and treatment sectors to ensure a continuum of quality care for the beneficiaries.

In the next two years, the focus is provision of high quality integrated laboratory services for scale up of TB/HIV prevention, care and treatment services. The TB/HIV program will prioritize the scale up of the rapid and proper diagnosis of TB and the roll out of Gene Xpert based on the National roll-out plan. USG will support the implementation of Gene Xpert and help MOHSW manage the implications (in terms of increased TB cases, including MDR-TB cases). PEPFAR will continue to support the MOHSW in the implementation of the 3Is nationwide, which includes supporting the training of health care workers to provide clinical prophylaxis and/or treatment for TB to HIV-infected individuals (diagnosed or presumed); and increasing the low enrolment of TB/HIV co-infected patients on ART from current 28% to 95% within the next two years, supporting the initiation of ART within the TB clinics. Enhancement of directly observed treatment implementation including community-based approaches to TB care and management. The USG will support GOL to train Village Health Workers (VHW) on

the 3 I's with the aim of raising awareness on the 3I's, increasing community knowledge on infection control and performing community based case finding and referral of TB suspects to the facilities. USG will continue to strengthen the M&E institutional capacity of the National TB program to detect and verify TB trends, use of data to evaluate TB program outcomes. Continued support of the integration of TB and HIV monitoring tools for improving monitoring and documentation of TB screening, TB status and TB treatment among PLWHA. The USG will support national efforts to mitigate the impact of TB in vulnerable populations which include migrant Basotho mine workers, Prisoners, Apparel workers, herd's boys. Emphasis is on strengthening referral and patient tracking systems to ensure early TB diagnosis, prompt treatment, treatment completion and improved outcomes. The PEPFAR program will continue to support efforts to improve efficiencies through support of TB/HIV technical working group coordination meetings, the district health management teams on coordination of TB/HIV activities within the districts

Alignment with Government strategy and priorities
PEPFAR care and support interventions are implemented in accordance with GOL guidelines and contribute towards the goals of National Strategic plans. PEPFAR is represented on all national TWGs.
Clinical care activities use the MOHSW guidelines for PMTCT, ART and TB/HIV. Partner work plans are jointly reviewed and approved by PEPFAR and the MOHSW. PEPFAR is represented on the NOCC. Program implementation is aligned with the GoL Child Protection and Welfare Act (2011), National Policy on OVC, OVC Strategic Plan 2006-2011 and the National Action Plan for OVC (NAP 2006). The OVC program is implemented in close collaboration with the Department of Social Welfare (DSW) in the MoHSW, which is responsible for coordinating the national OVC response. An OVC Situational Analysis for Lesotho will be finalized and disseminated in 2011; PEPFAR will fund the development of revised new five year National OVC Strategic Plan.
The USG supported TB activities are well aligned with the Lesotho DOTS Expansion Strategic Plan 2008- 2012 whose overall goal is reduce TB morbidity and mortality.
Policy advances or challenges (identified in the PF/PFIP): PMTCT and ART Guidelines have been updated according to WHO 2010 recommendations for PMTCT, care and treatment in children. The guidelines have been disseminated to all districts and GOL and CHAL health facilities, with trainings conducted for HCWs. NACS have been incorporated in this guidelines but more extensive support for the review of Infant Feeding Guidelines and job aids will be provided in 2012. Pediatric care and treatment services have been decentralized to the health center level using the GOL nurse driven model. These services are supervised by PEPFAR's implementing partners including EGPAF and Baylor. In 2012, the MOHSW and PEPFAR will focus more on the quality of pediatric treatment and care services in all districts, with emphasis on quality improvement. The National Strategy has included 'increased access to quality pediatric HIV treatment, care and support for all HIV infected infants, children and adolescents' as its fifth (5th) strategic objective, with laudable, feasible and achievable strategies and performance objectives.
The main challenges to expansion of pediatric HIV services are critical shortage of skilled HCWs due to staff attrition and critical staff shortages; deficits with Supply Chain Management of ARVs and nutrition commodities; and, challenges with reporting, collating and analyzing data for monitoring care and treatment services. Most of this is related to HR shortages at all levels of healthcare and poor resource and data management at district and central levels. In line with achieving the PF Goals 3 and 4 by 2014, PEPFAR has identified a central level HSS and SI partners to work with the relevant departments in the MOHSW to identify and fill gaps, determine priorities.
USG TB/HIV programs are also well aligned with the objectives of the Partnership Framework between the Government of Lesotho and USG, Specifically PF outlines four major goals including reducing morbidity and mortality and providing essential support to Basotho PLWHV, major focus of the TB /HIV program. PF goals is the collaboration between government and partners to develop policies and guidelines for effective treatment TB / HIV individuals and closely monitor policy interpretation and implementation at the district and facility levels
Major strides have been made with regard to policies for children identified in the PF. The GOL has over the past year enacted two bills essential to improving the well being of children in Lesotho: The Education Act (2010) and the Child Protection and Welfare Act (2011). Implementation of the National OVC Policy is tied to the National OVC Strategic Plan 2006-2011 which which will developed with PEPFAR-funding. In 2010, the Bureau of Statistics conducted a census of OVC in the country, which. The report was finalized in July 2011.
Efforts to Achieve Efficiencies: The USG TB activities complement existing resources already being utilized in

Lesotho. Specifically the PEPFAR TB program leverages resources for increased DOTS and MDR TB programs financed through the Global Fund, expand upon the infection control measures being supported by MCC and PIH, complementing laboratory infrastructure supported by global fund. Collaboration between government and non-government partners based on the principal that the MOHSW own and create a sustainable integrated TB/HIV program beyond USG funding. Key partners for continued collaboration, coordination and leverage resources for implementation of TB/HIV integrated activities include PIH, EGPAF, etc. and WHO for policy guidance. To maximize resources and avoid duplication, implementation will be done in close collaboration with key OVC stakeholders such as UNICEF and Global Fund Coordinating Unit (GFCU). UNICEF with funding from the European Union, has identified institutional capacity strengthening of DSW, support for the development of the National Strategic Plan and child grants as some of their areas of focus. The GFCU is supporting access to secondary education and vocational skills for OVC.
PEPFAR, along with other donors, has been involved in providing financial and technical support towards the national OVC situation analysis process. The situation analysis will contribute towards providing clear direction of where OVC response and resources should be focused. The baseline assessment of HIV Service provision in Lesotho, funded by PEPFAR, was released and adopted by the MOHSW. This report has been very instrumental to determinint baselines for various care and treatment indicators, design of the PMTCT acceleration plan and the NACS integration plan as well as planning for the PEPFAR funded Strengthening Clinical services project. Psychosocial Needs Assessment were conducted in seven districts contributing significantly to the development of the comprehensive psychosocial training curriculum for HCWs
HSS: In view of the GOL health sector decentralization plan, PEPFAR implementing partners will focus on strengthening the capacity of the national and district level staff of the DSW as well as staff of local community based organizations in leadership and management skills and service provision for OVC. Community Systems Strengthening (CSS) activities that will improve DHMT capacity and CHW involvement to stimulate demand for Care and Support services in the communities and at health facilities. In order to strengthen CSS activities for Care and Support, the Human Resources Alliance for Africa (HRAA) will support the pre-service training of 20 Auxiliary Social Worker at National Health Training College. The graduates will boost the capacity of the DSW to carry out field support visits to organizations that provide OVC and other social services in the communities. In addition, HRAA will support Institutionalization and formalization of the CHW cadre, and capacity building. PEPFAR will support MOHSW to develop a community health worker strategy that recognizes CHWs in the decentralized structures. PEPFAR in coordination with MOHSW will support in-service training in HIV diagnosis and monitoring tests, quality management, laboratory information and supply management using customized and standardized training modules. The HIV rapid testing has been task-shifted to counselors.

Adult Care and Support: PEPFAR programs promote a minimum package of care services for PLHIV, according to National standards. This package comprises, among others, PITC, adherence counseling, HIV Clinical Staging, CD4 counts, routine baseline investigations, TB Screening, routine OI screening and CTX prophylaxis. All HFs, including PEPFAR supported ones; provide all these services in ART, TB and PMTCT settings. While these services are provided, challenges still exist with linking all these services in the clinical setting, hence the drop off from 80% HTC rate to 27% ART initiation rate in TB clinics. Challenges still exist with linking community services to facilities, though we have tried to address this through the use of Focal persons to coordinate between HCWs in health facilities and VHWs in the communities. We plan to strengthen this approach through the use of innovative tools like the family books and appointment registers in all supported sites, development of low cost ICT technology to facilitate communication between HCWs and VHWs as well as hasten specimen result delivery (e.g. CD4 count results, DNA PCR results and Sputum results).
A major challenge exists with retaining Pre- ART clients in care. VHWs monitor patients on ART, but pre ART clients receive less attention as compared to the former category. Increased focus is being placed on this as evidenced in the Acceleration plan (Prong Four). The approach of comprehensive, client centered and family centered HIV service provision which is the hallmark of the SCS project (using ANC as point of entry to HIV care to families) will ensure that these services reach down to every HIV positive client. Also, planned integration of ANC, MNCH, SRH and HIV/ TB services, if effectively implemented (according to National Policy and our PMTCT Acceleration Plan) will ensure that clients receive quality care at all service delivery points and reduce LTFU. Increased attention will be placed on defaulter tracking and reduction of LTFU rates for all categories of patients,

whether 'Pre-ART' or on 'ART'.
Criteria for counting persons receiving HIV clinical care is based on the cumulative number of persons ever enrolled into HIV care. A drop off rate of 37% (averaging 20 – 30% default rate, 10% progression to ART and 5% death rate) is applied to this to arrive at the final figure. This was agreed upon by both national partners (ICAP and EGPAF) providing clinical care to be the closest estimate to the actual figure, as measured by actual program data in some facilities and modeling. This method is temporarily applied, pending the pilot and eventual dissemination of newly developed registers (which PEPFAR is supporting), tools and monthly summary forms in FY12 which will capture discreetly every patient coming to the facility to receive care services.
Pediatric Care and Support: Currently, 4458 children are enrolled in care services (as of SAPR 2011). Targets set for COP2012 and 2013 are 8953 and 10541 respectively. Major accomplishments have been discussed above. Provision of treatment services for children and their mothers are done together in the ANC, PNC and MNCH clinics up till 18 months of age, ensuring that both mother and HIV exposed or infected child receive their services jointly, including PITC and CTX prophylaxis Afterwards, they are referred to the ART clinics which is mostly integrated at the primary health center level. This Mother – Baby pair approach is the model employed by Baylor and EGPAF under the SCS project and this approach will be scaled up nationally, as stated in the National PMTCT and Pediatric HIV Elimination Plan, and with support from PEPFAR. SCS will continue to train new healthcare workers, provide supportive supervision and mentoring for all HCWs in all health facilities, including private facilities. Issues of adherence monitoring and support are addressed under priorities and goals. Linkage between facilities and community based care are addressed under adult care and support. Baylor will be expanding its SCOEs to more districts in the next years and more HCWs in GOL health facilities will receive supportive supervision and mentoring through SCS, as we expand our current national coverage of 87% to 100%.
Key priorities in the next two year include building national TB diagnostic capacity including Gene X pert roll-out, further microscopy decentralization, and Three Is implementation across the country, increasing enrolment on ART for the TB/HIV co-infected person. USG will continue to support interventions in the TB high risk groups including mine workers, prisoners and textile workers.
Currently USG is supporting the design and implementation of the Gene x pert national roll-out plan and the plan operational. This also includes the support for development of new diagnostic algorithms to incorporate the use Gene Xpert. Guidelines for the three Is have been completed and nationwide training completed. The next phase will focus on the country to scale up isoniazid preventive therapy (IPT) in PLHIV in at least 95% of the health care facilities including infection control.
Lesotho has adopted the WHO guidelines to initiate ART among all HIV/TB co-infected patients. USG is currently supporting efforts to increase the enrolment from 28% to >95%. This is through supporting accreditation of TB clinics to provide ART and on-going mentorship provided to all health care workers in Lesotho both in public and private sector.
The USG supported TB activities are well aligned with the Lesotho DOTS Expansion Strategic Plan 2008 2012 whose overall goal is reduce TB morbidity and mortality. USG TB/HIV programs are also well aligned with the objectives of the Partnership framework between the Government o Lesotho and USA, The USG has supported a comprehensive TB program analysis and this provides evidence for prioritization of activities to address gaps identified. Additionally USG has participated in the Midterm TB strategic plan review and is current supporting implementation of recommendations made.
The USG through its partners has supported the revision of TB and HIV to adequately monitor and evaluate TB and HIV activities. These tools are currently being tested will be implemented nationally beginning January 2012. USG has also supported the TB program to monitor performance of districts on a quarterly basis from reports which include case finding, sputum conversions, treatment outcomes and program management. US will in the next two years continue to support efforts to address weaknesses and barriers to service delivery.USG will also support national capacity to analyse, validate and use program data for program improvement
Lesotho is one of the focus countries for NACS integration with PMTCT acceleration. Nutrition Assessment, Counseling and Support is an integral part of the GOL National Plan for the Elimination of MTCT of HIV and Pediatric HIV. Implementation of NACS has been designed to contribute towards the PMTCT national goal and objectives which are aligned with the WHO guidelines. The NACS program objectives will: strengthen NACS services at community level; support integration of NACS within post natal care and MNCH settings and: strengthen central level organizational capacity to implement, monitor and evaluate PMTCT and NACS activities.

These objectives will be achieved using the revised MOHSW IYCF Policy and guidelines and will be implemented by both clinical and community partners. The clinical and community partners are currently linked through sub-partners supporting both clinical and community care, health facilities and community groups. Community health workers have also played a key role in strengthening community and clinical linkages. The NACS plan provides for an enhanced role of CHWs and other community members in conducting nutrition assessments, counseling and active case finding. This will improve the bi-directional referral system for follow up and monitoring. Although PEPFAR Lesotho does not have a technical assistance partner specifically designated to play leading role in food and nutrition work, both clinical and community partners implementing the NACS and PMTCT Acceleration program, will have designated funds specifically for NACS. No budget has been allocated for the procurement of therapeutic and supplementary foods as this is adequately covered by GOL and other donors. PEPFAR support will be used to strengthen the supply chain of the NACS commodities.

PEPFAR national level support will be through strengthening the MOHSW Nutrition TWG and provide technical support to the ministry's nutrition unit to implement and monitor nutrition programs, analyze program data, conduct surveillance activities and develop a framework for implementing nutrition activities for PLHIV in facilities and communities. Through the nutrition unit, the program will collaborate with the GOL's Food and Nutrition Coordinator's Office (FNCO) and specifically with the Breastfeeding Net work and Micro-nutrient Task Force of the FNCO. Greater collaboration and linkages are required among the PMTCT, nutrition TWGs and the FNCO. This collaboration will feed into the national food and nutrition surveillance systems. To enhance data collection at national and district levels, PEPFAR partners will support MOHSW to conduct routine M&E activities for nutrition and regular (annual) nutrition surveillance activities. Planned QI activities in the PMTCT acceleration plan will include nutrition activities at all hospitals and health centers in the two selected districts. Support will also be provided to the MOHSW to review the nutrition guidelines, develop/ review job aids and standard operating procedures for health care workers and community health workers for nutrition. Evaluations will be conducted in 2014 to assess impact of nutrition activities in two NACS focus districts.

The UNICEF/UNAIDS Children and AIDS Fifth Stocktaking Report, 2010 estimates the number of orphans as a result of AIDS at 130,000. The National OVC Policy, 2006, gives the DSW overall mandate over matters affecting OVC. Coordination of OVC services however remains a key challenge that was also noted in the draft OVC situational analysis report. PEPFAR OVC portfolio goals will focus on: systems strengthening to enhance the capacity of GOL, specifically the DSW; technical and organizational capacity strengthening of local CBOs/NGOs to scale up service delivery and; support GOL in implementing and disseminating policies that benefit the wellbeing of children. To maximize resources and avoid duplication, implementation will be done in close collaboration with key OVC stakeholders such as UNICEF and Global Fund Coordinating Unit (GFCU). UNICEF with funding from the European Union, has identified institutional capacity strengthening of DSW, support for the development of the National Strategic Plan and child grants as some of their areas of focus. The GFCU is supporting access to secondary education and vocational skills for OVC.

The Lesotho National OVC Policy and OVC Strategic Plan recognize that care and support services for OVC in the country are fragmented and poorly coordinated. The DSW continues to face challenges in effectively coordinating the national response. A key priority for the OVC portfolio is systems strengthening for OVC service delivery with specific focus on the DSW as the department mandated to coordinate the OVC response. Through the MSH/BLC program, PEPFAR has been providing leadership and management training and coaching to the senior managers and district staff of the DSW. One of the priorities identified by the Lesotho delegation to the Social Welfare Workforce Strengthening Conference held in 2010, identified training of child welfare officers in child protection as a key priority challenge. PEPFAR's OVC partner MSH/BLC has collaborated with UNICEF, GFCU and DSW in commencing this on-going process. During the next two years, capacity strengthening will also target key staff in other ministries such as, Ministry of Education and Training, Ministry of Local Government and Chieftainship (MOLGC), and Ministry of Gender and Youth, Sport and Recreation all with the responsibility of facilitating service delivery for children. Other in-service training targets local NGOs including umbrella organizations such as Letsema Network of OVC service providers. The capacity building strategy entails developing a cadre of trainers and mentors within the umbrella organizations for them to in-turn roll out skills of staff in umbrella organizations and communities. Furthermore, the Human Resources Alliance for Africa (HRAA) will support the pre-service training of 20 Auxiliary Social Workers per year at National Health Training College. The graduates will boost the

capacity of the DSW to carry out field support visits to communities.

To strengthen the capacity of families the PEPFAR partners Pact and MSH/BLC and the Ambassador's Small Grants Program, are sub-granting exclusively to local CBOs and NGOs who work directly with grass root entities. Key priorities include caring for caregivers with a focus on emotional support, skills transfer in parent /child communication and positive parenting. Economic strengthening activities will target both caregivers and older children by supporting income generation activities and small business skills training. The program will explore partnership with micro-financing institutions to diversify economic strengthening initiatives. Through sub-grants, partners will support families and communities to diversify food production to include vegetables, fruit and other crops. Skills in use of labor saving techniques such as key hole gardens will be enhanced. The implementing partners will help establish linkages to markets for agriculture produce and IGA products. The OVC program is implemented using age and sex specific approach ensuring that the needs of all children are met in a holistic manner. In order to ensure that the needs of children across the age span are met and there is no disruption of services to OVC, the implementing partners use a community-based approach that empowers families and community groups to identify the needs, develop and implement locally appropriate strategies. Additionally, MSH/BLC will support the development of referral directories by mapping clinical services, community services and delivery points in five districts. The directories will strengthen linkages and referral services. The OVC partners will collaborate with HIV prevention and treatment partners to support the community-based care of the HIV/AIDS continuum including linking expectant mothers to access ANC/PMTCT services. The OVC partners will implement the community component of the NACS program as part of the PMTCT elimination strategy.

Technical support to CBOs aims at ensuring that OVC and their families have access to quality services. The OVC portfolio will expand services to include early childhood care and development (ECCD), an area that has picked up momentum in the country. Linkages have been made with the USAID centrally funded Takalani Sesame and the Ministry of Education for this purpose.
Lesotho has made significant progress in recent years to address legal and cultural barriers to gender equity. New legislation including the Sexual Offences Act 2003, the Equality of Married Persons Act 2006, the Land Act 2010, the Education Act 2010, and the Children's Protection and Welfare Act 2011 clarifies and protects the rights and entitlements of girls and women. Despite this progress on the legislative side however, women and girls are still subject to a number of barriers and threats that may ultimately affect access to health services. The Lesotho PEPFAR program is developing a gender strategy to be ready by June 2012. This will provide further guidance to partners in their gender mainstreaming efforts. Currently, partner plans and activities aim at increasing gender equity by promoting access to services for both male and female beneficiaries. For reporting and tracking purposes, partners collect program data disaggregated by sex.
As a beneficiary of the Gender Challenge Fund, MSH/BLC and the Ambassador's Small Grants Program are collaborating with the with the Ministry of Gender, Youth and Sport and Recreation (MGYSR) in ensuring that the rights of women are protected. The program entails training of community facilitators on legal frameworks including the Married Persons Act, the Child Protection and Welfare Act and the Anti-trafficking in Persons Act. The expected outcome is to empower women and help them understand their socio-economic rights thus increasing women's legal protection. Furthermore, the partnership will support these women's support groups to explore economic growth opportunities such as accessing bank loans for small businesses and exercising their land use rights. The NACS Integration and PMTCT Acceleration program will use community mobilization to increase male involvement and participation in PMTCT improving the uptake of PMTCT services and adherence to ART; and, reducing defaulter and lost-to-follow-up rates. In order to strengthen gender integration across PEPFAR programming, Lesotho team will conduct a gender assessment in 2012.

USG investments in Human Resources for Health (HRH) in Lesotho all aim at achieving Goal III of the PF. PEPFAR has invested in improving the production, recruitment and retention of health care workers (HCWs). In FY 12 PEPFAR is expected to ensure that adequate numbers of HCWs are appropriately distributed to manage health facilities refurbished by MCC. Deficiencies in numbers of HCWs has led the MoHSW with no option but to task-shift some of the non medical functions to Community Health Workers (CHWs). Lesotho has a large base of CHWs who are not effectively utilized, remunerated, supervised or coordinated. CHWs have been providing services in Lesotho

since 1975 and adopted as a national strategy for service provision in 1979. Remuneration for CHWs was only instituted in 2008. CHWs are essential for delivery of PMTCT, social welfare and other health interventions at both the community and household levels, and for creating a demand for facility-based services through social mobilization.
PEPFAR is investing in strengthening social welfare workforce by providing coaching to the DSW staff in leadership and management and technical skills to enable them effectively coordinate the OVC response. The DSW has been mandated by the Child Protection and Welfare Act to coordinate issues affecting children. Furthermore, partners will enhance the capacity of caregivers, volunteers and staff of CBOs in technical skills for implementing OVC services.

In view of the planned Lesotho health sector decentralization plan, it becomes important that PEPFAR implementing partners focus on Community Systems Strengthening (CSS) activities that will improve DHMT capacity and CHW involvement to stimulate demand for care services at the level. In order to strengthen CSS activities for PMTCT, MCH and SRH services, PEPFAR implementing partners will champion the following strategies and activities:

Strengthen performance, supervision and mentorship of health and CHWs:
HRAA will strengthen quality improvement at the DHMT level through development of performance based systems. Facility and district level performance-based financing (PBF) will be piloted as a catalyst for stimulating productivity and accountability in decentralized health systems.

Support Institutionalization and formalization of the CHW cadre, and capacity building:
HRAA will support MOHSW to develop a community health worker strategy that recognizes CHWs in the decentralized structures. This will result in DHMTs and health facilities having clear CHW structures, work plans, guidelines, supervision tools and compensation plans.

Laboratory: Laboratory services in the country are provided at three tiers; central, district and health center levels. There are 21 heath facilities (central laboratory and district hospital laboratories) that provide from basic to more complex diagnostic and patient monitoring tests. The central laboratory provides referral testing services that include DBS based DNA-PCR test for early infant diagnosis of HIV, viral load and CD4 monitoring, TB and other microbial culture and drug susceptibility tests. The district hospital laboratories provide basic diagnostic tests and routine patient monitoring that include HIV rapid tests, TB smear microscopy, clinical chemistry/ hematology and CD4 monitoring. These laboratories support referral testing service to health within their local networks. There are more than 190 health centers which support HIV rapid tests and collect samples for referral testing services. As part of decentralization and increasing access for laboratory diagnosis and patient monitoring, rapid and point of care tests are introduced. These included CD4 point of care and GeneXpert for MDR TB which will be rolled out in primary and peripheral health facilities.
As part of strengthening national laboratory system, the MOHSW with partners developed the national laboratory policy and a five year strategic plan (2008-2013). The implementation of the strategic plan focuses on the establishment of quality assured and integrated laboratory services through throughout the health care network. The National Quality Assurance has been established and coordinated by the Quality Assurance Unit of the MOHSW. The External Quality Assessment (EQA) schemes have been implemented for all diagnostic and patient monitoring tests in all 21 laboratories. A standardized HIV testing algorithm as well as EQA schemes has been implemented in all 267 testing centers across the country. The WHO-AFRO accreditation scheme, Strengthening Laboratory Improvement Program towards Accreditation (SLIPTA), has been implemented in all laboratories.

Capacity Building: PEPFAR capacity building objectives are focused on strengthening local capacity through GOL systems strengthening, technical and organizational capacity building of local CBOs/NGOs to scale up service delivery and; enhancing capacity of individuals to effectively provide care. These priorities are determined by their potential effect on the expected outcomes and impacts.
At the individual level, the government and private sector have prioritized the training and on-going mentorship of HCWs, especially the nurse and VHW cadres. Several tasks have already been shifted to these cadres and it has

become apparent that their capacity to do an even better job needs to be strengthened. PEPFAR is currently supporting the MOHSW to develop a VHW strategy. Significant investments have gone into supporting the pre service education of nurses through NEPI and Jhpiego's support for GOL and CHAL health institutions. These interventions have been determined by the fact that HIV service provision in Lesotho is nurse driven. MSH/BLC is providing leadership and management training and mentorship to the DSW staff for them to effectively coordinate the OVC response. In addition, the PEPFAR partners are enhancing the skills of community care givers and NGO staff to enable them provide quality care and support to OVC. Implementing partners are supporting civil society by through technical and organizational development and sub-grants.
At the system level, it has become apparent that Lesotho's extensive CHW network needs to be exploited to create a robust healthcare system at the primary health level where most clients receive their HIV care and treatment. Potentially, the CHWs will be linked to HCWs in health facilities. There is also increased emphasis on improving patient referral systems between health facilities and communities, as well as specimen referral systems between health centres and laboratories. More than 190 of all health facilities now provide ART services, with HCWs in GOL and CHAL health facilities now supported to initiate ART. The MOHSW is becoming more aware of the need for collaborative TB and HIV treatment services while MNCH, Nutrition and ANC services will continue to be integrated in all hospitals. Increased attention is being paid to in country provision of quality diagnostic services for HIV and TB. Laboratory infrastructure is being improved with the construction of the new National reference laboratory by MCC, in addition to the construction and renovation of over 140 health facilities. The TB reference laboratory (built by Partners in Health) is almost complete and the new PPP Referral hospital collaboration between the GOL and Tsepong Pty) has been completed and is fully operational.
The GF has pointed the attention of the MOHSW to pending SCM issues, with the subsequent disbursement of funds now dependent on a resolution of these. This is considered to have positive impact of the support we are providing the MOHSW as they will now be more responsive to owning the pharmaceutical management tool and also develop effective DSM and SCM systems.
HIV and TB Drug resistance are increasingly more recognized and the recently conducted study on EWIs is an indication of rising national commitment in addressing this trend. Cervical Cancer and other HIV associated malignancies are also receiving more attention as the MOHSW recently agreed to collaborate with PEPFAR to upgrade the Senkatana HIV centre to a Centre of Excellence for HIV Referrals and cervical cancer screening.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	1,867,891	0
HVSI	2,622,168	0
OHSS	2,279,824	0
Total Technical Area Planned Funding:	**6,769,883**	**0**

Summary:
Health service delivery in Lesotho is provided by the public sector and privately registered practitioners under the Public Health Act 1970, which is currently being revised. The public health sector comprises the Ministry of Health and Social Welfare (MoHSW) and the Lesotho Defense Forces (LDF). According to the MOHSW, the public sector provides 60% of health care services in the country. The private for-profit sector comprises private hospitals, Private Surgery, Nurse Clinics and private pharmacies. In October 2011, the first Public Private Partnership (PPP) Tertiary Hospital (Tsepong) opened its doors to the Basotho population to provide high level tertiary medical services. The non-profit sector comprises faith-based organizations – with the Christian Health Association of Lesotho (CHAL) as an umbrella organization – and other non-governmental organizations (NGOs).

The major constraint which impacts all aspects and levels of the health care system in Lesotho is the paucity of health care workers (HCW) Lesotho has developed several well-crafted plans for strengthening human resource management and continuing education, expanding the capacity of national training institutions, and improving conditions of service for HCW. However there is a marked gap between stated intent and actual practice as Lesotho has failed to implement HRH strengthening plans. Addressing HRH challenges such as those facing Lesotho require long-term sustained efforts.

Pharmaceutical management in Lesotho has been plagued by a lack of qualified human resources, financial resources, and poor information concerning use of drugs and commodities. This has greatly affected the country's ability to procure commodities in a timely and cost-effective manner, and has impacted the country's access to Global Fund resources.
Lesotho is also challenged by an aging and inadequate service delivery infrastructure (insufficient number of facilities, accessibility challenges, and poor technical supervision). However, the collaboration between the Government of Lesotho (GOL) and the Christian Health Association of Lesotho (CHAL) has been reinforced to address these challenges. Additionally, Lesotho has benefited from a large grant from the Millennium Challenge Corporation to rehabilitate and construct 136 health centers.

The information requirements imposed by the HIV pandemic (i.e., increased need for longitudinal patient tracking) have dramatically altered the HIS environment and exposed the inadequacy of human resources, aging and inadequate infrastructure, and insufficient coordination of partners. The GOL is aware of this situation and has taken several measures to address it. The recruitment of district health information officers is a first step in this regard. Lesotho has the potential to better use its national resources (the HIS budget execution rate stands at 17 percent) and to tap into international goodwill to strengthen the HIS.

In 2011 Lesotho decentralized health and social welfare services, devolving responsibility for these services to district councils. While this change is welcome, challenges in HRH, financial management, HIS, and service delivery present a particular set of risks for successful decentralization of health and social welfare services. To its credit, the MOHSW has proceeded very cautiously with the decentralization effort. Several opportunities for strengthened health governance are available through the decentralization of processes, including more participatory strategic and operational planning and enhanced effectiveness of existing community groups.

Global Health Initiative
Despite the fact that Lesotho only receives PEPFAR funding, the Lesotho team is committed to support the GHI goals by contributing to existing efforts and platforms to strengthen governance and systems in Lesotho in collaboration with the Global Fund, and other development partners.

There is a strong focus on developing the organizational capacity of civil society organizations to ensure quality service provision. Civil society organizations in Lesotho have identified a need for capacity building in governance, financial and program management, and monitoring and evaluation. Approaches may include training in financial and organizational management, mentorship and networking strategies, developing standards of service and building data use capacity for program improvement. Strong supervision and mentoring activities are intended to be a priority, to ensure that these organizations are implementing good practices and following GOL guidelines. These targeted interventions, in synergy with other development partners' support, will help achieve the National Development Plan goal of improving governance and service delivery.

Under the GHI, PEPFAR Lesotho will continue to support improved access to integration of key services into existing health platforms, the delivery of other essential health care services can be strengthened with minimal additional costs. Under GHI, PEPFAR will continue its partnership with the GOL to increase health impact through integration of additional primary prevention services, including blood pressure checks, blood sugar screening and body mass index checks, into some of the HIV Testing and Counseling (HTC). This strategy increases demand for HTC while diminishing stigma around counseling and testing. These complementary, non-HIV services are provided by the lead PEPFAR HTC partner with funding from other donors. Through GHI, USG can also

continue to strengthen existing support to improving nutrition assessment, counseling and support through PMTCT services under PEPFAR. , which will indeed have a strong impact on treatment outcomes.

In FY2012 PEPFAR will continue to negotiate and explore Public Private Partnerships with a private bank (for credit to HCW as an incentive); Johnson and Johnson (to build leadership and management capacity within MOHSW) and with TEBA/AngloGold mines to improve adherence and tracking of TB/HIV patients.

Leadership and Governance and Capacity Building
Strengthening government capacity: PEPFAR, through a new mechanism; HRAA will work with the MOHSW to ensure that the HRH strategic Plan, HCW retention policies, structures and posts are established and costed to ensure a continuum of response to HIV service delivery. This will be done through effective health systems and community systems strengthening strategies within the decentralized health services. HRAA will provide support to the GoL to ensure availability of health care providers and at the same time stimulate the demand of health services from the communities. Recognizing that having adequate service providers could be a challenge; in the short term HRAA will build capacity of the MOHSW to develop task-sharing strategies and compensation plans for Community Health Workers (CHWs) in order to assure the provision of a continuum of health services at the primary health care (PHC) levels. In the area of pre-service training HRAA will work collaboratively with NEPI and Jhpiego to leverage resources with the MoHSW to produce adequate numbers of new graduates through , strengthened relevant curricula with enhanced scopes of practice for nurses and improvements in training infrastructure. These changes will also demand for enhanced and strengthened HCW regulatory frameworks in the country.
PEPFAR, through the EGPAF/ SCS project, provides TA to the MOHSW in policy development, human resource skills development and capacity building of MOHSW central and district level managers. Currently, we will explore a PPP with Johnson and Johnson to help build the capacity of HIV and PMTCT Managers at both levels, through this project. PEPFAR will continue to support extensive in service training, mentoring and supervision of newly graduated, newly enrolled and currently active HCWs and CHWs.
PEPFAR, through the MSH/ SPS/SIAPS project, is leveraging extensive knowledge base and networks to support the SCM and pharmaceutical governance needs of the MOHSW. PEPFAR also provides technical support and capacity building for laboratory services in Lesotho through 3 implementing partners; APHL, ASCP and NICD.APHL supports the laboratory services through implementation of the laboratory information system, establishment of national regulatory body for standardization and certification. APHL supports in-service training including laboratory management and leadership program. ASCP supports pre-serve training in Medical laboratory Science through revisions and development of training curriculum, training and mentorship students and faculty, and provision of teaching aids. NICD supports local capacity of reference by establishing advanced diagnostic tools, provision of in-service trainings and revision of equipment and supplies.
Strengthening civil society capacity: PEPFAR through HRAA, NEPI and Jhpiego will work with CHAL Secretariat and training schools to improve clinical laboratories, learning materials, teaching Aids and renovate the classrooms/ accommodation infrastructure in order to increase the number of new nurse graduates. The IPs will also work with the Lesotho Nursing Council (LNC) to strengthen regulatory standards among nurses. ARC a central mechanism will support and build capacity of the LNC to develop Continuing Professional Development programs (CPDs) and a credentialing system for nurses.
PEPFAR through MSH/LMS project is strengthening the capacity of the department of social welfare (DSW) under the MOHSW in leadership and management to ensure effective leadership and coordination of OVC service delivery. Furthermore, MSH-LMS and Pact are providing technical and organizational development capacity training for local Non Governmental Organizations implementing OVC and community based care for PLWHA. In addition, MSH-LMS is also providing sub-grants to local NGOs for OVC and PLWHA to strengthen capacity for community management and service delivery.
Strengthening Private Sector capacity: This is an area in which PEPFAR Lesotho might require support from OGAC and central agencies to assist develop and strengthen private sector response. Currently PEPFAR has been working through existing implementing partners to develop public private partnership (PPP) business models to improve the delivery of services to the Basotho population. The PEPFAR team has formed a PPP working group with focal point persons to champion the development of PPP activities. Some of the IPs with PPPs includes

EGPAF, ICAP and HRAA.
Strategic Information
In FY2012 USG is focusing on capacity building in M&E, technical assistance in surveys & surveillance, and both for supply chain management, which the fairly low levels of SI capacity in country indicate as critical needs. This approach is in line with the 4th goal of the partnership framework, which targets the strengthening of HMIS, organizational capacity, & supply chains. To address HMIS issues, the USG HMIS advisor is working closely w/ MCC/MCA, whose compact includes the development of an integrated HMIS.
Efforts to develop and implement a functional country HMIS are under way. A National HMIS vision, policy, strategic plan and monitoring and evaluation plan is in place. However, data management supervision and feedback mechanisms are still very weak at the district level because of the centralized nature of data management and human resource challenges at national level. Trained IT personnel have been lost by MOHSW due to lack of funding streams. Despite this drawback USG through its IPs, is supporting the MOHSW to develop and implement integrated HIV/AIDS registers that will allow for interfacing with various software products to improve data flow. There will be a central data repository serving health center, hospital, DHMT and Central levels, where all health related data for that level can be stored and accessed, utilizing a dashboard to extract integrated reports. Data quality will also be assured by a number of built-in computer tools and techniques designed to check the reliability and accuracy of data
With the DHS 2009 completed in 2010 and showing a stabilization of the epidemic at 23%, FY11 saw work begin on the 2011 round of the biannual HIV sentinel surveillance, which should be completed in early 2012. FY11 also saw the near-completion of a USG-supported situational assessment of OVC, the report for which is awaiting finalization. A facility assessment of neonatal MC services was also conducted in FY11 with USG support. Finally, USG took part in FY11's EPP/Spectrum workshop on HIV projections & estimates. In FY12, USG will continue technical & logistic support for HIV sentinel surveillance. USG is also working with MOHSW, via Macro, to evaluate the ongoing decentralization of health services. For all activities, USG is providing extensive technical assistance as well as funding for implementation. Still, with a larger budget, USG could do more to improve Lesotho's ability to know its epidemic via surveys & surveillance.
There is a great need for building SI capacity in Lesotho but due to limited funding, priority has in the past been placed on trying to build an M & E workforce able to support this demand. Various innovative strategies have included leveraging other partner's investment to work towards the improvement of in country systems in order to achieve the 'one national M & E system'. Through the one strategic Information partner John Snow Inc (JSI)/ Institute for Health Measurement (IHM), USG managed to support the MOHSW and NAC by providing technical assistance, training, mentoring and coaching practices for the improvement of M & E systems and quality data with involvement from EGPAF and ICAP looking more specifically at PMTCT, TB/HIV, treatment and care centered data collection activities respectively. Focus was placed on building capacity at district and local levels by way of revising collection tools and implementation of a Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) for the collection of community level data. To this end the MOHSW now conducts quarterly district reviews in order to measure performance in each district. There is also a move towards institutionalizing Routine Data Quality Assessments (RDQAs) to be implemented by district personnel.
Service Delivery
PEPFAR in Lesotho has committed to support the GoL implement their HIV/ AIDS programs through the Partnership Framework's goals number 1 and 2. Goal 1, states that HIV incidence in Lesotho is reduced by 35% by 2014 and Goal 2 reads, to reduce morbidity and mortality and provide essential support to Basotho people living with or affected by HIV and AIDS through expanding access to high quality treatment, care and OVC support services by 2014.
In order to attain the above stated goals the PEPFAR team recognizes the importance of supporting the MoHSW in strengthening their capacities to use epidemiological data to design programs that could directly impact outcomes for HIV/AIDS and TB services. In FY2012, PEPFAR will support the MoHSW through the IHM, ICAP, EGPAF, MSH-SIAPS, PSI, Jhpiego and HRAA to ensure that systems and capacities for health planning, SI and M&E are strengthened. In FY2011 PEPFAR Lesotho invited the Futures Group to hold a one week capacity and skills building workshop were staff from the MoHSW and NAC were trained on epidemiological/ population and economic based models for projecting the impact of program investments on HIV/AIDS outcomes across the Continuum of response. In FY2012 IPs will be expected to support the host government partners to imbed these tools during

HIV/AIDS planning across the health sector. In addition in FY2012 PEPFAR has invited HS20/20 to introduce and implement the HIV/AIDS Sustainability Analysis Tool (HAPSAT)which will assist the MoHSW understand the impact of service delivery models on human resources requirements across the continuum of response.
In the area of HIV/AIDS prevention PEPFAR uses three key implementing partners working on HIV/AIDS prevention systems strengthening (Jhpiego, EGPAF), PMTCT (EGPAF), behavior change and communication/ HTC (PSI) and biological interventions – VMMC (Jhpiego, PSI). PEPFAR will strongly engage the MoHSW on VMMC because it has the greatest potential of reducing HIV incidence by 36.6% within 15 years.
In the area of treatment, PEPFAR through EGPAF will in FY 2012 support implementation of the PMTCT Acceleration Plan in line with the National PMTCT and Pediatric HIV Strategic Plan (2011 – 2016); development of Sankatana HIV Center as a referral center for second and third line HIV management; management of complicated HIV and TB cases; and, screening and diagnosis of cervical cancer and other HIV related malignancies. The EGPAF SCS project will continue to support local capacity building by providing TA and support, including sub-grants to its local partners (LENASO, ALAFA and Baylor) and its regional partner (m2m). In FY2012, PEPFAR will be working with the EGPAF, ALAFA, MoHSW, textile factory owners and textile worker employee associations to develop sustainable approaches of providing affordable and accessible HIV services to PLHIV and their families. TB/HIV collaborative activities in Lesotho have been incorporated as major components of the Lesotho TB national strategy. PEPFAR support is aimed at strengthening TB/HIV collaborative activities through support for effective and coordinated action to improve TB diagnosis, care and prevention services for people co-infected with TB and HIV at all levels of the national health care system and guided by the National TB strategic Plan 2008 -2012. In FY2012 PEPFAR through ICAP will continue to support implementation of the 3 Is through implementation of the TB/HIV training plan and actual implementation of IPT in all districts according to availability of INH; Development of TB IC operational/ M&E plan for all health facilities; reach out to high-risk settings through mapping of TB/MDR-TB in miners/ex-miners and integrate TB and TB/ HIV activities within factories, prisons and military camps national wide; support MoHSW with the TB/HIV Strategic Plan; and strengthen TB diagnosis at all levels of health service delivery.
To strengthen the capacity of families the PEPFAR partners Pact and MSH/BLC and the Ambassador's Small Grants Program, are sub-granting exclusively to local CBOs and NGOs who work directly with grass root entities. The OVC program promotes the concept that OVC quality of life is connected to the strength and resourcefulness of the families and communities they live in. Key priorities include caring for caregivers with a focus on emotional support, skills transfer in parent /child communication and positive parenting. Economic strengthening activities will target both caregivers and older children by supporting income generation activities and small business skills training. The program will explore partnership with micro-financing institutions to diversify economic strengthening initiatives. Through sub-grants, partners will support families and communities to diversify food production to include vegetables, fruit and other crops. Skills in use of labor saving techniques such as key hole gardens will be enhanced. The implementing partners will help establish linkages to markets for agriculture produce and IGA products.
The OVC program is implemented using age and sex specific approach ensuring that the needs of all children are met in a holistic manner. Additionally, MSH/BLC will support the development of referral directories by mapping clinical services, community services and delivery points in five districts. The directories will strengthen linkages and referral services. The OVC partners will collaborate with HIV prevention and treatment partners to support the community-based care of the HIV/AIDS continuum including linking expectant mothers to access ANC/PMTCT services. The OVC partners will o implement the community component of the nutrition, assessment and counseling support (NACS) program as part of the PMTCT elimination strategy.
The OVC portfolio will expand services to include early childhood care and development (ECCD), an area that has picked up momentum in the country. Linkages have been made with the USAID centrally funded Takalani Sesame and the Ministry of Education for this purpose.
Both USG and the MoHSW recognize the need to strengthen both human and institutional capacities in the areas of quality assurance and M&E. Weaknesses in these areas make it very difficult to monitor effectively the efficiencies in delivery of health services. Although quality assurance, quality improvement and M&E are imbedded in most PEPFAR implementing partners' activities, in FY 2012, PEPFAR will utilize the services of the Regional Center for Quality in Health (RCQH) a sub-recipient under HRAA to strengthen quality assurance systems in the MoHSW.
IHM will be the lead implementing partner n the area of strategic Information, monitoring and evaluation.

Human Resources for Health
USG investments in Human Resources for Health (HRH) in Lesotho all aim at achieving Goal 3 of the Partnership Framework. The USG with investments through PEPFAR and the MCC compact has provided leadership in the health sector to improve the HRH situation in Lesotho. Whilst PEPFAR has invested in improving the production, recruitment and retention of health care workers (HCWs) much of MCC investment has gone towards improving the working environment through equipment and infrastructural improvements. In FY 12 PEPFAR is expected to ensure that adequate numbers of HCWs are appropriately distributed to manage these refurbished health facilities. PEPFAR hopes to attain the increase in density, balance in distribution and improved productivity/performance through the implementation of the following five key strategies:
National HRH/HSS plans, policies and systems operationalized and implemented – This activity will be mainly implemented through a new five year cooperative agreement (HRAA) implemented by the Eastern Central and Southern Africa Health Community Secretariat (ECSA-HC) with five sub-grantees. The main activities will involve the revision of activities and targets based on more recent HRH information and projections. The target revisions are also expected to contribute to the development of proposals for infrastructural development (medical housing), HCW recruitment and retention targets.
HRIS developed and the use of data for decision-making promoted –HRAA will also ensure that the HRIS begun under the Southern African Human Capacity Development Coalition (SAHCD) is scaled up to all the health facilities and training institutions in the health sector. With decentralization all DHMTs and training institutions will be expected to produce monthly HRH reports that show HCW densities, distributions and annual graduate numbers. The improved information is expected to be effectively used for HRH policy and management decisions.
Pre-service education systems for health and social welfare-related professionals, paraprofessionals and community health workers strengthened – The importance and significance of this strategy led to PEPFAR Lesotho designing five different implementing mechanisms to ensure that the production of HCW is achieved. PEPFAR Lesotho will enhance the production of HCWs through LDF, MSH-SPS, ASCP, HRAA, Jhpiego (MCHIP) and the Nursing Education Partnership Initiative (NEPI). Although HRAA will provide the overall HRH leadership and capacity strengthening among PEPFAR Partners; Jhpiego and NEPI are focused solely on the production of approximately 2100 nurses and midwives in government and CHAL training institutions. Nurses and midwives in Lesotho represent 70% of HCW capacity and provide a better potential to improve the delivery of HIV, SRH, PMTCT and TB services. In addition nurses are easily available, locally trained and as such the need to enhance their scope of practice through curriculum strengthening. NEPI will provide opportunities for the local nurse training schools to receive grants and also provide a platform for the schools to twin with other foreign nurse training institutions. The twinning will provide the local nurse schools with an opportunity to build research capacity and also improve the management of nurse training colleges. In addition, HRAA will also continue to support the strengthening of the in-service coordination system in all the 10 districts. HRAA will work with DHMTs to develop Human Resource Development Committees (HRDCs) that will monitor and manage the continuous education implementation plans. MSH-SPS and ASCP support the curriculum review process and production of Pharmacy and Laboratory graduates at NHTC and NUL. HRAA will also support an annual production of 20 auxiliary social welfare graduates. In FY2012 the LDF program will continue to provide tuition support to defense medical staff (doctors and nurses).
Workforce shortages addressed through improved worker recruitment, retention, and productivity, including the community/informal workforce – Although this is a shared strategy for all PEPFAR implementing Partners since retention of HCWs ought to begin from the first day of training; HRAA will work with the MOHSW to create new posts, support MOHSW/CHAL Job Fairs and develop retentions schemes that will adequately address the plight of health workers especially those in rural and remote areas. HRAA will also function as a mechanism for implementing the Development Credit Authority – DCA -public private partnership (PPP) initiative on housing and loans for medical staff. In addition, as a catalyst for productivity HRAA will leverage resources with other partners (World Bank) to pilot Performance Based Financing (PBF) in Maternal and Child Health services sites. HRAA will also work with the MOHSW to strengthen community systems activities that promote task-sharing and compensation of CHWs to enhance their retention at the PHC level.
Health professional regulatory bodies and associations strengthened (e.g., nursing councils which may register and credential health care workers, oversee continuing education, and/or accredit academic institutions) – This is another very important shared strategy among HRAA, Jhpiego and NEPI that aims at quality improvement of HCW production and service delivery. PEPFAR in FY12 will emphasize on HCW credentialing and accreditation of

health facilities. Lesotho has also been a fortunate recipient of the African Health Profession Regulatory Collaborative (ARC) funds and technical assistance which ear-mark the strengthening of continuous professional development (CPD) programs for nurses. The local Implementing Partners (IPs) will leverage resources with ARC to ensure that CPD programs for nurses are strengthened.
Finally, the MOHSW currently has so many HCW positions both at national and health facility levels that are under PEPFAR salary support. In FY 12 PEPFAR will work very closely with the HR Directorate to ensure that within 18 months such positions are transitioned to government established posts.

Laboratory Services
Laboratory services play a critical role for HIV/AIDS prevention, care and treatment programs and is expected to support the increasing demands for diagnosis, treatment monitoring and drug resistance surveillance of HIV, TB and other opportunistic infections. There are 21 heath facilities (central laboratory, National Blood Bank, and hospital laboratories) that provide from basic to complex laboratory diagnostic and monitoring tests. The laboratory services follow the three health tier system. The Directorate of Laboratory Services of the MOHSW coordinates and provides continuous guidance and support for laboratory services across the health network.

The objective is to strengthen the laboratory infrastructure, provide quality-assured and integrated laboratory services at all levels of the health care delivery system. As part of strengthening national laboratory system, the MOHSW with the support partners developed the national laboratory policy and a five year strategic plan (2008-2013). The implementation of the strategic plan focuses on the establishment of quality assured and integrated laboratory services throughout the health care network. The National Quality Assurance program has been established and coordinated by the Quality Assurance Unit of the MOHSW. The External Quality Assessment (EQA) schemes have been implemented for all diagnostic and patient monitoring tests in all 21 laboratories. A standardized HIV testing algorithm and EQA schemes have been role out in all testing centers in the country. Stepwise laboratory improvement process toward accreditation (SLIPTA) has been implemented and a significant progress has been made in improving the quality of services.

The MOHSW in partnership are providing the in-services training support, referral networking services, and improving the supply chain management system. PEPFAR in coordination with MOHSW have addressed human resource development by supporting in-service training in HIV diagnosis and monitoring tests, quality management, LIS, and supply management using customized and standardized training modules. The HIV rapid testing has been task-shifted to counselors. The pre-service training curriculum has been revised and implemented to improve the quality of the three years medical laboratory science training at NHTC. Technical and material support including equipment, teaching aids and mentorship are being provided to address the gaps and increase the enrollment of trainees by 50% by 2013.

Local capacity has been developed in providing the major diagnostic and monitoring tests including early infant diagnose and viral load, TB rapid diagnosis (GeneXpert) and TB culture and drug susceptibility tests. All the technical support provides by PEPFAR and other partners has been aligned with the national strategic and annual operational plans. PEPFAR/Lesotho played a key role in the development local capacity and will continue to assist the Government to meet the short and longer term need of laboratory system and make it cost effective and sustainable.

Health Efficiency and Financing
In FY 11, the PEPFAR team invited the Futures group to provide capacity building workshops to MOHSW and NAC on HIV/AIDS programming and the use of various health financing models to demonstrate cost effectiveness, efficient utilization of HIV resources for maximum impact. This was a first step towards developing HIV programs and responses that could have greater benefits and also contributing to the long term sustainability of the national HIV response in Lesotho. EGPAF in FY2012 will utilize one of the economic models to estimate the cost of scaling up Paedriatic HIV/AIDS response in Lesotho. PEPFAR will also work with the Health Systems 20/20 to support the MOHSW and NAC to implement the HIV/AIDS Program Sustainability Analysis Tool (HAPSAT). HAPSAT utilizes a computer-based model for forecasting and analyzing the sustainability of HIV/AIDS programs during periods of

service delivery scale-up and/ or when facing limited or unknown resource levels. HAPSAT produces estimates of the financial and human resources required to sustain and/ or scale up a comprehensive portfolio of quality HIV/AIDS services. A comprehensive sustainability analysis is possible with HAPSAT because it covers the core areas of HIV/AIDS resourcing; Costing and Gap Analysis; Programmatic Sustainability Analysis; and Resource Generation/ Innovative Financing. In FY2012, PEPFAR will be spearheading the collaboration and development of business models through public private partnerships (PPP) in an effort to leverage scarce resources with host government, private partners and the civil society. The PEPFAR team has formed a PPP team to develop business models that could benefit the Basotho and ensure sustainable HIV/TB services. PEPFAR's supported PPPs already in design stage include; the DCA Medical Housing Scheme, TB/MDR-TB in miners and the Johnson & Johnson Partnership in Management Development (PDM).

Supply Chain and Logistics

Efforts will be made in FY2012 to improve SCM of pharmaceuticals and laboratory commodities. A national SCM TWG has been constituted to handle logistics of pharmaceutical DSM. Already, an antimicrobial resistance study (AMR) study conducted with PEPFAR support will inform the revision of the EMLs and STGs. MSH/SPS/SIAPS will build local capacity to handle critical SCM TA and provide much needed support to the MOHSW and the NDSO. This project provides TA centrally to the MOHSW to review the Essential Medicines List (EML) and the Standard Treatment Guidelines (STGs), at district level to the DHMTs to utilize effective pharmaceutical management and information tools (RX-Solution), including strengthening the NDSO with its inventory and procurement needs for ARVs, OI medicines and essential medicines. In addition to all this, the project supports curriculum revision for pharmaceutical institutions (NHTC and NUL) and supports pre-service and in-service training of pharmacy technicians and pharmacists in country. PEPFAR, through the project, is currently working with the MOHSW on revising and presenting the Medicines Bill to parliament, a necessary step towards establishing drug regulatory and pharmacovigilance frameworks.

Gender

Lesotho has made significant progress in recent years to address legal and cultural barriers to gender equity. New legislation including the Sexual Offences Act 2003, the Equality of Married Persons Act 2006, the Land Act 2010, the Education Act 2010, and the Children's Protection and Welfare Act 2011 clarifies and protects the rights and entitlements of girls and women. Despite this progress on the legislative side however, women and girls are still subject to a number of barriers and threats that may ultimately affect access to health services. The Lesotho PEPFAR program is developing a gender strategy to be ready by June 2012. This will provide further guidance to partners in their gender mainstreaming efforts. Currently, partner plans and activities aim at increasing gender equity by promoting access to services for both male and female beneficiaries. For reporting and tracking purposes, partners collect program data disaggregated by sex.

As a beneficiary of the Gender Challenge Fund, MSH/BLC and the Ambassador's Small Grants Program are collaborating with the Ministry of Gender, Youth and Sport and Recreation (MGYSR) in ensuring that the rights of women are protected. The program entails training of community facilitators on legal frameworks including the Married Persons Act, the Child Protection and Welfare Act and the Anti-trafficking in Persons Act. The expected outcome is to empower women and help them understand their socio-economic rights thus increasing women's legal protection. Furthermore, the partnership will support these women's support groups to explore economic growth opportunities such as accessing bank loans for small businesses and exercising their land use rights. The NACS Integration and PMTCT Acceleration program will use community mobilization to increase male involvement and participation in PMTCT improving the uptake of PMTCT services and adherence to ART; and, reducing defaulter and lost-to-follow-up rates.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	2,238,615	0
Total Technical Area Planned	**2,238,615**	**0**

Funding:		

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	4,679,687	0
HMBL	811,119	0
HMIN	15,916	
HVAB	54,173	0
HVCT	3,481,050	0
HVOP	2,454,041	0
MTCT	3,094,466	0
Total Technical Area Planned Funding:	**14,590,452**	**0**

Summary:
The epidemic in Lesotho is a homogeneous one in that prevalence is above 15% in all districts, among both sexes and across all socio-economic classes. The 2009 Lesotho Demographic and Health Survey (LDHS) indicate a rapid rise in HIV prevalence among young people, particularly young women. The total number of HIV-infected females aged 15-49 is 27%, but significantly lower at 18% for men the same age. By the age of 20-24, approximately 24% of women are infected; prevalence increases to 35% for the age cohort 25-29 and peaks at 42% for women throughout their thirties. Male prevalence lags behind female prevalence by approximately five years, but similarly reaches 40% among men aged 30 – 45. With such high average levels of prevalence nationally, the pool of at–risk individuals is likely at or near saturation among adult men and women aged 25-44.

There are multiple layers driving the HIV epidemic in Lesotho, from proximal drivers such as multiple and concurrent partnerships (MCP) to distal drivers such as patterns of migrant labor and the broader macro-economic situation that may affect vulnerabilities for many Basotho. The 2009 LDHS indicates that MCP can be found throughout Lesotho with MCP being the source of the next 1,000 HIV infections in Lesotho (with MCP prevalence estimated at 24%, compared to the regional average of 10% and some studies showing 36% of individuals reporting MCP) . Sexual concurrency, often in the form of long-term secondary sexual partnerships is exceptionally high in Lesotho.

MARPS: Commercial sex accounts for an estimated 3% of all new infections while men who have sex with men and their female partners account for an estimated 3-4%. These vulnerable and marginalized groups, however, need to be studied in-depth using robust methodologies, since they have been historically under-studied. Circumcision rates are considerably lower among urban men than rural men (34% and 59%, respectively) and the prevalence of circumcision decreases significantly among men within the highest wealth quintiles (74% of men in the lowest quintile compared to 29% in the highest). In spite of evidence about the protective effect of circumcision from recent clinical trials, the 2009 LDHS data indicate that Basotho men who have been circumcised have higher HIV prevalence rates than uncircumcised men (21% and 16%, respectively. Only 30% of circumcised men received medical circumcisions in health facilities, and only those can be considered to have the beneficial protection

conferred by male circumcision as opposed to men who are partially circumcised during initiation ceremonies in Lesotho (2009 LDHS). The low levels of circumcision in Lesotho can be partially attributed to the Lesotho custom of conducting male circumcision at a later stage in life when young men have already been exposed to the risk of HIV infection. In addition, the traditional practice of male circumcision only partially removes foreskin and therefore does not seem to have the same protective and hygienic effect as medical circumcision.

Condoms: An additional challenge in Lesotho is low and inconsistent condom use. Many Basotho men and women engaging in high risk sex report not using condoms regularly. Although there is widespread condom distribution, many communities perceive condoms as not readily available and accessible. Urban and rural condom coverage is estimated at 69% and 33% respectively (2009 PSI condom distribution survey). Moreover, a relatively low percentage of Basotho have taken a HIV test and received their results. Only 43% of women aged 15 – 19 report having been tested and receiving results, though, this figure rises to 75% by the age 20 – 25. Only 26% of men aged 15- 25 have been tested and received results.

Gender: Gender dynamics can exacerbate HIV risk, for example, certain manifestations of male and female norms, behaviors and practices create vulnerability to HIV infection. The 2009 LDHS provides information on female empowerment and decision making within the home. Sexual and gender –based violence also increases the risk of HIV infection. In regards to domestic violence and the justifications cited for wife-beating, 37% of women aged 15-49 agreed with at least one reason that justifies violence toward a wife: these include but are not limited to burning food, arguing with the husband, going out without telling him, neglecting the children and/or refusing to have sexual intercourse. The corresponding response from men aged 15 – 49 was 48%. Among men aged 15 -49, 26% thought that men are justified in withholding financial support from his wife if she refused to have sex with him and 16% thought forced sex was justifiable (LDHS 2009). A study assessing sexual violence against women in Lesotho found that 61% of women reported having experienced sexual violence at some point in their life, with 40% reporting coerced sex, 50% assault, and 22% rape.

Linkages and Capacity Building: PEPFAR Lesotho actively increased the number of indigenous sub-grantees by bringing four new sub-partners on board to ensure transition support which includes partners providing services for OVC and prevention. Partners were provided with capacity and mentoring support in developing five year strategic plans and implementing capacity building plans, existing partners received MER capacity assessments, routine Data Quality Assessments (DQA) and an HIV/AIDS quality capacity assessment of partners' programs. PEPFAR Lesotho provided technical support to grantees focusing on HIV prevention, OVC and adult care and support in addition to reviewing curricula and relevant technical materials for quality assurance. Three civil society forums were convened to share information on select civil society matters, explore the evolutionary roles of key umbrella and network organizations; improve understanding of networking and coordination; and identify next steps for coordinating Lesotho's civil society response to HIV/AIDS and other national issues. Additionally, Lesotho is a recipient of the gender challenge fund being implemented in partnership with MCC and the Ministry of Gender, Youth, Sports and Recreation. The program is specifically targeting women for economic enhancement and is being implemented by MSH/BLC our prime OVC partner and the Ambassador's small grants program. Additionally, to ensure synergy between prevention and OVC activities, prevention and OVC partners are co- funding similar local organizations.

Currently PEPFAR Lesotho is building strong linkages between its clinical, care, prevention and community based care programs through ensuring collaboration between implementing partners through various forums, including quarterly and regular partner meetings. These meetings allow partners to compare strategies, and ensure appropriate linkages are made across various community based and facility based services (e.g nutrition corners, mobile clinics, joint prevention and care outreaches etc) targeting PLHIV. (Please see PMTCT acceleration plan for additional details on community/clinical activities and linkages).

With such a high level of new infections, Lesotho has a critical need for a comprehensive and evidence-based approach to prevention in order to slow the spread of new HIV infections. PEPFAR Lesotho will work towards a coordinated, multifaceted combination approach to prevention which will include behavioral, biomedical and

structural interventions. A combination approach to prevention is based on the effectiveness of the intervention, cost, and on its ability to reduce HIV incidence either individually or via synergies with other interventions. These interventions will target the appropriate risk populations through different but coordinated behavior and social change interventions for individuals, couples, families, peer networks and communities. Prevention activities will be guided by up-to-date evidence and data on the drivers of the epidemic and will be congruent across partners, settings and levels of interventions (mass media, community/group, inter-personal and individual).
PEPFAR will support multi-level, multi-channel social and behavior change communication, with particular attention to partner reduction, prevention for PLHIV and discordant couples, delaying initiation of sexual activity for young people and condom promotion and distribution. However, these activities should be situated within the context of a broader combination prevention package, including strong linkages to HIV counseling and testing, as well as PMTCT services; male circumcision services and referral to other HIV care and services.

USG prevention efforts will be guided by the National Strategic Framework, the National Behavior Change Communications Strategy, the forthcoming National HIV Prevention Strategy, as well as, priorities identified in the Lesotho Partnership Framework. Specific priorities to be addressed include building local capacity and sustainability. Partnership with Basotho organizations and communities to strengthen the technical capacity of indigenous partners to implement effective prevention interventions. Such partners include NAC, government ministries, civil society, faith-based organizations, private sector entities, traditional leaders, etc.

Donor Coordination: The PEPFAR Lesotho team works closely with other development partners through the Health Development Partners' Forum and the Global Fund Country Coordinating Mechanism to ensure that synergies across programs are enhanced and gaps are avoided and/or addressed. This is largely accomplished through PEPFAR's participation in a variety of in-country coordinating mechanisms at various technical and political levels. Several of these include: the Health Development Partners Forum, the Partnership Framework Management Team, and the Global Fund Country Coordinating Mechanism, of which the USG is a permanent member. PEPAR staff are also members of national technical working groups chaired and coordinated by MOHSW and NAC, including Prevention, Care and Treatment, Laboratory, Human Resources and Strategic Information.

HTC: Government of Lesotho made significant strides in HTC through the 'know your status' campaign in 2005-2007. As a result opt-out HTC services are available in all public health facilities. PITC is recommended for all patients accessing health services specifically for all pregnant women, TB patients, children under five and adults with signs and symptoms of HIV infection. Additional HTC services are available through support of civil society and government HTC services, with expansion plans to the public sector including the workplace through client-initiated HTC services guided by the WHO-MOHSW recommended HTC guidelines and testing algorithms.

PEPFAR is committed to working in conjunction with MOHSW to address counseling and testing needs in Lesotho. PEPFAR-funded activities in HTC are aligned with the goals and objectives agreed upon in the Partnership Framework, and augment the activities that are implemented by other donors. The allocation of PEPFAR resources is guided by the epidemiological trends of HIV in Lesotho, as revealed in the recent LDHS report. In addition, PEPFAR has aligned its strategy with the recently released National Multi-Sectoral HIV Prevention Strategy 2011-2015 (NSP), which aims to reduce the impact of HIV and AIDS in Lesotho through expanded access to HTC services and behavioral programming emphasizing evidenced-based sexual and biomedical prevention strategies.

PEPFAR Lesotho is committed to addressing prevention gaps to reduce prevalence in partnership with the GoL. PEPFAR will focus on addressing the lack of community-based services and the lack of couple testing (only 5% of those receiving their results do so with their partners). The lack of community-based services results in few Basotho knowing their status unless they become ill or attend antenatal care. This is a missed opportunity for early access to care and prevention interventions. According to the 2009 DHS, HIV prevention knowledge levels were lowest among women and men in remote rural mountain areas who have limited access to PITC compared to the same population in low lands and urban areas. Community-based services focus on making services accessible and increasing the number of individuals and partners who know their HIV status. These services also intend on increasing the practice of safer sexual behaviors including secondary abstinence, partners' reduction and correct

and consistent condom use, through counseling services.

In addition, resources in COP 2012 will support strengthening linkages and referral systems to appropriate follow-up services. PEPFAR's and prevention partner, PSI, will implement two complementary approaches: 1) direct delivery of services through high-capacity mobile teams targeting adult men, mountainous areas and identified districts with low uptake; and 2) provision of HIV prevention commodities (such as male and female condoms) as well as referrals to appropriate services (i.e. PMTCT, family planning, care, etc.).

Condoms: In general, condoms are available throughout Lesotho; however, on an infrequent basis there is poor forecasting on condom needs which has resulted in targets not being met. Previously there was no single entity serving in a commodities coordination capacity however, since October 2011, PSI (supported by CDC with PEPFAR funds) has seconded a staff member to the Ministry of Health whose role is to coordinate condoms nationally (since this is a relatively recent secondment, we expect to see improvements in condom coordination in the coming year). PSI has been distributing condoms to health facilities and community councils for free since 2004 and PSI's 'branded' condoms are provided to clients at a nominal cost out of the facilities. PSI currently sells branded condoms which are sponsored by the Dutch, in addition to, receiving generic male and female condoms from USAID and the GoL. Moreover, UNFPA is supporting interpersonal communications on condoms.

VMMC: National targets for VMMC are currently based on two partners piloting VMMC activities in country: JHPIEGO and DOD. Targets for COP 2012 have been set at 8,100 for adult VMMC and 550 neonate circumcisions. The PEPFAR team previously faced scale up challenges with the MOHSW and did not allocated resources in FY 11; however, the MOHSW, has changed its position on adult scale up and is allowing implementation to move forward at a pace that mirrors existing human resources. The program will start with six pilot sites, with medical doctors performing the procedures to those who walk in and request VMMC services. Due to limited resources and human capacity demand creation is not approved during this first phase of VMMC activity roll out. This initial program will not include task shifting, nor will it include any demand creation campaigns, since the MOHSW does not want to advertise a service and without adequate supply of resources.. Nevertheless, since the MOHSW has demonstrated progress on the planning of VMMC activities in Lesotho, the PEPFAR team is taking this opportunity to advocate for a more ambitious VMMC plan, and is more aptly able to do this if we can meet funding shortfalls in the MOHSW for human resources (created by a gap in Global Fund resources). Unfortunately at this time, we are unable to program a substantial amount of prevention resources to CIRC, since this would create a pipeline challenge. Although the MOHSW is not in a position to roll-out VMMC services at scale, we continue to seek additional funds at this juncture to support VMMC programming requests made by the MOHSW encourage further collaboration with MOHSW and encourage the Ministry to move forward with a more extensive VMMC program. Once buy-in from MOHSW is achieved and sufficient human resources are in place to meet existing MC demand, we expect the program to roll out quickly and effectively.

PwP: A major challenge in initiating prevention with positives (PwP) interventions is low disclosure rates, thus, a central focus for the implementing partner EGPAF is the endorsement of PLWHA support groups to tackle stigma, discrimination and the threat of gender-based violence. EGPAF, through its clinical and community based sub partners is providing psychosocial support and counseling for PLHIV, including sero-discordant couples, condoms/ barrier contraceptives, HIV preventive messages (risk behavior and safer sex counseling, promotion of positive living), facilitating HIV disclosure through partner support, incentives, promotional material and establishing and supporting support groups for PLHIV.

SBCC: PEPFAR Lesotho will continue and expand upon its current activities in coordinating effective and sustainable behavior and social change communication (BSCC) programming with all other prevention partners. Messages will be disseminated through multiple channels (mass media, interpersonal communication, clinical and HIV care and voluntary testing and counseling sites, religious settings, and others) and will focus on MCP, transactional sex and intergenerational sex, as they are common practices in Basotho culture. Activities will be targeted at men and women, as well as, youth as a means of reducing the likelihood of these risky behaviors and practices. PEPFAR Lesotho aligns its sexual prevention activities with priority target and most-at-risk populations

as identified by the National BCC Strategy. Among the general population, PEPFAR Lesotho will focus primarily on men and women of reproductive age (15-49 years old) and provide services nationally.

Having discordant couples learn their status and undertake measures to keep a negative partner from becoming infected will be a focus of programming. Couples will be identified via community and clinic-based prevention programs for PLHIV, where testing of the HIV infected person's sexual partner will be promoted; and potentially via promotion of male partners of pregnant women being tested in PMTCT programs. Interventions for discordant couples include risk reduction counseling, condom use, ART treatment for a positive partner, male circumcision when a male is the negative partner, and quarterly re-testing of a negative partner. Fundamental to this approach is a grassroots program that works through existing social structures and systems such as faith based organizations (FBO), community based organizations (CBO) and community councils and organizations. Activities will include local discussion and reflection, intensive mass media programs and campaigns.

Medical Transmission: PEPFAR supports the national blood-safety program through infrastructure development, equipment and supplies and training and donor recruitment campaign. As part of the blood-safety program, screening for transfusion-transmissible infections (TTIs) to exclude blood donations at risk of transmitting infection is a critical part of the support. The blood screening program has been implemented to prevent the risk of transmission of TTIs and all blood units collected from donors are screened for HIV and HBV, HCV and syphilis. Quality assurance programs for screening and blood processing will be supported. Through implementing partners, appropriate trainings are provided to health care works on universal precaution, blood safety, waste management and quality management. Guidelines and standard operational plans are in place. Youth blood donor clubs have been established to educate, motivate, recruit and retain young blood donors, called the 'Club 25' initiative. To sustain the program, the blood donor and recruitment program has been coordinated and led by MOHSW to educate communities on the significance of HIV/AIDS and the importance of safe blood in treating and saving life. To sustain the program, PEPFAR strengthens the capacity of the National Blood transfusion service, regional blood banks and hospitals that provide the service and coordinates the support with other organizations including WHO and the Red Cross Society, as well as care and treatment partners. To address infection control (IC), PEPFAR will support MOHSW with the implementation of a national infection control and waste management strategic and annual operational plan, implementation of the MOHSW-approved IC guidelines, establishment of an IC committee/focal person and adaptation of facility IC plan including proper IC practices, documentation and reporting according to facility IC plans. PEFPAR will also provide technical assistance for the implementation of the health care waste management program supported by MCC.

Gender: PEPFAR will address gender issues directly within the context of prevention and strengthen prevention efforts across sectors by linking with health and other development programs. Lesotho will be also benefit from the upcoming visit of the Gender TWG which will be an important opportunity to identify evidence based approaches to addressing gender related barriers to HIV prevention, care and treatment. Key challenges for strategic information are as follows: lack of incidence studies, lack of data on MARPS (no size estimates or prevalence data for CSWs or MSMs or herd boys). Collection tools need to be updated however; financial constraints have made this process difficult. Registers are not filled out properly at community, district and at times central level thus rendering national data incomplete and reporting rates being low. Despite these challenges PEPFAR Lesotho is working closely with the National Government mainly MOHSW to improve on their data collection systems. Registers are being updated through technical support of PEPFAR implementing partners, including other donors in country. PEPFAR Lesotho will be supporting an evaluation on the Health Sector Reforms in Lesotho starting from 2000 to 2010. The essence of this evaluation and support being provided, will ultimately inform MOHSW on the impact that the Health Sector Reforms have had on the country through various donor support Lesotho has received.

SI: Previously implementing partners where using parallel systems for reporting to the PEPFAR Lesotho office. However, there have been great strides in improving this by partners working together with MOHSW from district level to central. Currently the MOHSW is utilizing a paper based reporting system, but with financial support from Millennium Challenge Corporation (MCC) an electronic HMIS will be implemented. The electronic HMIS including EMR will be piloted in one site beginning of March 2012. Moreover, implementation of LIS is in its second phase of

being piloted from 4 sites in 2011, expanding to 5 sites by end of 2012.

Surveillance still requires additional attention, as the last BSS was conducted in 2001. Nevertheless, PEPFAR Lesotho has funding that can potentially be used to conduct a BSS but, focusing on one target population i.e. CSW, MSM, migrant laborers as well as funding to support ANC surveillance. The LHDS 2009 should form the basis of a baseline and priorities or research questions can be coined from the report in order to address questions such as why risk behavior seems to be increasing rather than decreasing, according LDHS data.

To document success and lessons learned, rigorous evaluation will be undertaken. The evaluations will be linked with national and district level data collection to measure behavior change as well as impact, where feasible. Basic output data will not be sufficient to measure or determine success of a program, and as such, process, outcome and impact data will be collected.

Strengthening human resources: The national prevention program implemented by PSI aims to train community members as peer educators to carry out community dialogues on concurrent partnerships. These educators will serve as trainers of community groups to disseminate CP knowledge and skills further into communities. PSI's prevention program will also train community Kick 4 Life 'coaches' on youth specific prevention curriculum and the formation of youth clubs in Lesotho. PLWA leadership will also be targeted for TOT training on prevention for positives and positive living. Community Action Council (CAC) leadership will also benefit from capacity building activities through the PSI program. Community role models and 'champions' will be identified and trained leadership skills and HIV prevention. Peer educators among factory workers in the apparel industry will be identified and trained on SMS promotion.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXS	1,340,444	0
PDTX	1,036,108	0
Total Technical Area Planned Funding:	**2,376,552**	**0**

Summary:

According to the Lesotho Demographic and Health Survey (LDHS) 2009, Lesotho has an HIV prevalence of 23.0%, the 3rd highest in the world. The GOL has provided strong political commitment to support a national response to the pandemic. After King Letsie III declared AIDS a national disaster in 2004, the MOHSW launched an ambitious national program to provide free antiretroviral treatment throughout the entire country. Although the GOL has a severe shortage of healthcare professionals at all levels, they have created policies and guidelines for best practice that have allowed care and treatment to be provided to more HCW and CHW cadres through task shifting and decentralization of health service provision.

The National Strategic Plan (NSP 2011 - 2016) is a five year multi-sectoral HIV and AIDS plan that covers the period from April 2011 to March 2016. It consolidates Lesotho's efforts to use evidence, focus on specific results for the national response, mainstream gender and human rights in the design, implementation, monitoring and evaluation of the response. It constitutes a multi-sectoral, decentralized response to HIV and AIDS and provides opportunities for all stakeholders to actively participate, including civil society and PLHIV.

The epidemic remains the most important obstacle to sustainable socioeconomic development in Lesotho. HIV prevalence seems to be stabilizing at a high prevalence of 23% with an annual incidence of 21,000 new infections in adults and 1,300 in children Death rate associated with HIV remains at a high figure of 12,000 annually. The epidemic has a gender bias with women having a higher prevalence (26.7%) compared to men (18%). Among young

people aged 15-19 years, HIV prevalence is estimated at 3.5% (women – 4.1% and men 2.9%) and considered to be the lowest. Similarly prevalence is higher in urban (27.2%) compared to rural (21.1%) areas.

In 2011 The MOHSW merged the STI/HIV AIDS Directorate and the National TB program, within the Directorate of Disease Control of the MOHSW, demonstrating its commitment to sustain an integrated response to the HIV/AIDS and TB. The MOHSW intends to ensure this integration permeates down to the district level, as decentralization of health services continues. With support from PEPFAR partners, three referral and integration models for TB/HIV which respond to country needs have been developed to ensure active linkages and referrals exist between TB and ART clinics. Implementation of these models will be actively supported in FY12.
In first half of 2011, the MOHSW was supported to adapt, finalize, print and disseminate the new PMTCT, Paediatric HIV and Adult HIV Care and Treatment guidelines, in line with WHO recommendations. In addition, national registers were reviewed, printed and distributed to the Health Facilities. PEPFAR TB/HIV and PMTCT partners, supported the MOHSW to review the ICF/IPT/IC guidelines and TB/HIV referral guidelines in line with WHO recommendations and these guidelines have been rolled out. The revision of national nutrition guidelines is still in process. Since 2008, Lesotho has used a CD4 cut off point of 350. This has increased the number of patients eligible for, and accessing HIV care and treatment services.
Currently, the national government procures all ARVs and OI medicines (including CTX and Isoniazid) from its recurrent expenditure and with significant support from Global Fund. Scale up of services receiving PEPFAR support is ongoing as PEPFAR partners continue to provide TA in clinical and monitoring activities to more GOL and CHAL facilities, including direct service provision in ANC, PMTCT and MCH clinical settings. Due to the increase in laboratory specimen being received for analysis, PEPFAR laboratory partners continue to scale up support to the MOHSW Central Laboratory, including support for EID and ICF (Gene Xpert Technology). The MOHSW will be equipped to meet the demands once the National Reference Laboratory is completed by MCC/MCA in 2012 and the construction of regional laboratory supported by PEPFAR. The focus of the PMTCT acceleration plan is to integrate PMTCT and paediatric HIV services into Maternal, Neonatal and Child Health (MNCH) and Sexual Reproductive Health (SRH) clinics in all public and accredited private health facilities in Lesotho (see Acceleration Plan for more details). TB screening services are an integral part of HIV services in Lesotho, though efforts are now being made by PEPFAR's lead TB/HIV partner to ensure that these services conform to national guidelines, are well documented, reported and monitored. PEPFAR's TB/HIV and PMTCT partners collaborate closely to ensure that TB screening is offered in all TB/ HIV, PMTCT and MNCH settings. The role out of IPT has just commenced, with full implementation in the district of Berea. Constraints encountered preventing national roll out include inadequate quantification and distribution of INH, hence shortages or stock out in the product. Supply chain management will be strengthened through the PMTCT Acceleration Plan, while the National TB Program (NTP) and the STI/ HIV Directorate continue to work with GF on availability of INH. As MCC/MCA continues to renovate and expand infrastructure available at selected health facilities, emphases are being placed on ensuring these support implementation of infection control practices.
The lead PMTCT partner strengthens ART delivery at facilities through technical assistance at national level to support the policy and guideline development process in the Family Health Division (of Primary Health Care) and Directorate of Disease Control of MOHSW. PEPFAR also supports TA to District Health Management Teams (DHMT) and district managers at district level, strengthening the capacity of all staff along the health information continuum to be more effective managers and users of data generated. (through development of SOPs, checklists, and feedback processes); support provision to District Health Information Officers and the site-level data clerks to improve their collection and reporting of quality data, data management, analysis and utilization skills (through regular supportive supervision, mentorship, and onsite trainings); site level direct support to HCWs includes on-site mentoring, clinical training, support supervision and human resource building. ART service delivery in Lesotho is nurse driven. All cases of treatment failure are handled centrally by experts within the MOHSW coordinated TWG and advice about switching to 2nd line is given as appropriate. This approach ensures that limited experience in management of treatment failure is addressed adequately and the capacity of clinicians in the districts to manage this category of patients is built.

PEPFAR provides support for pharmaceutical governance and TA for the national supply chain management (SCM) system All ARV procurements are done by the MOHSW through the National Drug Service Organization (NDSO),

with support from the Global Fund and UNITAID (through UNICEF). Considerable support is also provided by CHAI. In FY2012, PEPFAR will support the establishment of a pharmacovigilance network within the MOHSW. Quality improvement for data and supportive supervision of activities in ART and PMTCT settings will be introduced and scaled up in FY2012, building local national capacity to do same concurrently by FY13. PEPFAR through its PMTCT partner has already started discussions with the relevant departments of the MOHSW on QI. PEPFAR Lesotho's lead human capacity development partner will support the HR department of the MOHSW, in collaboration with all IPs in country to coordinate pre-service and in service trainings, curriculum revision and development; and, standardization of current and new guidelines for HCW development.
PEPFAR Lesotho will be conducting its first expenditure analysis and ART costing exercise with resources from the PMTCT Acceleration plan. The overall goal of the costing exercise is to equip the MOHSW with realistic information on the average cost per patient for key interventions in PMTCT and ART, ensuring long-term sustainability of any scale up of these services.

As part of PEPFAR's care and treatment programs the lead PMTCT partner is required to build the capacity of local NGO sub partners to manage ART programs. This includes skills transfer, administrative support and human resources. Nationally, the MOHSW is sub recipient of GF resources and implements activities funded under these grants directly, or occasionally through international and local partner NGOs. There is therefore still a heavy reliance on external support from development partners, even though the absorptive capacity of donor resources (e.g. GF) is still very low. The MOHSW has a contingency budget for ARVs based on past consumption. During quantification, there is a 2 months' supply overage included to cater for any emergencies. Summarily, local capacity to manage or support ART programs is still largely insufficient and inconsistent at this time, although the GOL has great financial input into the procurement of ARVs.

PEPFAR has made significant contributions to scale up of pediatric HIV services in the country from FY2010 – FY2011. A total of 158 Health workers were trained in HIV care and treatment, including 54 doctors who were trained specifically in comprehensive pediatric HIV management. In addition, 60 health workers were trained in psychosocial counselling. PEPFAR also offered direct service provision through its HIV technical advisors and medical officers in the management of complicated patients enrolled for care and treatment at supported Health Centers (HCs), through telephonic referrals and onsite presence for consultation. To link more children to care and treatment services at supported HCs and Baylor clinics, we supported the initiation and scale up of PITC for children in under-five clinics.

Five EID/HTC counselors were hired by the SCS project to conduct PITC at pediatric wards in Queen Elizabeth II, Machabeng, Motebang, Botha Bothe and Mokhotlong Hospitals with over 90% of children screened at each site being discharged with a known and documented HIV status throughout the reporting period. Nutritional corners were revitalized in all major hospitals in the ten districts with four of them scaled up and established within MNCH, as part of an integrated approach. Play therapy and psycho-stimulation program was started at Queen Elizabeth II Hospital mainly for admitted severely malnourished children, with tremendous success recorded and support by caregivers and health care providers.

Teen Clubs were established at Qacha's Nek and Leribe Satellite Centers of Excellence (SCOEs) and have been operational since September 2010. To date, 108 teenagers have been enrolled into teen clubs. Psychosocial support, Health Education and Life Skills training has been regularly provided to teen club members during monthly sessions and caregivers' days. This has enhanced the ongoing psychosocial support provided to these affected young people and their caregivers. Six Ariel clubs have also been established and supported by EGPAF for HIV positive children and teens.

The SCS project has contributed to scaling up pediatric HIV treatment, having newly enrolled 1,012 children in treatment in FY11 at 172 health facilities (of 216 HFs) across the country (APR 2011). In the first year of the project (March 2010 – March 2011), in order to reduce risk of mother to child transmission, out of 7,143 women who tested HIV-positive during pregnancy or knew their positive status at entry, 5,212 (73%) were initiated on ARVs for prophylaxis according to national PMTCT guidelines while 21% of these (1,110) who were eligible for

ART were initiated on treatment. In the FY11 APR reporting period, 68% (5,072 out of 7,436) of identified HIV positive women received ARVs for prophylaxis, with 31% (2,331 women) being eligible for ART and receiving them in that half year reporting period alone. From these results, the drop off rate from HTC to ARV prophylaxis and ART remains at averagely 72.5% while the number of pregnant women requiring ART for their own health has doubled.

Within the first implementation year, a total of 6,088 infants received DNA-PCR testing. Of the 82% (4,972) results returned from the laboratory to the health facilities, 446 infants (9.0%) were positive. The previously long turnaround time of approximately 12 weeks for DNA-PCR results has been reduced to about 3-4 weeks through the use of 3-G internet technology to transfer DNA-PCR to the health facilities. Of these DNA PCR tests, 372 were done in textile industry (through ALAFA) clinics with eight of the HIV-exposed children testing positive (HIV-infected). The eight HIV-infected children were tracked back to review the circumstances that could have led to this, notable among which was late presentation for ANC and treatment. Six of these children have since been enrolled in care. From the FY11 APR result, approximately 6% of all newly enrolled people on ART are children (0 - <15 years of age) while 5% of people currently on ART are within the same age range. By end of FY 11, 91% of USG supported sites were offering pediatric ART services, under supportive supervision and mentoring from Baylor SCOEs spread across 4 districts in Lesotho. Significant scale up of pediatric ART services in all the health facilities (GOL, CHAL and private) is expected, required and prioritized in the PMTCT Acceleration plan.

By end of FY2012, PEPFAR plans to enrol an additional 2,202 children in treatment and to scale up the number of facilities that offer pediatric treatment to a total of 188 sites. In addition, PEPFAR will enrol 2,268 children on treatment in FY2013. To meet increased demand for pediatric ARVs in the next two years due to the scale up of ART services nationally; the increase in HTC (current estimated percentage of those who know their status is 33%) through various community level interventions such as Family Health Days, PEPFAR will ensure that appropriate systems exist to forecast the need, quantify the demand, ensure continued resource availability for procurement of the ARVs through other partners (such as GF) and that logistics to distribute these ARVs to the lowest level of clinical healthcare provision (i.e. health centers) are made available to increase access to pediatric ART.
Increased focus on adherence, retention, and a more complete continuum of care will be achieved by building the capacity of existing community-based structures (such as CBOs, CSOs and FBOs; existing male, female, adolescent, peer and mothers – in - law support groups; existing MOHSW Village Health Workers; other Community Health Workers) to link clients to facilities and track defaulters.
To reduce loss to follow-up (LTFU) in infants and children, HIV-positive mothers and their exposed or positive infants will continue to receive all their HIV services within the setting of the regular MNCH unit (at hospitals). Efforts to improve initiation and access to facility level care such as the Mother – Baby – Pairs and nutrition corners will be scaled up. Similarly, efforts to link laboratory DNA PCR testing and results with facility level clinical data will ensure exposed children receive results early and defaulted ones can be effectively tracked through the health facilities and the community structures.
PEPFAR Lesotho will conduct a national PMTCT Impact and pediatric ART evaluation in FY12. This evaluation is required to measure the progress of the national PMTCT program in Lesotho from 2006 to 2011. As we plan to eliminate pediatric HIV, we need to assess the impact of current interventions and prioritize interventions in the new PMTCT and Pediatric Elimination Strategy (2012 – 2016) of the GOL. Currently there are no pediatric HIV surveillance activities and none is planned. It is hoped that in the next EWI and HIVDR survey, pediatric patients will be included. PEPFAR will support provision of adolescent friendly services in MOHSW adolescent corners to ensure this category of PLHIV have access to quality treatment, prevention, care, SRH and other services.
In FY12, SCS will continue to support trainings for health care workers in pediatric treatment, followed by on-site mentoring and support supervision, to ensure the quality of Pediatric ART is sustained. QI activities will also be initiated and implemented by EGPAF and the PEPFAR SI partner, MSH/ IHM, across selected HFs in all the districts to assess level and quality of pediatric care and treatment.
With support from UNICEF and PEPFAR, the MOHSW recently finalized the National PMTCT and Pediatric HIV Plan (2012 – 2016) which serves as the basis for activities prioritized under the Lesotho PMTCT Acceleration Plan. The PMTCT Acceleration and NACS Integration Plans were developed in close consultation with the MOHSW and other stakeholders in the PMTCT TWG. All strategies in these plans were aligned with the GOL's priorities for

PMTCT and Pediatric HIV Elimination, as stated in the National PMTCT and Pediatric HIV Plan. Through this new plan, PEPFAR will commit another $9m over the next two years towards scaling up pediatric HIV services with the goal of eliminating MTCT and pediatric HIV in Lesotho by 2015. This plan cuts across the four prongs of PMTCT and specific cross cutting areas such as HRH, SCM and SI.
Support for SCM of pediatric ARVs is provided through the strengthening pharmaceutical systems project implemented by MSH. In 2012, we would provide more extensive support to the MOHSW pharmaceutical directorate (PD) for advocacy and pharmaceutical governance. We would scale up capacity of the PD through support for establishment of the Logistics office in the MOHSW for SCM; provide logistic support to the National Drug Service Organization (NDSO) for procurement and distribution of all ARVs to all health facilities; explore PPPs with viable private partners in the Lesotho and South African pharmaceutical sector; and, provide support for the piloting and roll out of the ARV and pharmaceutical functionality of the MOHSW EMR. The roll out of the Outpatient functionality of this new system, supported by MCC/ MCA, is expected to be complete by September 2012.
Currently, the national government funds ARVs, OI drugs, and all other health facility staff, with some financial assistance from Global Fund. Because of the current financial situation and declines in SACU revenues, we don't expect much change in the levels of government support over the next two years. However, the support currently provided by UNICEF for pediatric ART and PMTCT will end in June 2012; at this point, it's unclear who will provide this support. The Global Fund (GF), through HIV rounds 7 and 8, provides resources through its prime (Ministry of Finance) to the MOHSW for procurement of Pediatric ARVs and commodities for nutrition support (therapeutic foods); employment of key personnel such as health professionals, data clerks and other HCW cadres; support for central level TA, trainings and the TWG. CHAI contribute significantly to scale up of pediatric HIV services through central level TA, support for SCM of ARVs and HR provision. In addition to TA provided, UNICEF also supports procurement of pediatric ARVS and the Minimum Package until mid 2012.

PMTCT and ART Guidelines have been updated according to WHO 2010 recommendations for treatment in children. These guidelines have been printed and disseminated to all districts and GOL and CHAL health facilities, with trainings conducted for HCWs with support from PEPFAR and other stakeholders. NACS have been incorporated in this guidelines but more extensive support for the review of Infant Feeding Guidelines and job aids will be provided in 2012. As MOHSW finalizes the National Paediatric HIV Strategic Plan, a major component of the plan is a costing of ART services required for elimination. This has not been concluded.
Pediatric ART services have been decentralized to the health center level using the GOL nurse driven model. These services are supervised by our implementing partners including EGPAF and Baylor. Baylor Center of Excellence is located in Maseru with Satellite Centers of Excellence (SCOEs) in Qacha's Nek, Leribe, Mohale's Hoek and Berea. These SCOEs are staffed with clinicians (doctors and nurses) with vast clinical HIV pediatric experience and management skills and provide services, including management of referred cases from health centers, to hospitals and TA to DHMTs. In 2012, the MOHSW and PEPFAR will focus more on the quality of pediatric treatment and care services in all districts, with emphasis on quality improvement. The National Strategy has included 'increased access to quality pediatric HIV treatment, care and support for all HIV infected infants, children and adolescents' as its fifth (5th) strategic objective, with laudable, feasible and achievable strategies and performance objectives.
The main challenges to expansion of pediatric HIV services are HR, SCM and Data related.
HR: Lesotho still faces critical shortage of skilled HCWs due to chronic attrition and lack of a retention policy for HCW. In addition to the lack of HCW, inadvertent 'skill shortage' has been created by policies around rotation of qualified nurses amongst hospitals and departments, limited will of MOHSW authorities for further task shifting, limited recognition of various CHW cadres (only VHWs are recognized by the MOHSW) and movement of qualified medical personnel to more favorable management and private health facility positions. PEPFAR has identified an HSS/ HRH partner to support the MOHSW in this area.
UNICEF funding support for pediatric ARVs expires mid 2012. No alternative funding has been identified up till now. The GOL already funds >70% of all ARV and OI procurements, in addition to essential medicines for the health sector. These include ARVs for the private sector and textile industry clinics. In addition, systems for forecasting, quantification and procurement are often multiple and parallel with the effect that distribution of ARVs are uneven and not equivalent to needs in some districts. Closely related to these are frequent test kit and reagent stock outs. PEPFAR will, through the Acceleration Plan, the new SCM project (planned for 2012) and with GF

support, assist the MOHSW to identify a sustainable system that finally addresses these SCM issues for both ARVs and laboratory commodities. This has been identified by PEPFAR and GF as critical, moving forward.
The MOHSW still has critical challenges with obtaining data for pediatric HIV and PMTCT. Most of this is related to HR shortages at health center level and poor resource and data management at district and central levels. PEPFAR has identified a lead SI partner which will work with the MOHSW Health Planning and Statistics Department (HPSD) to identify and fill gaps, determine priorities and work with other PEPFAR IPs on the way forward.
In Lesotho, PMTCT, ANC and MNCH services are currently being integrated to improve efficiencies around pediatric ART treatment. The integration starts from ANC where all HIV infected pregnant women receive ARV prophylaxis and ART for their own health. Integration in Maternity is also done by provision of all HIV services in maternity ward for women who were missed during ANC. At MNCH, early infant diagnosis (EID) and nutrition assessment are carried out as part of neonatal, infant or U5 clinic activities. HIV testing (PITC)is done for children according to national guidelines in these settings. All HIV infected children who are less that 18 months are initiated on ART at MNCH and the mother baby pair followed until the baby is 18 months. The introduction of the Lesotho MBP/Minimum package has helped in the integration since the mother baby pair medicines are dispensed in one package.
Nationally, there are central and district level constraints to data collection which border on lack of skilled human resources and poor resource management for program monitoring and evaluation. Analysis of health program data is only done yearly for the AJR while analysis of PMTCT data (for the whole country) is done quarterly by a skilled epidemiologist at the central level. Feedback of this information to district and clinical teams, as well as partners and stakeholders, is not routinely done. Hence, information from pediatric HIV data collected is not utilized for program design or planning. However, Baylor, an SCS partner, uses pediatric HIV data reported to PEPFAR for program planning purposes.
This has been identified as a gap by MOHSW and PEPFAR and has been included, as an intervention area, in the National PMTCT and Pediatric HIV Plan (2012 – 2016), under Strategic Area 7 (Health Systems Strengthening). Specifically, Strategic Objective 7.5 of this plan indicates that M&E systems for PMTCT and Pediatric HIV programs will be developed and strengthened. This includes the impact evaluation, mapping of communities to link population and vital data, development of database for HIV infected women and children at all levels, development of the EID portion of the LIS, linkage of the new laboratory information system (LIS) to MNCH and ART data, establishment of the national EMR system (linked to LIS), training of HCWs on timely and accurate data collection, compilation and reporting. All these services are, and will be, supported by PEPFAR.
The international procurement and supply chain stakeholders in Lesotho are 1) GOL, which funds most ARVs, OI drugs. 2) National Drug Supply Organization, an account of the MOF, procures and distributes medicines to MOHSW HFs. 3) UNICEF for paediatric ART and PMTCT (till June 2012); supports procurement of pediatric ARVS and the Minimum Package or Lesotho MBP 4) The Global Fund (GF), through rounds 6 and 8, provides resources for procurement of Pediatric ARVs and commodities for nutrition support (therapeutic feeds); employment of key personnel such as health professionals, data clerks and other HCW cadres; support for central level TA, trainings and the TWG. 5) CHAI contribute significantly to scale up of pediatric HIV services through central level TA, support for SCM of ARVs and HR provision. 6)PEPFAR provides TA for pharmaceutical governance, pre and in-service training, pharmaceutical management with Rx Solution, medicines use and adverse effects monitoring.
Pharmaceutical quantification is done annually based on an adjusted consumption method to cater for program expansion. PEPFAR supports this through capacity building at facility and national level in procurement supply management and pharmaceutical data management at facility and national levels.
Currently, the MOHSW and NDSO meet on an ad hoc basis when problems are anticipated. Apart from two month reserves, there is currently no risk mitigation strategy. NDSO, however, is investigating regional pooled procurement for paediatric ARVs procurement, a direct consequence of the UNICEF/ UNITAID support ending June 2012.
Roll out of the pharmaceutical management tool (Rx Solution) has faced a myriad of challenges which include technical in country staff capacity constraints, lack of ownership and therefore inconsistent routine data use for decision making; erratic use of the system at facility level and lack of supervision by the MOHSW; lack of infrastructure and delayed site readiness; and, on-going MCC/ MCA refurbishments in some of the hospitals

scheduled for roll out.
Critical staffs are urgently required within the PD for more appropriate responsiveness to national and district level DSM issues, including ownership of Rx Solution and regulation of drug importation, exportation, rational use and pharmacovigilance. The capacity of the PD and DDC to effectively address SCM issues with ARVs and related medicines, make evidence based decisions around SCM of medications and provide supportive supervision to districts need to be urgently strengthened technically, logistically and numerically. Individual staff capacity at district and hospital levels for DSM need to be improved through more focused training and more rigorous supervision and mentoring, while equipping the pharmaceutical staff with necessary tools to effectively and efficiently carry out their supply chain duties. Nurses and HCWs at the health centre level need to be relieved of their management and reporting burden (which has become so apparent due to critical skilled staff shortage) through either deployment of more staff to the primary health care level or provision of easy to use tools for DSM and M&E.

Sustainable access to medicines and other health technologies critically relies on availability of skilled workers to provide and manage pharmaceutical services. PEPFAR, through its TBD Pharmaceutical Capacity Strengthening Partner, will support the MOHSW to look more comprehensively at workforce planning in order to address challenges such as increasing demands (due to HIV service provision), resource constraints, and health workforce policy reforms. A PEPFAR strategy for promoting sustainability and country ownership is currently not available because we provide technical support and assistance to the national and district levels and are not involved in procurement. However, since we would be focussing more on SCM from FY2012, such a strategy (specific to our situation) will require us to build on existing systems and local capacity to increase country ownership, therefore ensuring sustainability of interventions in the long term. Focus will be placed on local capacity building for country-led sustainable solutions. Flexible approaches will be considered in designing tailored interventions; implement and manage that intervention; monitor performance; and measure outcomes. To increase pharmaceutical sector efficiency, PEPFAR implementing partners will work with stakeholders to assess the pharmaceutical supply system's capacity to manage pharmaceuticals at all levels, from facility to national. A stakeholder consensus approach should be used to identify areas for improvement and develop long term interventions to strengthen the system, such as building capacity among facility- level staff to track medicine consumption, monitoring or tracking post occupancy rates, and other critical supply chain performance areas. No pharmaceutical products are procured in country.

In 2011, 1012 HIV infected children (<15 years of age) were newly enrolled on ARVs and 2817 are currently receiving ARVs and 2,474 received CTX prophylaxis in GOL PEPFAR supported sites. Through the SCS implementing partner EGPAF, we currently support 170 health facilities to provide paediatric ART services. The SCM TWG within the DDC of the MOHSW is tasked with all paediatric HIV supply chain management issues, though it has not been fully functional mostly due to HR challenges and lack of sustained technical expertise. Stock outs of pediatric ARVs are rare. However, there was a shortage of Abacavir 60 mg for around 3 weeks in the past two years. There have been occasional 'pseudo' stock outs in which case redistribution of ARVs effectively aborted such occurrences. These redistributions also prevent products expiring on shelves. There have been test kit stock outs but the recently launched LMIS which is intended to manage logistics data for laboratory commodities should address this (as described in more detail under laboratory).

The laboratory services are provided at three tiers; central, district and health center levels. There are 21 health facilities (central laboratory and district hospital laboratories) that provide from basic to more complex diagnostic and patient monitoring tests while the central laboratory provides referral testing services that include DBS based DNA-PCR test for early infant diagnosis of HIV and ART monitoring (viral load and CD4 monitoring).
The implementation of the National Laboratory Policy and Strategic plan (2008-2013) focuses on the establishment of quality assured and integrated laboratory services throughout the health care network. To oversee the implementation of QMS, certification and accreditation of facilities, the National Laboratory Regulatory Frame work (policy and legislation) have been initiated. National Quality Assurance has been established and coordinated by the Quality Assurance Unit of the MOHSW. The External Quality Assessment (EQA) schemes have been implemented for all diagnostic and patient monitoring tests in all 21 laboratories. A standardized HIV testing

algorithm as well as EQA schemes has been implemented in all 267 testing centers across the country. The WHO-AFRO accreditation scheme, Strengthening Laboratory Improvement Program towards Accreditation (SLIPTA), has been implemented in all 28 laboratories. Since the implementation of SLIPTA, 50% of laboratories have scored significant progress in the quality management system. Standard operating procedures, QA and biosafety manuals are in place cross a tiered laboratory network. To improve the laboratory databases and M & system, the lab requisition, reporting and logbooks are standardized in all clinical laboratories. The laboratory information system has been operational in 25% of the clinical laboratories and expected to be scaled up.
As part of implementation of the national strategic plan and quality system, PEPFAR supports the procurement of diagnostic and monitoring equipment and supplies, standardization of testing plate forms, equipment maintenance and supply chain management. To address the gaps in logistic and distribution of supplies in the country, PEPFAR is supporting the implementation of laboratory logistic management information system (LMIS). The consumption data, forecasting, procurement and distribution of commodities are being coordinated between the MOHSW and National Drug Supply Organization (NDSO). For sustainability, human resource development, pre service training, in service training and curricula revision have been conducted.
Overall, in FY2011, 16,601 patients were enrolled in treatment in our health facilities. Of these, 1012 were children (<15 years) and 15497 were adults (>15 years). There were 1223 pregnant women newly initiated, in addition to the above. Roughly an equal proportion of male and female children were newly enrolled but the proportions for adults deferred greatly, with only 36.9% being men and 62.1% being women. While the burden of HIV is relatively greater in women than men (LDHS 2009), these results can be interpreted as signifying that fewer men than women attended or were initiated in PEPFAR health facilities this year. There has been very minimal increase in the ration above from FY10 results (36.8%) and we can therefore demonstrate the need to focus more attention on increasing male involvement in treatment programs. 38.4% of 53,197 patients currently on treatment are male, justifying the points made above and extrapolating the trend in treatment over the past four years.
According to the PMTCT Acceleration Plan, PEPFAR Lesotho will focus on increasing male involvement and participation in PMTCT and treatment programs. The National Strategy also has objectives and activities targeted at increasing the number of male adolescents and adults enrolled and retained in ART services, especially scaling up adolescent clinical services and provision of HIV services to men at more convenient times respectively. Innovative programs are being designed to provide ART and TB treatment services to migrant workers, the majority of which are men. Community based approaches such as Male support groups have been established with the intention of reaching out to more men through supportive structures they respect and accept.
In line with the Third One Principle, our Care and treatment partner has aligned itself to supporting and reporting through the MOHSW M&E data system. This is not without its challenges as the national M&E system has critical staff, coordination and capacity challenges. There is currently insufficient M&E and SI capacity at central level, for all programs. The national monitoring and evaluation system for treatment information is also currently paper based and this presents challenges in accessing accurate timely data. Currently, monthly aggregate data is used to report against treatment targets as our IP has no access to client level data (paper based system, no MOHSW tools currently capture facility level client specific data for treatment).

Reporting against T1.1.D and T1.2.D is based on a proxy indicator (# patients collecting ARVs at the health facility). The accuracy of this proxy needs to be evaluated considering factors that surely affect the numbers being reported. As per national policy, each patient should pick up their ARVs monthly. This is not the case in all health facilities as some patients receive >2 months of ARVs at each appointment and may be missed out in the counts reported monthly or for a specific reporting period.

Regarding the use of treatment information at district and facility levels, there are currently no strong formal structures for data feedback from the higher (central or tertiary) to lower levels of healthcare or health facilities where treatment data is generated. Feedback system to implementing partners and development partners either do not exist or are on an ad hoc basis such as annually during the AJR. Data verification is done centrally, making data use and analysis very slow, cumbersome and impossible.

It is expected that the establishment and proposed deployment of National EMR will resolve this issue. Pilot of the EMR has commenced and the roll out is expected to commence by the end of FY12. Data feedback systems need to

be put in place by the MOHSW, through the support of partners. PEPFAR currently supports minimal feedback to districts through its treatment IP's district structures. The ongoing integration of HIV treatment and HIV Care registers will ease the reporting burden of HCWs and is essential as we integrate ANC, MNCH, TB and HIV services and decentralize healthcare services. Data verification exercises will also be conducted in FY12 and scaled up significantly for PMTCT and treatment under the Acceleration Plan. PEPFAR will, in FY12, conduct strategic M&E planning meetings with the HPSD of the MOHSW to establish a capacity needs assessment for M&E in the department and determine a transition period within which our SI and treatment partners can support and build the capacity of the MOHSW to efficiently handle M&E data at both central and district levels. Logistic support and TA will be provided during this period. A national M&E road map which encompasses all aspects of M&E and integrates programs across the HIV response continuum will be discussed with the MOHSW by our SI partner in FY2012.

At the individual level, the government and private sector have prioritized the training and on-going mentorship of HCWs, especially the nurse and VHW cadres. Several tasks have already been shifted to these cadres and it has become apparent that their capacity to do an even better job needs to be strengthened. The VHW strategy is currently in development, with PEPFAR support, for a consultant to work with the MOHSW on this. Significant investments have gone into supporting the pre service education of nurses through NEPI and Jhpiego's support for GOL and CHAL health institutions. These interventions have been determined by the fact that HIV service provision in Lesotho is nurse driven.
At the system level, it has become apparent that Lesotho's extensive CHW network needs to be exploited to create a robust healthcare system at the primary health level where most clients receive their HIV care and treatment. Potentially, the CHWs will be linked to HCWs in health facilities. There is also increased emphasis on improving patient referral systems between health facilities and communities, as well as specimen referral systems between health centres and laboratories. More than 190 of all health facilities now provide ART services, with HCWs in GOL and CHAL health facilities now supported to initiate ART. The MOHSW is becoming more aware of the need for collaborative TB and HIV treatment services while MNCH, Nutrition and ANC services will continue to be integrated in all hospitals. Increased attention is being paid to in country provision of quality diagnostic services for HIV and TB. Laboratory infrastructure is being improved with the construction of the new National reference laboratory by MCC, in addition to the construction and renovation of over 140 health facilities. The TB reference laboratory (built by Partners in Health) is almost complete and the new PPP Referral hospital collaboration between the GOL and Tsepong Pty) has been completed and is fully operational.
The GF has pointed the attention of the MOHSW to pending SCM issues, with the subsequent disbursement of funds now dependent on a resolution of these. This is considered to have positive impact of the support we are providing the MOHSW as they will now be more responsive to owning the pharmaceutical management tool and also develop effective DSM and SCM systems.
HIV and TB Drug resistance are increasingly more recognised and the recently conducted study on EWIs is an indication of rising national commitment in addressing this trend. Cervical Cancer and other HIV associated malignancies are also receiving more attention as the MOHSW recently agreed to collaborate with PEPFAR to upgrade the Senkatana HIV centre to a Centre of Excellence for HIV Referrals and cervical cancer screening.
Currently, the DCA is the only PPP currently approved for FY12. This PPP specifically focuses on financial and capital investment by private sector banks for housing and other needs and of health professionals. This PPP will reduce staff attrition and improve the quality of treatment services available in country as more trained and skilled HCWs are retained.
A PPP to reduce the TB/ HIV burden in miners working across borders has been proposed but is yet to be finalized. This PPP will reduce the default rates amongst HIV/ TB co-infected mine workers and therefore reduce the risk of treatment failure. More of these patients will also be initiated on treatment therefore resulting in increasing numbers of patients enrolled on ART.
A PPP for Effective Management by district and central level managers has also been proposed for FY2012 to ensure that these managers know how to manage their resources, including pharmaceuticals and laboratory commodities. This nationwide alliance will have skilled and experienced business managers train and mentor selected personnel from the MOHSW and DHMTs for a period of one year, with the development and implementation of district and national action plans at the core of the program.

Currently, HIV treatment is initiated by nurses at all levels of healthcare. CHWs have been employed in monitoring patients and ensuring that defaulters are returned to treatment at the health facility. Linkage of CHWs to HFs has been successfully done in some districts using the Focal persons. The MOHSW is more predisposed to improving the quantity and quality of its VHW system rather than adopting the extensive CHW system developed by partners. However, discussions are still on-going in this regard and subsequent steps depend on the finalization of the National VHW Strategy.
PEPFAR, with other development and implementing partners, has commenced the process of developing and promoting continuous professional development with the MOHSW. First steps in this direction include the harmonization of the different in-service training schedules for HIV treatment, PMTCT and TB.
Training and mentorship programs are in the pipeline or advanced stages to develop the capacity of different non clinical cadres at central, district and facility to effectively manage HIV resources and HIV data.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2013	Justification
P1.1.D	P1.1.D Percent of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	41,200	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	74 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	8,573	
	Number of HIV-	11,536	

	positive pregnant women identified in the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	5,525	
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	53	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	0	
	Single-dose nevirapine (with or without tail)	0	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)	0	
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)	0	
	Sum of regimen type disaggregates	5,578	
	Sum of New and	0	

	Current disaggregates		
P5.1.D	Number of males circumcised as part of the minimum package of MC for HIV prevention services per national standards and in accordance with the WHO/UNAIDS/Jhpiego Manual for Male Circumcision Under Local Anesthesia	36,000	Redacted
	By Age: <1	500	
	By Age: 1-9	0	
	By Age: 10-14	20	
	By Age: 15-19	0	
	By Age: 20-24	0	
	By Age: 25-49	0	
	By Age: 50+	0	
	Sum of age disaggregates	520	
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection through occupational and/or non-occupational exposure to HIV.	72	Redacted
	By Exposure Type: Occupational	36	
	By Exposure Type: Other	0	

	non-occupational		
	By Exposure Type: Rape/sexual assault victims	36	
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions	2,200	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are	42,980	

	based on evidence and/or meet the minimum standards required		
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	39,900	
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive	n/a	Redacted

	interventions that are based on evidence and/or meet the minimum standards required		
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	20,884	
	By MARP Type: CSW	0	
	By MARP Type: IDU	0	
	By MARP Type: MSM	0	
	Other Vulnerable Populations	20,884	
	Sum of MARP types	20,884	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	141,400	Redacted
	By Age/Sex: <15 Male	0	
	By Age/Sex: 15+ Male	0	
	By Age/Sex: <15 Female	0	
	By Age/Sex: 15+ Female	0	
	By Sex: Female	77,480	
	By Sex: Male	63,920	
	By Age: <15	100	

	By Age: 15+	141,300	
	By Test Result: Negative	91,946	
	By Test Result: Positive	12,654	
	Sum of age/sex disaggregates	0	
	Sum of sex disaggregates	141,400	
	Sum of age disaggregates	141,400	
	Sum of test result disaggregates	104,600	
P12.3.D	Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses the legal rights and protections of women and girls impacted by HIV/AIDS	2,900	Redacted
	By Age: <15	1,180	
	By Age: 15-24	1,150	
	By Age: 25+	570	
	By Sex: Female	2,035	
	By Sex: Male	865	
P12.4.D	Number of adults and children who are reached by an individual, small-group, or	2,000	Redacted

	community-level intervention or service that explicitly aims to increase access to income and productive resources of women and girls impacted by HIV/AIDS		
	By Age: <15	1,000	
	By Age: 15-24	880	
	By Age: 25+	120	
	By Sex: Female	1,360	
	By Sex: Male	640	
C1.1.D	Number of adults and children provided with a minimum of one care service	126,092	Redacted
	By Age/Sex: <18 Male	0	
	By Age/Sex: 18+ Male	0	
	By Age/Sex: <18 Female	0	
	By Age/Sex: 18+ Female	0	
	By Sex: Female	79,108	
	By Sex: Male	46,985	
	By Age: <18	39,752	
	By Age: 18+	86,340	
	Sum of age/sex disaggregates	0	
	Sum of sex disaggregates	126,093	
	Sum of age disaggregates	126,092	

C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	82,858	Redacted
	By Age/Sex: <15 Male	0	
	By Age/Sex: 15+ Male	0	
	By Age/Sex: <15 Female	0	
	By Age/Sex: 15+ Female	0	
	By Sex: Female	55,395	
	By Sex: Male	27,467	
	By Age: <15	0	
	By Age: 15+	0	
	Sum of age/sex disaggregates	0	
	Sum of sex disaggregates	82,862	
	Sum of age disaggregates	0	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	75 %	Redacted
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	61,730	
	Number of HIV-positive individuals receiving a minimum of one	82,858	

	clinical service		
C2.3.D	C2.3.D Proportion of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	n/a	Redacted
	Number of clinically malnourished clients who received therapeutic and/or supplementary food during the reporting period.	200	
	Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period.	0	
	By Age: <18	0	
	By Age: 18+	0	
	Sum by age disaggregates	0	
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	101 %	Redacted
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	83,347	
	Number of	82,858	

	HIV-positive individuals receiving a minimum of one clinical service		
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	4 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	3,070	
	Number of HIV-positive individuals receiving a minimum of one clinical service	82,858	
C4.1.D	C4.1.D Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	65 %	Redacted
	Number of infants who received an HIV test within 12 months of birth during the reporting period	7,535	
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-	11,536	

	positive at entry)		
	By timing and type of test: virological testing in the first 2 months	1,070	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	5,965	
C5.1.D	Number of adults and children who received food and/or nutrition services during the reporting period	20,298	Redacted
	By Age: <18	12,323	
	By Age: 18+	7,975	
	By: Pregnant Women or Lactating Women	640	
	Sum of age disaggregates	20,298	
T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART	22,774	Redacted
	By Age: <1	0	
	By Age/Sex: <15 Male	1,144	
	By Age/Sex: 15+ Male	6,172	
	By Age/Sex: <15 Female	1,144	
	By Age/Sex: 15+ Female	14,314	
	By: Pregnant Women	2,270	
	Sum of age/sex	22,774	

	disaggregates		
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	101,800	Redacted
	By Age: <1	0	
	By Age/Sex: <15 Male	3,075	
	By Age/Sex: 15+ Male	32,935	
	By Age/Sex: <15 Female	3,000	
	By Age/Sex: 15+ Female	62,790	
	Sum of age/sex disaggregates	101,800	
T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	78 %	Redacted
	Number of adults and children who are still alive and on treatment at 12 months after initiating ART	14,610	
	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who	18,700	

	have died, those who have stopped ART, and those lost to follow-up.		
	By Age: <15	0	
	By Age: 15+	0	
	Sum of age disaggregates	0	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	21	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international standards	4	Redacted
H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	678	Redacted
	By Cadre: Doctors	3	
	By Cadre: Midwives	210	
	By Cadre: Nurses	387	
H2.2.D	Number of community health and para-social workers who successfully completed a pre-service training program	50	Redacted
H2.3.D	The number of health	12,383	Redacted

	care workers who successfully completed an in-service training program		
	By Type of Training: Male Circumcision	60	
	By Type of Training: Pediatric Treatment	4	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7455	U.S. Department of Defense (Defense)	Other USG Agency	U.S. Department of Defense	GHP-State	351,000
8772	American Society of Clinical Pathology	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	100,000
10432	Association of Public Health Laboratories	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	500,000
10456	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	1,650,000
10457	National Institute for Communicable Diseases	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	400,000
10458	JHPIEGO	University	U.S. Agency for International Development	GHP-State	4,252,500

10459	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Agency for International Development	GHP-USAID, GHP-State	5,550,000
10480	Pact, Inc.	Private Contractor	U.S. Agency for International Development	GHP-State	750,000
10739	Ministry of Health and Social Welfare – Lesotho	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,530,000
11018	U.S. Peace Corps	Other USG Agency	U.S. Peace Corps	GHP-State	0
11030	U.S. Department of State	Other USG Agency	U.S. Department of State/Bureau of African Affairs	GHP-State	175,000
12098	Ministry of Health and Social Welfare – Lesotho	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	750,000
13484	Population Services International	NGO	U.S. Department of Defense	GHP-State	465,000
13981	Population Services International	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,225,000
13983	Eastern, Central	NGO	U.S. Agency for	GHP-State	500,000

	and Southern African Health Community Secretariat		International Development		
13987	Columbia University Mailman School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	3,200,000
14026	Ministry of Health and Social Welfare – Lesotho	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	0
14072	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-USAID, GHP-State	1,110,000
14301	Population Services International	NGO	U.S. Agency for International Development	GHP-State	2,000,000
16766	University Research Corporation, LLC	Private Contractor	U.S. Agency for International Development	GHP-USAID, GHP-State	800,000
16768	Mothers 2 Mothers	NGO	U.S. Agency for International Development	GHP-USAID, GHP-State	400,000
17098	Institute for Health Measurement	NGO	U.S. Agency for International Development	GHP-USAID, GHP-State	650,000
17123	TBD	TBD	Redacted	Redacted	Redacted
17124	TBD	TBD	Redacted	Redacted	Redacted

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7455	**Mechanism Name: DOD PEPFAR Support to LDF**
Funding Agency: U.S. Department of Defense	Procurement Type: USG Core
Prime Partner Name: U.S. Department of Defense (Defense)	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 351,000	
Funding Source	**Funding Amount**
GHP-State	351,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY2012, DOD/PEPFAR activities supporting Lesotho Defense Force (LDF) will continue the successful collaboration which has been ongoing since 2002. The Lesotho Defense Force has seen tremendous scale up of their HIV/AIDS activities which include interventions to reduce stigma among military members living with HIV as well as military family members who are HIV positive. Military health care workers have been trained to provide home based palliative care for chronically and terminally ill clients. DOD supported the LDF to renovate and upgrade their current laboratory and procured a state of the art equipment, training of LDF nurses for ART, pharmacy training, provision of a mobile clinic for outreach to remote bases and surrounding communities, building of a wellness center which supports integrated care, conducted seropreavalence and risk factors study in the LDF and conducted a stake holders meeting for the dissemination of the results of the study, and implementation of an innovative electronic health record with portability for mobile services. PEPFAR funding has also supported education and sensitization of all ranks and family members on HIV prevention. DOD has also supported peer education, counseling and testing services. In 2012 DOD/PEPPFAR will support continued PMTCT training and provide alternative feeding supplements and training for mothers who choose not to breastfeed, LDF will hold workshops to disseminate the results of the seropreavalence and behavioral study to LDF senior officers and other ranks, support feeding for chronically and terminally ill patients and basic care activities including training to

target reduction of stigma and discrimination, palliative care training, procurement of supplies for mobile clinic, training for peer educato

Cross-Cutting Budget Attribution(s)

Construction	35,000
Food and Nutrition: Commodities	25,000
Gender: GBV	50,000
Gender: Gender Equality	50,000
Human Resources for Health	30,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7455**		
Mechanism Name:	**DOD PEPFAR Support to LDF**		
Prime Partner Name:	**U.S. Department of Defense (Defense)**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	50,000	0

Narrative:

In FY13 DOD will support the care component of the Lesotho Defense Force HIV prevention program. The activity is focused on providing basic elements of clinical care and home based care, psychosocial care, and stigma reduction to military members living with HIV, as well as for any military family members. Services include prevention and treatment of opportunistic infections including provision of cotrimoxazole prophylaxis, provision of

izoniazid preventive theraphy (INH) for eligible clients, screening and care for sexually transmitted infections (STI's) screening and alleviation of of HIV related symptoms and pain. DOD will support training of LDF health care workers in proper prophylaxis and management of OI's including screening and tuberculosis treatment (TB) DOD will also support short term therapeutic feeding for clinically malnourished patients according to MOH entry and exit criteria and health care professionals will be trained on nutrition assessment.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	0	0

Narrative:

Care for OVC is a growing concern in the Lesotho Defense Force, funding will support activities that strenghten comminities and families to meet the needs of children and families affected by HIV/AIDS. Activities will include supplementary feeding for malnourished children,hosting technical assistance to enable development of OVC programs in LDF. Based on needs assessment, specific interventions may include training caregivers and providing increased OVC access to education, food, and other supportive services. A number of 11 districts will be targeted for OVC's services and they will receive paediatric support from the Naval medical center. Assessementt and interventions will include participatory approches and program evaluations. This initial focus will determine the numbers and needs of the OVC dependants for service delivery in the Lesotho Defense Force and intergrated service delivery program, with related activities described in the prevention and palliative care sections.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	70,000	0

Narrative:

Lesotho Defense Force will use the funding to continue TB activities that have been ongoing. HIV infected clients will be provided with Antiretrovals {ART] , TB clinical care will continue to be part of a package of comprehensive HIV/AIDS care strategy by improving the infrastructure at the military hospital and also by procurement of equipment for the TB clinic, training military health providers to diagnose, treat and monitor, and report TB progression trends. Preventive cotrimoxazole prophylaxis will continue to be integrated into HV care package for adults and children to encourage prevention and reduce clinical disease. Efforts will be made to ensure that hundred percent of HIV positive adults and children enrolled into care in military sites receive TB screening and treatment and if TB is confirmed patients will be tested for HIV. All TB/ HI/V co-infected adults and children eligible for ART will be automatically enrolled and followed up. TB preventive cotrimoxazole prophylaxis will also be provided to HIV infected adults and children enrolled on care to ensure successful TB prevention. TB exposed children of TB/HIV co-infected adults will be identified, evaluated and provided with appropriate prophylaxis or treatment as indicated by the national guidance for TB management in children. HIV positive children identified will be enrolled on in ART services as part of a familyapproach to TB/HIV services provision and part of efforts to improve the quality of services offered military personnel and their families. These activities

support the national plan for TB/HIV and PEPFAR goals to prevent, diagnose and treat patients with both TB and HIV.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	40,000	0

Narrative:

Lesotho Defense Force in collaboration with DOD and Ministry of health and social welfare have supported the building of a military LAB at the military hospital. DOD will support recruitment of senior LAB technologist in order to ensure that there is a qualified personnel in the LAB to ensure appropriate use of new equipment and provision of quality services and sustainability of services at the military services. As the ART services expand, CD4 testing becomes an important tool for determining clinical eligibility for HAART coupled with other basic laboratory tests for monitoring HIV disease. The LDF has indicated that it is essential to perform CD4 testing as well as other basic monitoring tests within the military laboratory in order to ensure effective and sustainable ART provision within the military Health Delivery System. Therefore DOD will procure on-site CD4 machine (PIMER). Efforts will be made to upgrade the LDF laboratory to provide laboratory diagnosis of HIV, immune function and opportunistic infections, and hematological status, on-site training of LDF laboratory personnel will increase the number of technicians in the military.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	40,000	0

Narrative:

DOD has supported an electronic medical record (EMR) system for Lesotho Defense Force HIV program, FY13 funds will continue to support the LDF EMR, an additional benefit is that those involved in counseling and testing, support activiies andt in patients treatment wil now have access to on-line support materials and a wider network of expertise, funds will support training of personnel in data collection and data enrty, monitoring and evaluation techniques and reporting. This is currently one of the weakest aspects of the LDF effort. This activity will specifically target miliyary personnel and their family members, especially those living with HIV/AIDS. DOD will support procurement of netbooks computers for nurses and HIV counselor testers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	56,000	0

Narrative:

Funding will support Lesotho Defense Force HIV program by providing counseling and testing services to the

military members, to train military nurses and HIV counselors in counseling and testing and to support the monitoring and evaluation and quality assurance though PSI. This activity will continue to support LDF HIV program by providing military community and their families with counseling and testing services at the counseling and testing sites. DOD will support mobile CT services to the rural bases, provider iniated CT(PICT) will be strenghtened testing on major campaigns will also be supported during the army day celebration and sports days where a large number of soldires will be counseled and tested with routine testing and PSI will train LDF counseors thereby building the capacity for health professionals to manage the epidemic. military personnel who test HIV positive will be reffered to ART services and will be monitored to ensure adherence DOD will support.identification of discordant couples and enhance HIV care particularly positive prevention programs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	20,000	0

Narrative:

"The Lesotho Defense Force will increase access to PMTCT services to military personnel and their families. Services also target other uniformed services. DOD will provide technical assistance to the LDF for delivery of quality, integrated PMTCT services within the platform of MNCH services provided at the hospital. The LDF will offer a standard package of PMTCT services as defined by WHO guidelines, contributing to the achievement of goals defined in the Lesotho PMTCT Acceleration plan and the National Plan for the Elimination of MTCT and Pediatric HIV. Services include CT with informed consent, ARV prophylaxis using combination regimens and HAART for eligible women, counseling, support, referral for family planning, MNCH services, follow-up of HIV-exposed infants for referral to appropriate services, and early infant diagnosis.

While the LDF currently does not have an accurate unit cost per patient, LDF will be included in a comprehensive costing exercise to be conducted with Acceleration funds.

In order to increase male involvement LDF will support couples and family-centered counseling and testing. PEPFAR Lesotho is currently developing a gender strategy which will help to strengthen interventions in this area. Although LDF has limited funding for care and support and OVC activities, LDF will ensure access to a comprehensive network of services for PMTCT clients and their families by linking with PEPFAR partners which have more substantial funds in these technical areas.
Mothers to Mothers will provide health education for clients to increase patient involvement and community participation in PMTCT services. In FY2011 LDF health care workers received training in prevention for PLHIV, which will also be integrated in the standard package of services provided to clients. In FY 2011 LDF personnel participated in MEASURE Evaluation training in order to improve the capacity of the LDF to routinely collect data. M&E continues to be a challenge for the LDF. With support from the lead SI PEPFAR partner, LDF facilities will receive technical support and training to improve the quality of data and monitor quality of services.

"			
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HTXS	75,000	0
Narrative:			
Department of Defense works to improve the capacity of the Lesotho Defense force to provide quality HIV treatment and care for military personnel and their families. In FY13 DOD will support provision of a continuum of care and treatment services which includes clinical staging and CD4 counts for all patients, STI/OI's screening and treatment, provision of cotrimoxazole prophylaxis, ART, ART adherence support, psychosocial support, family planning, nutition counseling and support, prevention for positives. DOD will also continue to support and emphasize HIV prevention with positives through training of health professionals and lay counselors providers will be trained on how to assess patients with regard to risk behaviours, medical adherence, condom use. DOD will continue to provide technical and material support to the military treatment site to ensure provision of quality ART services to PLWHA.			

Implementing Mechanism Details

Mechanism ID: 8772	**Mechanism Name: PEPFAR Laboratory Training Project**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Society of Clinical Pathology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHP-State	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

ASCP works in affiliation with in-country partners to progressively build capacity of local and national groups to respond to the global HIV and AIDS epidemic. With the aim of sustainability, ASCP is focused on achieving CDC-Atlanta's established performance goals of developing, customizing, and deploying country-specific in-service training packages for lab testing and accreditation; continuing education; and (as in Lesotho) mentorship/technical assistance support and pre-service curricula for schools of medical technology.

In Lesotho, ASCP's Technical Assistance for Pre-Service strengthens the knowledge and core competencies of tutors, students, and partners of the National Health Training College's (NHTC) lab science programs. The next steps involve implementing the newly revised MLS curriculum. These steps are guided by close collaboration with CDC-Lesotho, NHTC, and MOH. For example, MOH directed that NHTC increase enrollment of students from 20 to 30. This directive challenges NHTC to adequately equip the extra students with teaching staff and training aids. ASCP will also support curriculum development of a mid-level training program designed to provide rapid capacity-building.

With the primary goal of preparing students for the work of clinical lab professionals, the planned scope of work for the next two years involves strengthening the implementation of the new curriculum and improving the quality of the overall medical lab education at NHTC: Teaching Methodology Technical Assistance/Mentorships; Continuing Education; Equipment and teaching aids. Once approved, the design of the mid-level program will include a Stakeholders' Meeting, Curriculum Development Workshops, Technical Assistance/Teaching Methodologies and Faculty Mentorship Workshops.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	8772		
Mechanism Name:	PEPFAR Laboratory Training Project		
Prime Partner Name:	American Society of Clinical Pathology		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	100,000	0

Narrative:

Content Development Workshops: Involve small group task-based assignments and large group discussions of challenges, strategies, and best teaching practices of implementing curriculum. This includes lesson planning, using PowerPoint, and writing exams in accordance with competency based objectives.
Teaching Methodologies and Mentorships: To enable faculty to integrate new techniques. They also help to assess strengths and gaps of curriculum implementation. The participants will also observe model classroom lectures, lab demonstration and peer presentations and the opportunity to review, revise, and complete the Clinical Assessment Checklist/ Training.
Grant Writing & Publishing Workshop: addresses recently identified gaps in institutional sustainability, specifically, financing and disseminating NHTC research into the global scientific community. Through didactic and experiential components, the goals are: To provide tools to obtain research funding; To outline journal writing process; To equip the production of manuscripts for publication.
Continuing Education and Professional Development involves 2 options for NHTC faculty to share and broaden professional knowledge, network opportunities, and participate in scientific communities, that of attending conferences and visiting successful lab science programs where they can share and observe classroom and labs.
Management Workshop: Addresses the need to develop capacity in lab management and operations and teaching this MLS course more effectively.
Supply, Equipment, and Textbook Procurement: To provide the material resources needed to create a sustainable medical technology pre-service education program in Lesotho. ASCP proposes item provision to equip the classroom with computers, teaching microscopes, textbooks, analyzers, and other items TBD. As cost effective strategies, ASCP is working closely with NHTC to find the least expensive options for purchasing and identifying local vendors.
M & E Workshop: To help faculty assess their medical lab science programs through examinations student evaluations of each course, faculty evaluations of students, NHTC evaluations of faculty and other related activities.

Implementing Mechanism Details

Mechanism ID: 10432	Mechanism Name: APHL Laboratory Assistance

Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Association of Public Health Laboratories	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHP-State	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Association Public Health Laboratories (APHL) is a membership organization comprised of public health laboratories and has about 5,000 professionals. It has diverse expertise to support HHS/CDC including strategic planning for national laboratory networks and providing US-based and in-country advanced training for laboratory professionals.

APHL laboratory technical assistance project is a cooperative agreement awarded by HHS/CDC from 2009 to 2014, with a total potential value of $2.8 million in Lesotho. APHL supports strengthening of public health and clinical laboratories with emphasis on national strategic planning, policy development and implementation, HIV quality testing, management and information system in Lesotho.

The five-year strategic plan for APHL activities include core training initiatives that support laboratory strengthening, country-specific action plans, and strategic partnerships. APHL provides comprehensive training in test methods, quality management systems, laboratory safety and policy development. APHL supports the program by deploying consultants to provide technical assistance in the country including training-of-trainer activities. APHL has developed quality training tools such as External Quality Assessment (EQA) for HIV and equipment maintenance and provided technical assistance in laboratory capacity building.

APHL implements specific short-term best practices to strengthen laboratory services while working systematically to gain long-term improvements in quality management and infrastructure of laboratories. APHL adapts its work plans and training materials to meet the specific needs and outcome objectives of each country plan. APHL organizes the technical assistance (TA) teams and logistical support to complete the activity suc

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	**10432**		
Mechanism Name:	**APHL Laboratory Assistance**		
Prime Partner Name:	**Association of Public Health Laboratories**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	500,000	0

Narrative:

FY2012 activities:

1) National laboratory Quality assurance program: APHL will assist in preparation of laboratories towards accreditation through Stepwise laboratory improvement process toward accreditation (SLIPTA/ SLMTA) through training, site supervision, mentoring and assessment of quality improvement. The standard check lists developed using the ISO 15189 will be used to implement quality system. Five laboratories will achieve the maximum score 5 stars as recommended by WHO for accreditation. Out of the five facilities that scored five stars, one will be accredited by ready for accreditation. APHL will support a third round of SLMTA, for 30 participants, in the form of providing trained faculty for the workshop as well as supervisory visits and assessments. APHL will support a laboratory management training workshop for 25 lab professionals. In addition technical assistance will be provided to strengthen the national laboratory regulatory body in Lesotho that will over sight monitor and the

implementation of policy, guideline and accreditation of lab services. *(2) HIV rapid test EQA and training: APHL will also continue quality improvement of HIV rapid testing including strengthening the EQA, revision of training modules and support TOT in partnership with MOHSW and HIV testing and counseling partner(s). The HIV Rapid Testing Algorithm will be evaluated and validated through the provision of technical assistance in conducting the evaluation, including testing and analysis. Two members of the quality assurance unit will be trained. A stakeholder meeting will also take place for 30 HIV testers/counselors from the national and district level.* *(3) Strengthening implementation of laboratory information system (LIS):, APHL will support the expansion of LIS to the remaining 8 sites including procurement of LIS hard ware and accessories, furniture and fixture, refurbishment, installation and connectivity. A total of 88 Laboratory staff will be provided training on basic computer skill and management of LIS. APHL will ensure that the Central Repository System is fully linked with other HMIS. APHL will also ensure that early infant diagnosis integrated with the LIS system and systems that will support the PMTCT acceleration plan in the country. This included, referral testing networks, tracking of samples and timely reporting of results to facilities.* *(4) Strengthening laboratory data base and M & E system: This included HIV Rapid testing registers and reporting system. APHL will provide assistance with managing this data for use with surveillance and policy development activities. APHL will assist the MOHSW in developing and implementing a sustainable LIS.*

Implementing Mechanism Details

Mechanism ID: 10456	**Mechanism Name: Southern Africa Building Local Capacity Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,650,000	
Funding Source	**Funding Amount**
GHP-State	1,650,000

Sub Partner Name(s)

Lesotho Network of People Living with HIV/AIDS	Lesotho Society of Mentally Handicapped Persons	Phelisanang Bophelang
Society for Women and AIDS - Lesotho		

Overview Narrative

The MSH/BLC project is aligned to contribute towards two Partnership Framework goals: to reduce morbidity and mortality and provide essential support to Basotho people living with or affected by HIV and AIDS through expanding access to high quality treatment, care, and OVC services by 2014. The project reaches 47,000 OVC and care givers in five districts.

The project goals are: 1) technical and institutional systems strengthened and capacity built in Lesotho; 2) community-based outreach program developed and strengthened that can provide needed community-based care and support services and effective tracking and referrals to clinical settings for people infected with and affected by HIV/AIDS; 3) a mechanism developed and strengthened for providing needed community-based care for OVC and; 4) national policy and guidelines strengthened for comprehensive community-based care and a supportive environment for OVC affected by HIV/AIDS.

To ensure sustainability of program activities, MSH/BLC emphasizes capacity strengthening and empowerment of communities and local organizations. The project plans a 'phase out approach' to exit from a community, resulting in minimizing the need for external inputs, strengthening the community capacity and transferring responsibilities as quickly as possible.

Vehicle needs: BLC project is being implemented in the lowlands, foothills, Senqu river valley, and mountains Mohale's Hoek, Qacha's Nek, and Thaba Tseka characterized by limited communication and transport infrastructure. Transport and communication between communities is almost exclusively limited to Four-wheel drive vehicle, foot or pony since existing paths are often too narrow or steep for even a motorcycle to pass.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	200,000
Education	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	95,000
Gender: GBV	30,000
Gender: Gender Equality	50,000
Human Resources for Health	50,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**10456**
Mechanism Name:	**Southern Africa Building Local Capacity Project**
Prime Partner Name:	**Management Sciences for Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	300,000	0

Narrative:

The BLC project, has partnered with LENASO, LENEPWHA and CCJP to support provision of community base care and support services for adults and adolescents predominantly women who are the caregivers. These include socio-economic security; food security and nutrition; care and support; health and; psycho-social support.
The project implements activities in five districts: Mohale's Hoek, Quthing, Qacha's Nek, Mokhotlong, and Thaba Tseka. BLC contributes to the Partnership Framework Goal: to reduce morbidity and mortality and provide essential support to Basotho people living with or affected by HIV and AIDS through expanding access to high quality treatment, care, and OVC services by 2014. The program contributes to the following strategic options of Lesotho National HIV/AIDS strategic plan 2006-2011: Increase access of OVC households to treatment, care and support services, develop standardized basic support package for OVC, and establish community based mechanisms for provision of social and psychological care for use by community home-based care givers.
BLC project ensures that community referral systems are strengthened to provide a holistic continuum of care and support. Services include: Social welfare services, Child protection, nutrition, spiritual and pastoral counseling and

clinical services to PLWHA who provide care to children. The program maps types of community-based care services, and the delivery points and shares the information with community groups and other stakeholders. The program will develop referral tools. The BLC project facilitates referrals for PLWHA to clinical and community-based care services. This includes home-based care, palliative care, stigma reduction, HIV prevention, positive living, livelihood opportunities, legal rights to prepare for the future of the children and/or nutritional support programs, and adherence to treatment.

BLC has developed monitoring tools to be used by sub-grantees providing care and support for PLWHA. The project trains CBO staff in M&E to collect field level data for monthly activity reports to track activities and output level data. Detailed activities for community based nutrition activities are outlined in the FY12 NACS integration plan.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	1,350,000	0

Narrative:

Management Sciences for Health/Building Local Capacity for delivery of HIV Services in Southern Africa (BLC) project; International NGO

The project goals are: 1) technical and institutional systems strengthened and capacity built in Lesotho; 2) community-based outreach program developed and strengthened that can provide needed community-based care and support services and effective tracking and referrals to clinical settings for people infected with and affected by HIV/AIDS; 3) a mechanism developed and strengthened for providing needed community-based care for OVC and; 4) national policy and guidelines strengthened for comprehensive community-based care and a supportive environment for OVC affected by HIV/AIDS.

Key Strategies:

Capacity strengthening of GOL systems and local CBOs for OVC coordination and service delivery: BLC is strengthening the Social Welfare workforce through training and mentoring of senior staff in leadership and management;

Invest in pre-service and in-service education through working with academic institutions to mainstream leadership and management concepts and practical problem-solving techniques into the Social Welfare curricula.

Sub-granting and capacity building of local organizations to expand quality service delivery of OVC and community based care services including training of community workers in nutrition assessments and counseling for PMTCT.

Pediatric care and support: The program will strengthen two-way referrals between health facilities and communities and implement community based activities for HIV exposed infants. This will include nutrition assessments, counseling and support.

Dissemination of relevant legislations and legal frameworks related to children's rights and welfare.

Challenges: This is a new partner so program challenges were associated with start-up, e.g. getting the MOU with

the Department of Social Welfare signed. This has since been achieved.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

MSH subgrantee, IHM, will build SI capacity among key stakeholders via strategic engagements of partners at national, district, & community level, & specifically for the Directorate of Planning (MOHSW), where M&E is located. IHM's goals & objectives are based on the MOHSW NSP, HMIS Strategy, & USG's PFIP. IHM will provide technical assistance, training, & mentoring. Specifically, IHM will:

• Advocate that GOL fill M&E staffing gaps & retain current staff & lobby for inclusion of M&E curricula in medical training institutions;
• Conduct 2 basic M&E training for data clerks, district Information officers, & other staff;
• Train 60 people on routine DQA for HIS staff;
• Adapt a training curriculum on data demand & use, to train program managers & other end users;
• Provide targeted TA to communities & districts & create a tracking system for M&E trainees.

IHM will also support community-based M&E initiatives, like LOMSHA, & support the restructured NAC. As needed, IHM will provide SI TA to CSOs (e.g., LENASO).

To enhance data quality & its use, IHM will provide supportive supervision at district & national levels. To ensure basic data quality criteria & monitoring of quality assurance & improvement procedures, IHM will continue to use the RDQA & the PRISM tools to identify key SI interventions for communities, districts, & centrally. Additionally, IHM will acquire 2 HMIS staff to support MOHSW data collation, verification, analysis & reporting. They will support the data quality review processes at districts & centrally. To ensure greater coverage, the project will leverage MOHSW's Global Fund activity to conduct data quality audits & provide TA for this activity.

IHM will also:
• Develop SOPs for reporting at community & district level to ensure the production of quality data;
• Conduct DQAs in a sample of facilities & support the development & implementation of DQA plans;
• Conduct basic training in data analysis & report writing to ensure that data clerks & M&E officers can analyze & understand their data;
• Support the institutionalization of the data quarterly review process by providing technical support to at least 2 rounds of district quarterly reviews annually.

Implementing Mechanism Details

Mechanism ID: 10457	**Mechanism Name: Quality Assurance Initiatives for Lesotho Laboratories**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National Institute for Communicable Diseases	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 400,000	
Funding Source	**Funding Amount**
GHP-State	400,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The main objective of the Lesotho Quality Assurance project is to assist the public health and clinical laboratories to attain readiness for accreditation through Stepwise laboratory improvement process toward accreditation (SLIPTA). NICD will ensure the standard 12 elements of a quality system will be used as a working framework. The key areas that will be reviewed include management requirements, (organization and management), current quality management system (QMS) in place, document control, technical records, external service including referral laboratory testing, internal audits, management review, environmental and accommodation, and safety. Support also included training, supportive supervision and mentoring,

There are 21 laboratories nationwide and NICD support to for quality improvement and plans to accredit 5 laboratories and/or score 5 stars based on WHO SLIPTA by the end of 2014.

NICD will implement the project in line with the national laboratory strategic plan. It will coordinate activities with partners to avoid duplication and to strengthen activities where NICD provides specific support that is not provided by partners e.g. External Quality Assurance/Proficiency Panel Testing (EQA/PT) for patient monitoring including CD4 and viral load testing. The activities that will that require close coordination with partners include QMS implementation and training. The NICD assumes responsibility for EQA/PT for patient monitoring tests and regular proficiency panels are distributed to all participating laboratories in lesotho. The NICD will therefore

ensure that the laboratories are enrolled in the appropriate program and triangulate information from EQA/PT with ongoing QA implementation for continuous quality improvement.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	50,000

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	**10457**		
Mechanism Name:	**Quality Assurance Initiatives for Lesotho Laboratories**		
Prime Partner Name:	**National Institute for Communicable Diseases**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	400,000	0

Narrative:

Main objective is to assist laboratories to improve quality of diagnosis and patient monitoring and attain readiness for accreditation through mentoring and coaching of the laboratory staff. Major activities include
Activities:
1) Quality Assurance implementation:
Assist in mentoring the QA manager in terms of roles and responsibilities (on-site mentoring as well as formal training e.g. SANAS or ACILT). Assist in strengthening the Quality assurance Unit of MOHSW by active assistance and by providing opportunities for training such that the necessary knowledge and skills are obtained to

assist the MOHSW reach its objectives.
On-site mentoring will be provided that will strive to avoid disrupting the routine activities. Planned visits to laboratories for three months will be undertaken to ensure that there is sufficient time to cover test methods in terms of QA requirements. At the end of the period, processes will be assessed for completeness and milestones documented for processes that are not complete. Information will be collated to assess infrastructure by lab, range of staff employed, range of test procedures, qualifications, reporting structure, and other elements required for a functional QA system, i.e. a gap/needs analysis.
Continue to enroll and monitor all Lesotho laboratories in relevant EQA/PT schemes for chemistry, microbiology, hematology and molecular tests.

2) Strengthening Molecular Diagnostics: Early Infant Diagnosis (EID) and viral load:
NICD will provide technical assistance in technology transfer including additional training, assessment of readiness to perform routine PCR testing, equipment/reagent procurement, enrollment in PT schemes. It will support PCR and viral load and other tests and develop capacity of the central laboratory to perform these tests in the long term. NICD will assist with a re-testing program of 10% of EID samples tested in Lesotho and EQA/PT schemes.

NICD will continue supporting the referral testing services and transfer the technology and skills to in-country laboratory by the need of FY 2012 COP
NICD will provide M & E in terms of the number of infants born to HIV positive women who received an HIV test within 12 months of birth, and establishing databases
NICD will provide necessary expertise in areas of Antiretroviral Drug resistance testing including technology transfer, equipment/reagent procurement, and enrollment in PT schemes activities
3) Biosafety:
Support the development of safety policies and guidance to improve safety and establishment of programs for occupational health and waste management.

4) Equipment maintenances and procurement:
NICD will assist the MOHSH in support the equipment maintenance including development of guidelines on preventive and curative maintenance. It will also support the procurement of equipment accessories and supplies as a stop-gap measure
5) Training:
NICD will support and facilitate appropriate in-service training using the African Center for Integrated Laboratory Training (ACILT), for courses including EID, National Laboratory Strategic Planning and Biosafety. Training workshops on laboratory equipment preventive and curative maintenance

Implementing Mechanism Details

Mechanism ID: 10458	Mechanism Name: MCHIP - Maternal and Child Health Implementation Program
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 4,252,500	
Funding Source	**Funding Amount**
GHP-State	4,252,500

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The MSH/BLC project is aligned to contribute towards two Partnership Framework goals: to reduce morbidity and mortality and provide essential support to Basotho people living with or affected by HIV and AIDS through expanding access to high quality treatment, care, and OVC services by 2014; and, the human resource capacity for HIV service delivery is improved and increased in 3 key areas (retention, training and quality improvement) by 2014. The project reaches 47,000 OVC and care givers in five districts (Quthing, Mohale's Hoek, Qacha's Nek, Mokhotlong, and Thaba Tseka). The project goals are: 1) technical and institutional systems strengthened and capacity built in Lesotho; 2) community-based outreach program developed that can provide needed community-based care and support services and effective tracking and referrals to clinical settings for people infected with and affected by HIV/AIDS; 3) a mechanism developed and strengthened for providing needed community-based care for OVC and; 4) national policy and guidelines strengthened for comprehensive community-based care and a supportive environment for OVC affected by HIV/AIDS. The MSH/BLC capacity building and sub-granting strategy is focused on ensuring that program activities are fully owned by local entities. Specifically, BLC supports local community and government structures; Strengthens government systems in leadership and coordination. Vehicle needs Transport and communication between communities is almost exclusively limited to Four-wheel drive vehicle, foot or pony since existing paths are often too narrow or steep for even a motorcycle to pass. For timely and effective implementation and monitoring of the project activities, the BLC project will require robust and reliable four wheel drive vehicle.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	250,000
Human Resources for Health	450,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support

Budget Code Information

Mechanism ID:	**10458**		
Mechanism Name:	**MCHIP - Maternal and Child Health Implementation Program**		
Prime Partner Name:	**JHPIEGO**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	0	0

Narrative:

MCHIP will continue its successful work to strengthen the CHAL Schools of Nursing capacity to house and educate nursing and midwifery students. Building upon work undertaken in FY13, MCHIP will strengthen education for nursing and midwifery students through increased rural clinical placements; and strengthen the ability of the CHAL Schools of Nursing to train and educate nursing and midwifery students.

MCHIP will continue its ICT component with a focus on improving learning methods (students), teaching methodologies (teachers/educators) as well as systems (performance management, teacher-school communication)

to ensure that the CHAL SONs are well-equipped to graduate students better prepared for "today's world". MCHIP will continue to work hand-in-hand with the CHAL SONs to expand the rural clinic placement program. As the majority of primary health care is provided in the rural area, it is essential to have newly graduated nurses achieved competencies in order to be the 'front line' worker. New graduates need the competency to assess, diagnose and treat common conditions. Expanding on these rural clinical placements will allow the nursing students at CHAL schools to expand their clinical knowledge by increasing their contact with a variety of clinical experiences and cases as well as exposing them to the rural community health environment that they are likely to be placed in post-graduation.

MCHIP will continue to work closely with CHAL to strengthen the SON's faculty and clinical staff. Nursing faculty are often dependent upon hospital staff for clinical instruction of their students but many of these nurses have not been trained to serve as clinical instructors for the SON. The clinical setting is where nursing students are able to apply and integrate their theory-based knowledge from the classroom into clinical skills in the hospital or community setting. To produce competent, quality graduates, faculty and preceptors must have the tools and skills necessary to implement the competency-based curriculum. Activities will continue to focus on the following key areas: Clinical education: Preceptor development, preceptor TOT development, technical updates, clinical objective tools, clinical quality improvement, and linking didactic to clinical education; Didactic education: Training in effective teaching skills and student performance assessment, development of standards and competencies, and the provision of ongoing supportive supervision; Mentorship: Provision of in-depth supportive supervision of faculty and clinical preceptors; and Clinical site and school collaboration: Support the building of relationships between the schools and clinical sites - a key to the success of good clinical experiences for nursing students.

The project will continue to support the development of an enabling regulatory environment for nursing education through strengthening the Lesotho Nursing Council, focusing on policy/regulatory environment and advocacy issues. Expected results include increased capacity of the LNC to develop and strengthen the regulatory framework of Lesotho; increased capacity of LNC operational procedures, through implementation of the LNC strategic plan and a strengthened LNC board; and increased capacity of the LNC's current registration and licensing processes.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	4,252,500	0

Narrative:

MCHIP will continue to support the MOHSW and the MC Technical Working Group (TWG) to finalize the development of VMMC guidelines, strategy, and training materials for Lesotho, inclusive of EIMC, as part of the MOHSW's larger Prevention Program. As part of this MCHIP introduce and adapt a VMMC operational guide for Lesotho and support the development of framework and service delivery model to scale up adult VMMC.

MCHIP's Lesotho based VMMC Technical Advisor will provide direct support and oversight of MCHIP's activities, with support from Jhpiego's regional and headquarters VMMC technical experts. Geographic coverage will be national as policies and guidelines created are to cover the country. Facilities have not yet been agreed upon with the MOHSW so a clear geographic area for service delivery cannot yet be identified. Quality assurance standards will be developed in accordance with international standards and guidelines and facility staff oriented. A system of provider certification will also be established. Jhpiego will meet with facilities to discuss the project and develop shared expectations and working assumptions in MOUs with the District. MCHIP will procure supplies and equipment necessary for services for agreed upon sites, including devices, surgical instruments, gloves, sutures, local anesthesia, and other consumables. MCHIP will continue to work with communications organizations such as PSI, and together with them as well as the MOHSW and the TWG to develop IEC materials.

Up to three trainings for 16 service providers each are planned. MCHIP will also aim to conduct three five-day MC counseling training course for up 18 participants each. This program builds upon Jhpiego's competency based clinical training approach, and the WHO/UNAIDS/Jhpiego learning package in Male Circumcision under Local Anesthesia, and provides a unique opportunity to early infant circumcision – which the MOHSW is strongly in favor of rolling out. MCHIP will provide supportive supervision and follow-up for newly trained MC service providers, health educators and counselors in their workplaces. Upon MOHSW endorsement task sharing and task shifting to scale up VMMC will be piloted.

Implementing Mechanism Details

Mechanism ID: 10459	**Mechanism Name: Strengthening Clinical Services (SCS) Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 5,550,000	
Funding Source	**Funding Amount**
GHP-State	2,991,176
GHP-USAID	2,558,824

Sub Partner Name(s)

ALAFA (Apparel Lesotho Alliance to Fight AIDS)	Baylor University International Pediatric AIDS Initiative	LENASO (Lesotho National AIDS Service Organisations)

Overview Narrative

The Strengthening Clinical Services project supports all 4 of the Partnership Framework goals: 1): HIV incidence reduced by 35%; 2) reduce morbidity and mortality and provide essential support to PLWH; 3) HR capacity for HIV service delivery is improved and increased; 4) Health systems are strengthened.

The project's main targets are: • 100% of facilities offer comprehensive PMTCT services by the end of 2011. • 100% of facilities offer HIV care & support by the end of 2013. • 90% of facilities offer HIV treatment initiation by the end of 2013. Coverage of activities and services is across all districts of Lesotho, targeting all Basotho in need of HIV prevention, care, and/or treatment services. Project activities are designed to meet 5 goals: 1) High-quality, comprehensive, integrated, client-centered HIV services at health facilities 2) Family-centered HIV services available at all points of contact 3) Universal access to comprehensive PMTCT services 4) Strengthened national health system 5) Up-to-date national policies, protocols, & guidelines

An underlying theme central to activities under SCS is to support the MOHSW and work within existing systems to ensure sustainable programming and local ownership of the project's activities and results. Several of the implementing partners are local organizations and this project works closely other organizations to promote local ownership of project interventions.

The effectiveness of the project is measured by the extent to which the objectives and targets are met at the facility and population levels. The PEPFAR NGIs and other indicators have targets against which actual performance/achievements is compared. The major source of data for the indicators is the service data from the service sites.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	150,000
Gender: GBV	50,000
Gender: Gender Equality	50,000
Human Resources for Health	2,000,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**10459**
Mechanism Name:	**Strengthening Clinical Services (SCS) Project**
Prime Partner Name:	**Elizabeth Glaser Pediatric AIDS Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	500,000	0

Narrative:

The SCS project provides adult HIV care & support services at health facilities and communities in all districts of Lesotho; one of the project's targets is to support 100% of facilities to offer HIV care & support by the end of 2013. Currently we are in 201 HFs. With a client-centered approach, the patient becomes the focus; clinical services are made readily accessible to each client in an integrated approach. When appropriate, patients are referred for appropriate care at their own health center, thereby reducing burden on overcrowded hospitals. SCS uses the m2m program where present, building on their model of pairing mentor mothers with HIV-positive women.

SCS supports providers to offer routine screening and treatment of all pregnant women and families for OIs/STIs. ALAFA clinics provide free STI screening and treatment for all apparel workers. To strengthen the follow-up of HIV-positive workers enrolled in care, all ALAFA patient records are integrated into an electronic database enabling program staff and ALAFA service providers to effectively track patients who have missed their ARV refills, missed clinic visits, or lab evaluations. Lists generated centrally are shared with Adherence Support officers at

clinics who track patients within the factories through HIV coordinators and peer educators.

In FY12, LENASO will conduct bi-directional outreach activities to improve adult care & support services at the community level. The strategy includes working with the Community Councils as the "gateways" to HIV service delivery. Focal Persons (volunteers located in each community councils) link communities with health facilities and promote utilization of health services. This approach reaches men, youth, couples, and others who might not use traditional programs. Strategies like Child Health Days, Sports against AIDS tournaments, public gatherings, and focus groups are conducted to increase uptake of HTC. HIV-positive clients are linked to health facilities for care services. In Year 1 of SCS, coverage for care services was about 80%. Quality of care assessments will be conducted in 2012.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	200,000	0

Narrative:

Within PMTCT, Adult, Adolescent and pediatric HIV Clinics, EGPAF will continue to support ICF (TB screening of HIV positive patients) as per national guidelines, ensuring that TB Suspects are adequately assessed and all HIV and coinfected TB patients are referred to the appropriate clinics for ART initiation or initiation of antituberculous regimen respectively. Within textile industries and private clinics, these services will continue to be supported. TB screening within these settings (and potentially HTC settings) and establishment of proper linkages to appropriate treatment are very important to reduce the impact of the TB/ HIV syndemic, and, to reduce the drop off rate between coinfected patients tested for HIV and initiated on ARVs. Based on the national guidelines, all TB unifected HIV patients will be enrolled on IPT, in collaboration with the PEPFAR TB/ HIV prime partner (ICAP). An integrated training program is being developed by both partners to ensure all HCWs in GOL and CHAL facilities receive training, mentoring and supervision in both HIV Care and treatment and TB/ HIV. The SCS project, along with the TB partner ICAP, will also continue to support the integration of all treatment and care registers, following the WHO interlinked register model. Support has been provided for the review of all data collection and monitoring tools and these will be disseminated for use in GOL health facilities in FY2012. EGPAF and Baylor will continue to participate in TB/ HIV TAC meetings, providing TA to the MOHSW and supporting HCW trainings in IPT and IC for pediatrics and PMTCT clients.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	200,000	0

Narrative:

At hospitals (total of 17), EGPAF establishes nutrition corners where mothers are counseled on IYCF and children and mothers are screened for malnutrition. Children of unknown status are offered PITC. Baylor trains and mentors the providers at nutrition corners to support HIV-infected and malnourished children. Nutrition corners

and nutrition activities such as distribution of micronutrients and IMAM (Out- patient Therapeutic program) are integrated into MCH.

SCS subgrantee Baylor will continue to focus on the provision of PSS for children and adolescents by making PSS clubs available to HIV-positive adolescents and Ariel Clubs/Camps for HIV-positive children, which provide education and social connections for children affected by HIV. Where Baylor is not present at the district-level, EGPAF will establish and support Ariel Clubs which will be handed over to Baylor. Consultative meetings will be held with the MOHSW to inform the process including a needs assessment for psychosocial counseling training for health providers.

Support groups for HIV-infected adolescents (Teen Clubs) were established in Qacha's Nek and Leribe SCOEs. The teen clubs have ongoing monthly meetings where education is delivered to adolescents on health related issues and opportunities to share experiences. Additional teen clubs will be established in FY12. A standard curriculum for adolescent support groups is being developed by Baylor for adaptation and use with all Teen Clubs in Lesotho. Baylor physicians, social workers and EID/HTC counselors will participate in Mamohato Camps, in partnership with Sentebale and the Association of Hole in the Wall Camps for psychosocial support and education for HIV-infected children aged 10-18.

Specialist psychology services being provided at Baylor's Maseru COE and a "Play Therapy and Psychosocial Stimulation" program for severely malnourished children will be expanded. A Psychosocial training curriculum for health care providers will be finalized. HCWs will be trained on psychosocial support and screening for psychological disorders.

SCS will engage in developing effective 2 way referrals for EID (DNA PCR) between PMTCT, MNCH settings and national laboratories.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	350,000	0

Narrative:

PEPFAR will support implementation of workplace programs in settings where HIV Work Place Policies exist. An example of such a setting in Lesotho where we will support this is in the textile industry. Currently, challenges exist in HIV/ AIDS service provision in textile factories as this is almost fully paid for by ALAFA. EGPAF will work with ALAFA to explore and establish sustainable approaches such as health financing/ stellite clinics to ensure services are available to diagnosed and undiagnosed factory workers and their families.

As a way to advocate for institution of workplace policies in the public sector, PEPFAR will support the establishment of a crèche in the MOHSW to ensure working nursing mothers (and fathers) in the establishment are supported, educated and empowered in proper and exclusive breastfeeding techniques and therefore all women, irrespective of HIV status provide proper nutrition to their babies. This positive example will be evaluated as best practice and scaled up by the MOHSW to other government and public sector in subsequent years (context from PMTCT Acceleration Plan).

EGPAF will continue to support ALAFA's program, expanding PMTCT and HIV care and treatment services to more workers in private textile factories. In addition, EGPAF will build and expand the capacity of its other local partners for USG supported programs, developing an exit strategy from subgrantee status for them by 2015.

TA for MOHSW HSS activities (in HIV/ AIDS policy development, guidelines review and service provision and nutrition activities) will continue to be supported, as required, within the FHD and the DDC.

A Public Private Partnership between PEPFAR, MOHSW and with Johnson and Johnson/ University of Cape Town on Management Development for central and district level managers for PMTCT, HIV Care, HIV Treatment, and other HIV related services (such as laboratory services, SCM, Local Councils) will be supported in FY2012. This intensive 1 year program will be evaluated by partners.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	2,500,000	0

Narrative:

Since launching in Feb. 2010, SCS continued to ensure new facilities were supported to initiate PMTCT services, while focusing on improving quality of services provided in all districts. Between Feb 2010 and Jun 2011, 31 additional sites were aided by SCS to provide PMTCT services, bringing the national total to 203 sites. Targets for FY12 are for 9,536 pregnant women to receive ARVS for PMTCT (2,861 receiving ART). Progress will be measured and reported to PEPFAR quarterly through the standard MOHSW reporting tools, supported by a more in-depth mid-project assessment. In FY12, SCS will build the capacity of health workers by a) supporting MOHSW to roll out the 2nd phase of the national PMTCT trainings; b) supporting the MOHSW in accreditation of new PMTCT sites, especially private facilities; c) ensuring provision of high quality PMTCT services through on-site mentoring and supportive supervision.

To improve retention and adherence, HIV-positive mothers and their infants will receive all HIV services within MCH unit. Thus, providers are able to keep track of the infant's health, provide CTX, do DNA/PCR test at 6 weeks, initiate treatment if positive, and continue to monitor both mother and baby up to 18 months post-delivery before referral to their clinics. More activities in FY12 under MTCT and care and treatment for HIV positive mothers and

children are detailed under the acceleration plan.

At 19 hospitals, SCS will strengthen nutrition corners where caretakers are counseled on infant feeding and children/mothers are screened for malnutrition. Children of unknown status will receive PITC. In FY12, subrecipient Baylor will continue to train and mentor providers at nutrition corners to support HIV-infected and malnourished children. LENASO, a CBO will mobilize communities to improve ANC attendance and facility deliveries.

SCS's support for MOHSW District Health Information Officers to verify data will be expanded. EGPAF is working on a more structured and formalized way of verifying these data including the use of standard verification tools (to be developed in discussion with the MOHSW in FY12). PMTCT Impact Evaluation, FHDs and National ART Costing will be conducted.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	1,000,000	0

Narrative:

As of Jun 2011, the SCS project was supporting 196 facilities to provide adult ART services in all 10 districts. During FY12, EGPAF will support 10 more facilities to provide ART and to initiate 32,733 adults on ART. The SCS project strengthens ART delivery at facilities, through technical assistance, on-site mentoring, clinical training, support supervision, human resource building, and supporting the national-level policy development process. SCS does not procure medications or implement a parallel system.

Health worker training and capacity building is one of the key activities of SCS and is also one of the strategies of PEPFAR. Skills-based trainings will be conducted for MOHSW staff to equip them with relevant knowledge and skills. These are short (2 -10 days) didactic courses, 1-2 hours onsite training, followed by on-site mentorship and support supervision. The onsite mentorship and supportive supervision aims at enhancing health workers skills, confidence, and competence to ensure that knowledge acquired during didactic training is translated into practical action. At the district level, update training will be provided to health providers who have already received initial trainings. For health providers who are new, comprehensive trainings will be facilitated. SCS will enhance pre-service training of medical students (finalist) in health training institutions through IMAI. This is paramount and cost effective as it will enable the GoL build sustainable local capacity with the skills needed to appropriately manage HIV patients. It is anticipated that through this approach, sustainable services will be assured beyond SCS support.

SCS will improve the capacity for all staff along the health information continuum to be better managers and users of the data they generate by developing SOPs, checklists, and feedback processes. SCS M&E Officers will provide

support to District Health Information Officers and the site-level data clerks to improve their collection and reporting of complete, accurate and quality data, and their data management and utilization skills, through regular supportive supervision, mentorship, and onsite trainings.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	800,000	0

Narrative:

The SCS project has contributed to scaling up pediatric HIV treatment, having newly enrolled 783 children in treatment in the first half of FY11 at 172 health facilities across the country. During FY12, SCS plans to enroll an additional 1,012 children in treatment and to scale up the number of facilities that offer pediatric treatment to a total of 188 sites.

To reduce loss to follow-up and improve adherence, HIV-positive mothers and their exposed or positive infants will continue to receive all their HIV services within the setting of the regular MNCH unit (at hospitals). This way, providers will be able to keep track of the infant's health, provide CTX prophylaxis, perform DNA/PCR testing at six weeks, initiate treatment if positive, and continue to monitor both mother and baby up to 18 months after delivery. At that time, HIV-positive children will be referred to the Baylor SCOE.

In FY12, SCS will continue to support trainings for health care workers in pediatric treatment, followed by on-site mentoring and support supervision.

Five EID/HTC counselors were hired to conduct Provider Initiated HIV Testing and Counseling (PITC) at Queen Elizabeth ll, Machabeng, Motebang, Botha Bothe and Mokhotlong Hospitals. A large number of children and caregivers in pediatric wards and outpatients departments were screened for HIV through this program, with over 90% at each site being discharged from the hospital with a known and documented HIV status throughout the reporting period.

SCS District Clinical Coordinators in the districts continually work with the MOHSW District Health Information Officers to verify data submitted by facilities before they are submitted to centrally. EGPAF is working on a more structured and formalized way of verifying these data including the use of standard verification tools (to be developed in discussion with the MOHSW in FY12).

Implementing Mechanism Details

Mechanism ID: 10480	Mechanism Name: PACT Umberella Granting Mechanism
Funding Agency: U.S. Agency for International	Procurement Type: Cooperative Agreement

Development	
Prime Partner Name: Pact, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 750,000	
Funding Source	**Funding Amount**
GHP-State	750,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Pact is implementing a 5-year Cooperative Agreement which seeks to provide a mechanism for implementing a grants management program that includes targeted technical assistance and capacity development for HIV/AIDS programs. The program is aimed contributing to the achievement of the goals of the Lesotho Partnership Framework (2009-2014); PEPFAR Strategy and the Lesotho's National AIDS Strategy (2006-2011). In collaboration with partner organizations, Pact's program specifically contributes to the realization of goals 1, 2, and 4 of the partnership framework. The overall goal sought is to "Reduce the impact of HIV and AIDS and improve health care for Lesotho". Pact's primary objectives are:

1. To prevent HIV transmission through multiple strategies that promote abstinence, faithfulness, partner reduction and other prevention activities including promotion of condom use

2. To provide quality, comprehensive and compassionate care and support services for orphans and other vulnerable children

Pact's partners are awarded PEPFAR funding through a competitive process to implement programs in Sexual Prevention; Orphans and Vulnerable Children (OVC) services and Health System Strengthening (HSS). Through the sub-granting mechanism, Pact will continue to build capacities of community based organizations to provide HIV services to the communities. To ensure adequate and quality technical support to the grantees, Pact will provide on-going technical support to implementing partners through training, mentoring and supportive supervision. In addition, technical input to strengthen national HIV/AIDS strategies and policies will be provided.

Pact's program shall include cross cutting mechanisms for economic strengthening, and education. With regard to gender-based violence, Pa

Cross-Cutting Budget Attribution(s)

Gender: GBV	10,000
Gender: Gender Equality	30,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10480**		
Mechanism Name:	**PACT Umberella Granting Mechanism**		
Prime Partner Name:	**Pact, Inc.**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	750,000	0

Narrative:

Pact's overall goal and strategies is to prevent HIV transmission through multiple strategies aimed at changing behavioral and social structural characteristics related to increased risk for HIV infection by influencing attitudes, skills, normative perceptions, and other mediators that promote abstinence, mutual faithfulness, partner reduction and other prevention activities including promotion of condom use

Pact partners to implement sexual prevention activities include: ADAAL, ALAAFA, Kick4Life, LENEPWHA and PHELA. Target population include; factory workers, youth aged 10-24 years, adults aged 25 & above, PLWHAs and individuals in relationships. The prevention program will cover 6 districts of Lesotho including; Mafeteng, Butha Buthe, Quthing, Leribe, Maseru and Mohale's hoek.

Pact will focus on providing program beneficiaries with a comprehensive package and will link all its partners with PSI LETLAMA that will be providing sevices beyond abstinence and being faithful but also other prevention such as

HIV prevention services which include:
1) Abstinence through BCC messages focusing on delayed sexual debut for youth 10-18 years old and abstinence/mutual fidelity and/or partner reduction messages for youth aged 15-24 years old; Pact will use an HIV/AIDS peer education model to provide information on HIV risks, benefits of behaviors promoted and life skills to build self-esteem and self-efficacy; "OneLove" campaign on partner reduction and use of power of sports in HIV prevention programs will be promoted, reduction in transactional, inter-generational sex and addressing related social norms influencing risky behaviors as well.
2) Behavior change counseling to supplement HIV/AIDS education i.e one-on-one risk reduction counseling and community/school-based alcohol counseling to individuals understand the need for behavior change.
3) Provision of information on correct and consistent condom use and linking people to other relevant services to increase access to condoms, HTC, prevention and treatment of STIs.
4) Strengthening capacity of HIV prevention service provision structure through improved community infrastructure, and personnel training to deliver quality HIV prevention services. ie training personnel on BCC message design and development for production of more accurate and critical information to support behavioral change
5) Assessing GBV-related activities and improve them according to the context
6) Strengthening PMTC referrals from communities to health facilities

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

Pact's overall goal and strategies is to prevent HIV transmission through multiple strategies aimed at changing behavioral and social structural characteristics related to increased risk for HIV infection by influencing attitudes, skills, normative perceptions, and other mediators that promote abstinence, mutual faithfulness, partner reduction and other prevention activities including promotion of condom use

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1) Abstinence through BCC messages focusing on delayed sexual debut for youth 10-18 years old and abstinence/mutual fidelity and/or partner reduction messages for youth aged 15-24 years old; Pact will use an

HIV/AIDS peer education model to provide information on HIV risks, benefits of behaviors promoted and life skills to build self-esteem and self-efficacy; "OneLove" campaign on partner reduction and use of power of sports in HIV prevention programs will be promoted, reduction in transactional, inter-generational sex and addressing related social norms influencing risky behaviors as well.

2) Behavior change counseling to supplement HIV/AIDS education i.e one-on-one risk reduction counseling and community/school-based alcohol counseling to individuals understand the need for behavior change.

3) Provision of information on correct and consistent condom use and linking people to other relevant services to increase access to condoms, HTC, prevention and treatment of STIs.

4) Strengthening capacity of HIV prevention service provision structure through improved community infrastructure, and personnel training to deliver quality HIV prevention services. ie training personnel on BCC message design and development for production of more accurate and critical information to support behavioral change

5) Assessing GBV-related activities and improve them according to the context

6) Strengthening PMTC referrals from communities to health facilities

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

Pact implements a multifaceted HIV prevention program in nine out of the ten districts of Lesotho. Through five partners (ADAAL, ALAAFA, Kick4Life, LENEPWHA and PHELA), it implements tailored interventions for specific target audiences including, youth aged 10-24 years, adults 25years+, and the most at risk population of immigrant factory workers. The program targets a total of approximately 53,308 individuals with 37,000 of them being youths and community individuals reached with individual and/or small group level preventive interventions primarily focused on abstinence and/or being faithful; while 16, 308 are MARPs.

Pact's program provides beneficiaries with a comprehensive HIV sexual prevention services on promotion of Abstinence and faithfulness, reduction in Multiple Concurrent Partnerships (MCP), and provision of correct information on condom use and its distribution. Additionally, Pact implements structural interventions to cause social change aimed at addressing reduction in transactional, inter-generational sex and related social norms that influence risky behaviors such as gender-based violence, reduction of stigma and discrimination, and drug and alcohol abuse. Beneficiaries especially the in-school youth are also provided with individual behavior counseling services to supplement HIV/AIDS education and community dialogues on MCP reduction.

Pact is not the direct implementer of programs at the community but works through the five CBOs above. As part of this grant, Pact provides organizational and technical capacity development services matched with grants to local partners to promote HIV prevention. Pact conducts in-depth organizational capacity assessments of each local

partner and develops an institutional capacity building plan that targets each organization's weaknesses. The assessments are followed by training, mentoring, and oversight through site visits, technical assistance, and reporting and performance evaluations in order to improve their data quality management skills, program evaluation and financial management.

Implementing Mechanism Details

Mechanism ID: 10739	**Mechanism Name: Support to the Ministry of Health and Social Welfare in Lesotho for HIV/AIDS**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Welfare – Lesotho	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: PR/SR	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 1,530,000	
Funding Source	**Funding Amount**
GHP-State	1,530,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY2012 COP, the following activities will be implemented

1) Infection Control Measures: Procure N95 Masks,paper masks,sputum jars, refurbishment of St James Hospital, Mantšonyane to accommodate TB Patient separately from general patients to enhance infection control.

2) TB Monitoring and Evaluation: TB/HIV will be supported through procurement of lap top. Strengthening Advocacy, Communication and Social Mobilization (ACSM) nationally will be done through commemoration of World TB day. Activities will include development and dissemination of IEC material according to the current Stop TB Partnership tool kit and support branding of TB messages.

3) Site assessment and supportive supervision: In order to help set a baseline for determining the true magnitude of the TB problem in the country, the 2010 external programme review recommended to conduct at least one TB

disease prevalence survey in the country before 2015.According to the WHO 2010 report the prevalence of TB is 635/100,000. Information gathered through prevalence survey will assist the programme to design targeted activities with clear knowledge on where to put more efforts. There is also a concern of low notification in other districts like Thaba-Tseka and without the survey it becomes difficult to appreciate that indeed the TB prevalence is declining in such districts.

4) Human resource-training: The program will support admin and technical staff to implement the TB-HIV coordination at national and district levels. As part of human resource strengthening, the National TB Program (NTP) plans to send at least two officers to attend IUATLD trainings and conference.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	300,000

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	**10739**		
Mechanism Name:	**Support to the Ministry of Health and Social Welfare in Lesotho for HIV/AIDS**		
Prime Partner Name:	**Ministry of Health and Social Welfare – Lesotho**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVTB	200,000	0
Narrative:			
In FY2012 COP, the following activities will be implemented			

1) Infection Control Measures: Procure N95 Masks,paper masks,sputum jars, refurbishment of St James Hospital, Mantšonyane to accommodate TB Patient separately from general patients to enhance infection control.
2) TB Monitoring and Evaluation: TB/HIV will be supported through procurement of lap top. Strengthening Advocacy, Communication and Social Mobilization (ACSM) nationally will be done through commemoration of World TB day. Activities will include development and dissemination of IEC material according to the current Stop TB Partnership tool kit and support branding of TB messages.
3) Site assessment and supportive supervision: In order to help set a baseline for determining the true magnitude of the TB problem in the country, the 2010 external programme review recommended to conduct at least one TB disease prevalence survey in the country before 2015.According to the WHO 2010 report the prevalence of TB is 635/100,000. Information gathered through prevalence survey will assist the programme to design targeted activities with clear knowledge on where to put more efforts. There is also a concern of low notification in other districts like Thaba-Tseka and without the survey it becomes difficult to appreciate that indeed the TB prevalence is declining in such districts.
4) Human resource-training: The program will support admin and technical staff to implement the TB-HIV coordination at national and district levels. As part of human resource strengthening, the National TB Program (NTP) plans to send at least two officers to attend IUATLD trainings and conference

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	760,000	0

Narrative:

In FY2012, the following activities will be implemented
1) Expansion and strengthening the National Quality Assurance Program. To ensure high quality services are being offered by all health facilities providing diagnostics and monitoring services quality assured and tiered laboratory services will be supported. MOHSW will implement the WHO-AFRO Stepwise laboratory accreditation approach in all facilities. The support will include refresher trainings, site assessment and supportive supervision and EQA schemes. The QA Unit will support the preparation and distribution of the HIV Rapid proficiency panels and quality control samples to all 266 facilities twice a year. TB smear microscopy panels will be prepared, distributed and on site assessments will be conducted. Annual Quality Review meetings will be conducted, where all participants will be sharing their achievements, experiences and challenges.
2) Strengthen referral test services and scale up EID: Referral of samples has been maintained through courier services and sample transporters. Facilities have benefitted from the installed Toll free line for the speedy access of DNA-PCR results, timely management of exposed infants has been achieved and the activities will be continuing and referral system will be strengthened through courier services. In FY2012, 65% of infants born to HIV-positive women will receive virologic HIV testing (DNA PCR) in the first 2 months of life.
3) Equipment maintenance: In order to provide uninterrupted laboratory services, MOHSW will Rapid support

equipment maintenance and validation through vendor contract for major laboratory equipment. Procurement of minor equipment will also be provided.
4) Procurement of minor equipment and laboratory supplies and inventory management: Laboratory Supply Chain Management will be strengthened to ensure that there is constant supply of reagents/testing kits for PMTCT clients
5) Expansion and Strengthen CD4 monitoring: CD4 monitoring services will be available at hard to reach facilities with high workload, six POC analyzers, reagents and consumables will be procured, as CD4 testing is being done by non-laboratory personnel intensive supportive supervision will be conducted.
6) Minor renovation and furnishing with basic equipment will be supported for 5 hospital/health center laboratories. This will improve the workflow laboratory diagnosis and monitoring, biosafety, storage and cold chain system. The health center renovation will ensure the PMTCT lab packages are provided at primary health care level, laboratory services will be established at health centers. This included renovation of facilities and furnishing with minor equipments. .

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	160,000	0

Narrative:

In FY2012 the following activities will be implemented.
1) Two specific surveys will be conducted i.e. the HIV Sentinel Surveillance and Drug Resistance survey. They will assist the ministry to monitor the extent and trends of the national HIV and AIDS Epidemic besides the DHS and also contribute to the overall national strategy of the HIV and AIDS and STI. These surveys have been partially supported through the Global Fund Round 8, Phase 2 year 3. The COP2012 budge will be used to fill the finical gaps required to complete the surveys.
2) Support DHMT: will continue mentoring 10 districts to collect, clean, analyze, use and demand data. The formal feedback and data utilization mechanisms through Performance Reviews will be strengthened. All the districts, the central programs and the Health sector will continue to be supported to execute their performance reviews. Four performance review meetings will be held at the district, central and one annual review meeting in which all stakeholders participate. The M&E Unit will continue to sensitize staff working at all levels, including health leaders, on data demand and use concepts emphasizing the potential programmatic benefits of using data for decision making.
3) Strengthening institutionalized Routine Data Quality Assurance (RDQA) at district level: Poor data quality limits health leaders at the level ability to use data for evidence-based decision making and has a negative impact on facilities' strategic planning activities and their efforts to advocate for resources. To address data quality concerns the M&E Unit is institutionalizing Routine Data Quality at district level. The Unit will conduct one M&E system assessment and continue to mentor RDQA champions at district level and support the 10 districts to carry out data verifications per quarter. The system will be assessed to establish its capacity to manage data and also monitor

capacity improvements and performance of the data management and reporting system at the level
4. Strengthening Strategic Information (SI) HR capacity
The unit in collaboration with Institute for Health Measurement (IHM) and will facilitate access to regional and in-country M&E training events.
The M&E Unit will continue to sensitize staff working at all levels, including health leaders, on data demand and use concepts emphasizing the potential programmatic benefits of using data for decision making.
SI seeks to secure four positions to support and ensure functionability as well as sustainability of the integrated HMIS.
Two (2) HMIS officers trained in Regional M&E curricula
60 data clerks trained in M&E concepts locally; data collection tolls and reporting mechanisms
Total In service training completed is 125

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	260,000	0

Narrative:

Human resource
The Ministry of Health will continue support personnel for efficient implementation of cooperative Project programmatic activities towards improved health services. The following positions will be supported with salaries and administrative and technical staff already employed. These include project Manager, Logistics Coordinator, Administrator, administration assistances (2), LIS Focal person, Laboratory Technologists and Data Clecks (10) and 60 M & E data clerks.
In FY 20212, there will be a need to strengthen human resource at health centre level-employment of ten (10) lab data clerks will be required to supplement existing staff and task shift activities from the laboratory technologists. The newly developed data ware house requires technical support by these people. There is need to put in place two (2) Information officers and retain some of the key HMIS personnel (3) is very crucial. An addition of one (1) M&E Officer and Two (2) HMIS officers also stems as very essential. These key HIMS personnel ensure proper data management while also strengthening data flow and reporting mechanisms. The MOHSW will support and supervise the 60 data clerks. They will be provided refresher training in basic M&E especially honing down to MOHSW data collection and reporting tools

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	150,000	0

Narrative:

Lesotho's HIV prevalence is 3rd highest in the world at 23% and a generalized HIV epidemic. An estimated 290,000 people are living with HIV. Currently, only about 62% are on antiretroviral therapy. Approximately 21000

new adult infections occur every year.
Key gaps and challenges in the HTC program include low levels of HTC. Limited access of HTC services by most at risk populations (sex workers and MSM), quality assurance for HTC services (pre-test and post-test counseling) is inadequate. Other challenges include inadequate linkages and retention into care and treatment to ensure continuum of response.
Key Lesotho priority actions include expanding scale up of quality HTC services to ensure timely and universal access to prevention, treatment and care. An effective HTC program will result in a larger number of people with HIV receiving an early diagnosis of, and care and treatment for, HIV. Approximately 572,000 HIV tests are required every year with incremental increases as the program grows. Currently resources for HTC commodities and supplies and HTC personnel are cost shared between the Global fund, Government of Lesotho and PEPFAR. In addition PEPFAR has a targeted HTC programs for mobile populations and home based HTC through the TARGET program. Community mobilization, promotion of HTC activities and creation of demand is currently also funded by PEPFAR through the LETLAMA project.

The HTC funding in this grant will mainly focus on improving the coordination of the Provider initiated counseling in health facilities both in public and private settings;
(1) Strengthening of provision of HTC services to support scale up of the treatment program with focus on PMTCT, VMMC, TB, HIV care and Treatment clinics, STI, outpatients and inpatient wards.
(2) Support and strengthen linkages to ensure continuum of response from testing into care and treatment. Linking HTC and care/treatment remains a challenge as most patients tested are lost to follow up into care and/or documentation of such a system is very weak. This includes strengthening referral systems in TB, VMMC, PMTCT including national tools, referral guidelines, and use of mobile technologies to track leakages from the cascade.
(3) Strengthening of monitoring and evaluation of HTC services nationally both Provider and Client initiated settings.
(4) Quality assurance, quality improvement for HTC services and mentorship of HTC personnel implemented according to the WHO and Lesotho HTC guidelines and standards.
(5) Coordination of HTC services. There is also a weak central level coordination in the provision of HTC services from all sites (GOL, private and NGO) and the necessary referral to ART services, and as a result district level coordination of HTC services also and needs to be strengthened. A steady and uninterrupted supply of HTC commodities is another essential element in the strengthening of services provision as the recurrent stack outs negative impact on the services. Therefore central level coordination between provision of HTC services nationwide and a steady provision of the required medical supplies and commodities need to be strengthened. To effectively coordinate the program, one national HTC coordinator; one HTC Supply Chain Manager and 10 District Senior Counselors/coordinators will be supported in this budget period

Implementing Mechanism Details

Mechanism ID: 11018	Mechanism Name: Peace Corps
Funding Agency: U.S. Peace Corps	Procurement Type: Grant
Prime Partner Name: U.S. Peace Corps	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Peace Corps/Lesotho (PC/L) will continue its support of the National HIV/AIDS Strategic Plan of the Government of Lesotho (GoL) and the PEPFAR Partnership Framework by contributing to the reduction of HIV incidence, providing high quality OVC services, improving human resource capacity and strengthening the health system in all 10 districts. PC/L will train all of its approximately 60 Volunteers in the Community Health and Economic Development (CHED) and Education projects and their counterparts to promote behavior change related to sexual prevention. PCV will also support the GoL's PMTCT goals through community mobilization.

Through the recruitment of 15 PEPFAR-funded 2-year Volunteers, PC/L will expand its activities in the areas of human capacity development and health systems strengthening. PC/L will assist local HIV/AIDS umbrella groups by building their organizational capacity and expanding their outreach efforts. Volunteers will promote the development of life skills among young people and address behavior change related to multiple concurrent partners among adults. They will also teach, coach and mentor OVCs using a Life Skills curriculum; create linkages between OVC services and underserved communities; and assist with establishing programs and support mechanisms for keeping OVCs in school. PCV will help promote PMTCT among community members. These 15 PCV will be strategically linked to USG implementing partners in Lesotho to strengthen community-based interventions.

PC/L will continue to support activities through Volunteer Activity Support and Training (VAST) in the areas of other prevention and basic health care and support for people living with HIV. They will also work with PLWA groups at the district level to help organize income generating activities.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	**11018**		
Mechanism Name:	**Peace Corps**		
Prime Partner Name:	**U.S. Peace Corps**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	0	0

Narrative:

In all 10 districts, Peace Corps/Lesotho (PC/L) Volunteers work with OVC (boys and girls under 18 years) in their communities to develop life skills (including HIV prevention skills), create income generating activities and household gardens and link them to other GoL social welfare programs. Some Volunteers work with local leaders to ensure that accurate records of OVCs in the community are kept.

In FY12, PC/L will recruit 15 PEPFAR-funded Volunteers for the Community Health and Economic Development (CHED) project. These Volunteers will contribute to strengthening the health system by developing human resources in clinics and communities and strengthening linkages and coordination between communities and HIV and AIDS service organizations, particularly those addressing the needs of OVC. PC/L also plans to support the

MOHSW's efforts to improve data collection and monitoring and evaluation by coaching data clerks at the clinic level.

To ensure quality, PC/L partners with local and international organizations, such as Kick4Life, PSI, Lesotho Planned Parenthood Association, C-Change, and PHELA Development and Communications to train Volunteers and their counterparts using evidence-based curricula to disseminate prevention messages through mass media, interpersonal communications. Volunteers' activities are monitored by PC/L staff through site visits and quarterly reporting.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

In all 10 districts Peace Corps/Lesotho (PC/L) Volunteers collaborate with the MOHSW and the Ministry of Education on age-appropriate HIV prevention at the individual, small group and community levels with in-and out-of-school youth under the age of 24. The approximately 60 PC Volunteers in the Community Health and Economic Development (CHED) and Education projects work with counterparts and young people to form youth clubs, organize sports tournaments, and hold youth empowerment camps as ways to develop life and leadership skills among young people, educate them about HIV prevention and promote gender equality. Volunteers will contribute to strengthening the health system by developing human resources in clinics and communities and strengthening linkages and coordination between communities and HIV and AIDS service organizations. In addition, PEPFAR funds will continue to be set aside for small grants for community-initiated prevention projects.

PC/L focuses on addressing the major driver of the epidemic in the country, multiple and concurrent partnerships (MCP), by training Volunteers and their counterparts to support the "One Love" campaign and raise awareness in their communities on the risks of having MCPs, engaging in transactional sex and trans-generational sex, and couples living apart for extended periods. Volunteers will also continue to help communities address male norms and gender-based violence through the Men As Partners program, and promote prevention among PLWA. Volunteers will also mobilize communities increase uptake of HIV testing and counseling in ANC settings.

To ensure quality, PC/L partners with local and international organizations, such as Kick4Life, PSI, Lesotho Planned Parenthood Association, and PHELA Development and Communications train Volunteers and their counterparts using evidence-based curricula to disseminate prevention messages through mass media, interpersonal communications. Activities will be implemented in sites with PCV presence, currently in all 10 districts in Maseru.

Implementing Mechanism Details

Mechanism ID: 11030	**Mechanism Name: PEPFAR Small Grants Program**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Grant
Prime Partner Name: U.S. Department of State	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 175,000	
Funding Source	**Funding Amount**
GHP-State	175,000

Sub Partner Name(s)

TBD		

Overview Narrative

The overall goal of this activity is to provide funding opportunities for local, community-based organizations already engaged in responding to HIV/AIDS pandemic. 1. Community groups typically provide home-based palliative care and support to HIV+ patients in their homes, or assist them in getting to the clinic for their regular consultations. Some Support Groups also monitor patients' medication adherence and some volunteers may be trained to administer medicine. The target group for the Community Support Groups are HIV+ adults who need care and support. The groups providing home-based care also extend care, support and referral services to children and caregivers in house household made vulnerable by HIV/AIDS.

2. This grant will be available to groups located in all ten districts, targeting more remote, rural regions in Lesotho.

3. Support groups are staffed by dedicated volunteers who actively follow their HIV+ patients. Patient retention in these groups is high and often the community groups are well known within the community and aware of who is in need of care and support.

4. The Community Support Groups know of the clinics in their areas and often accompany patients to the clinics and assist them with medication adherence. Income-generating projects allow the groups to provide patients with much needed food, basic toiletries and even clothing. Support Groups sometimes request training for their members so that they can deliver a better service. Training and organizational capacity developement support for these local grantess is provided by linking with PEPFAR and other partners. PEPFAR Lesotho also links grantees

with Peace Corps volunteers as appropriate to ensure support for the management and oversight the grants as well as technical assistance.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	50,000
Gender: Gender Equality	50,000

TBD Details

(No data provided.)

Key Issues

Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Child Survival Activities

Budget Code Information

Mechanism ID:	**11030**
Mechanism Name:	**PEPFAR Small Grants Program**
Prime Partner Name:	**U.S. Department of State**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	75,000	0

Narrative:

1. Community groups typically provide home-based palliative care and support to HIV+ patients in their homes, or assist them in getting to the clinic for their regular consultations. Some Support Groups also monitor patients' medication adherence and some volunteers may be trained to administer medicine. The target group for the Community Support Groups are HIV+ adults who need care and support.
2. The goal is to provide support to groups located in all ten districts, especially in the remote rural regions.

3. Support groups are staffed by dedicated volunteers who actively follow their HIV+ patients. Patient retention in these groups is high and often the community groups are well known within the community and aware of who is in need of care and support.

4. The Community Support Groups know of the clinics in their areas and often accompany patients to the clinics and assist them with medication adherence. Income-generating projects allow the groups to provide patients with much needed food, basic toiletries and even clothing. Support Groups sometimes request training for their members so that they can deliver a better service. Training for Support Groups is invariably conducted by external groups and could include organisations such as Peace Corps, BAYLOR or MOHSW.

5. Special Projects maintains regular contact with the group at all stages of the grant, from disbursement, to monitoring spending, to providing advice/information. All requests for training from the Support Group come through the Special Projects Office for evaluation and approval. Site visits by the Special Projects team evaluate the projects and suggest improvements, where needed. The Public Affairs Office will fund innovative and creative small grants projects which raise HIV prevention awareness and reduce stigma in the media and in communities ($20,000).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	100,000	0

Narrative:

1. Priority grants are for Community support and coordination and Family/household strengthening

2. Target population: OVCs in remote rural villages who have limited access to services.

3. By allocating income-generating grants to remote rural communities the communities will learn micro-enterprise skills

as well as generate food for the OVCs from the sale proceeds or from the project itself (e.g., poultry projects). Income-generating projects will encourage the communities to work together and support themselves. Having a purpose in Lesotho, where unemployment is estimated at 50%, helps self-esteem and community self-sufficiency. Proceeds from the sales of the goods produced will also be used to train community members in HIV/AIDS care.

4. Income-generating projects will generate proceeds which will be used to provide OVC basic needs, such as education expenses and food, as well as potentially teaching them and the community micro-enterprise skills.

5. Successes will be providing OVCs with food, reducing the numbers of hungry children, providing the community with a means to earn money and to work as a community, giving OVCs the opportunity to continue their education as opposed to missing school and trying to find a job to earn money for their livelihood. Not only are the successes evident for the community but projects in remote and rural areas generate huge amounts of positive goodwill for the US as is evident when we visit the communities.

6. The challenges are in reporting information to PEPFAR according to their timeframes and requests given that the communities have minimal grasp of English and bureaucracy. These grants are short term and only for one year, so there is a lot of reporting required for a 12 month long project.

Implementing Mechanism Details

Mechanism ID: 12098	**Mechanism Name: Support to the Government of the Kingdom of Lesotho (GOL) to Strengthen and Expand Safe Blood Transfusion Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Welfare – Lesotho	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: Yes	Managing Agency: HHS/CDC

Total Funding: 750,000	
Funding Source	**Funding Amount**
GHP-State	750,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Ministry of Health and Social Welfare (MOHSW) is the sole provider of blood transfusion services in the country with regulatory, coordination and oversight responsibility. The Lesotho Blood Transfusion Service (LBTS), a unit within MOHSW, supplies all of the nation's hospitals with safe blood through the recruitment, collection, screening, storage and distribution of blood. LBTS collects about 3 units per 1,000 populations per year, which is far less than the WHO-recommended 10-20 per 1000 population. In the coming two year, LBTS plans to scale up and collect 7 units of blood per 1,000 populations per year.

This goal will be achieved through the education and outreach to the population, recruitment of voluntary, non-remunerated blood donors, screening and processing blood, establishing a quality management process, and training health care providers and donors. As part of strengthening the infrastructure of the blood transfusion services in the country, three regional centers will be constructed and furnished. Human resources capacity will be strengthened through training and the development of retention schemes. Physicians, nurses and laboratory technicians will be trained in basic principles and

In FY 2010 COP funding, the LBTS has purchased two cars: A 4x4 double cabin for donor recruitment, mobilization at the field and post-donation deliveries. The sedan car is used for superiority site visits to hospitals

and regional banks. For the decentralization of LBTS activities and increase scale up donor recruitment and mobilization coverage, two additional vehicles (4x4 double cabin) will be purchased.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12098**
Mechanism Name:	**Support to the Government of the Kingdom of Lesotho (GOL) to Strengthen and Expand Safe Blood Transfusion Services**
Prime Partner Name:	**Ministry of Health and Social Welfare – Lesotho**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	750,000	0

Narrative:

In FY 2012 COP Lesotho Blood Transfusion Services will be strengthened through human resources development, public awareness campaigns, the establishment of quality management systems, and monitoring and evaluation systems. The following are the major activities planned for COP FY2012

(1) Strengthening human resource capacity

Refresher courses based locally and internationally, will be organized for staff, the country in the following areas: donor recruitment and motivation, selection and counseling, phlebotomy, cold chain management, component production, quality management systems, effective clinical use of blood and blood components, information management systems and leadership and management.

(2) Minor renovation, Procurement and Logistics support *Minor renovation and refurbishment of hospital blood banks will be supported to improve the workflow, storage and the cold chain system will be supported. Adequate equipment and supplies will be purchased to build the capacity and expand services.* *Purchase of Vehicles: Two additional vehicles (4x4 double cabs) will be required at regional centers for donor mobilization and delivery of blood donor results.* *(3) Increase public awareness and involvement in regular voluntary blood donation* *In collaboration with District Councils, private sector and other Non-Governmental Organizations (NGO), public awareness in donor recruitment, counseling and blood donation will be increased and information, education and communications materials (IEC), advertising and motivation of donors will be set up for its sustainability of the blood banks.* *(4) Improvement of quality management systems* *Quality management systems will continue and be maintained in all the hospital blood banks. Supervision support will include quality control checks on operations to improve services and safety standards. The Policy and strategic plan will be reviewed.* *5) Monitoring and evaluation (M&E) and information system*

Implementing Mechanism Details

Mechanism ID: 13484	**Mechanism Name: PSI/DOD support**
Funding Agency: U.S. Department of Defense	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 465,000	
Funding Source	**Funding Amount**
GHP-State	465,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

PSI will work with LDF to use data collected in 2010 SABERS to strengthen, tailor, and focus their prevention

program. Activities supported by PSI will assist LDF to embrace a comprehensive prevention program including activties to improve factors influencing HIV prevention, behavioural change programs including peer education outreach sports related activities and male circumcision. Sports centred activities such as VCT and peer education at football matches were highly successful and will be continued. Peer education will be strengthened and using the SABERS, peer educators will have enhanced content training and monitoring and evaluation training. Military specific condoms will be procured in the context of the overall prevention program promoting the military duty to protect one's self, familty and country. PSI will also intergrate MC messaging in to all prevention modalities. PSI will continue commodity procurement like military condom pouches, military branded male condoms, female condoms, they will also carry out edutaintment events, activities will inlude which those that depicts real life choices and dilemmas facing soldiers, lectures with questions and answers sessions will be conducted. PSI will support a series of workshops for the military to disseminate the result of the SABERS and come up with the recommendations.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	10,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Military Population
Mobile Population
Family Planning

Budget Code Information

Mechanism ID:	**13484**
Mechanism Name:	**PSI/DOD support**

Prime Partner Name:	Population Services International		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	400,000	0

Narrative:

The overall goal of these activities is to decrease new HIV infections in the military,through expansion of male circumcision (MC) services, emphasizing that MC be offered as part of an expanded approach to reduce HIV infections in conjucton with other prevention programs, including HIV testing and Counseling (HTC), treatment for other sexually transmitted infections (STI's), promotion of saver-sex practices and condom distribution. MC will not replace other known methods of HIV prevention and will be considered as part of a comprehensive HIV prevention package. PEPFAR worked closely with the Ministry of Health (MOH) and other donors in a national task force to develop policy that recognizes MC as an effective HIV prevention method alongside the ABC strategy. Expanding MC in the military is considered vital since the military is predominantly male, typically young, and highly mobile, and is considered a high risk group. DOD/PSI will ensure that male circumcision efforts are rolled out as an additional method for HIV prevention. Though PEPFAR/DOD support, the military has expanded HIV care and treatment, PSI will built capacity for MC in the military through the development treatment ptotocols, training of providers, sensitization of soldiers and their partners for save male circumcision, and the enhancement of physical infrustructure of clinical sites so that proper circumcision may be conducted. MC wil be conducted on a voluntary basis on HIV-negative soldiers and those who test positive will be given services depending on their CD4.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	65,000	0

Narrative:

The overall goal of these activities is to decrease new HIV infections in the military, behaviour change communication(BBC) with a focus on correct and consistent use of condoms. While some soldiers practice sexual abstinence and fidelity, factors such as separation from their families, mobility and age increase their HIV risk. The Lesotho Defence Force military (LDF) and Population Service International (PSI) are implementing community based activities among soldiers, their sexual partners and surrounding communities to promote safer sexual behaviours. Key prevention strategies are: Capacity building of peer education and interpersonal communication (IPC) including drama group, capacity building of LDF support group clubs, promotion of counseling and testing services. The Lesotho Defence Force with the assistance of PSI will update communication material to reflect best practices in the following area: AB, couples counseling and testing, intergaration of familiy planning(FP) in to HIV/AIDS prevention including PMTCT, condom use and prevention of alcohol abuse. PSI will provide training of peer educators, counselor testers, sensitization workshops for LDF senior and junior officers. Combination prevention is being promoted as an effective strategy for HIV prevention. Having an appropriate mix of bevioural, biological, structural and crosscutting activities is expected to lead to improved HIV prevention.

Militaries require strong HIV prevention programs and provide excellent sources for evidence based programming for effective interventions. Lesotho Defense Force will fill in major activity gaps for HIV prevention and increase the intensity of interventions.

Implementing Mechanism Details

Mechanism ID: 13981	**Mechanism Name: TARGET: Increasing access to HIV counseling, testing and enhancing HIV/ADIS prevention**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 3,225,000	
Funding Source	**Funding Amount**
GHP-State	3,225,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The objectives of this project are to: (1) Increase knowledge of individual and partner status through expanded community-based HTC services; (2) Increase practice of safer sexual behaviors, including secondary abstinence, partner reduction and correct and consistent condom use, parallel to and following use of HTC services; and, (3) Increase use of post-test services through improved referral systems. The project will contribute to the National Multi-Sectoral HIV Prevention Strategy 2011-2015 (NPS) by reducing the impact of HIV/AIDS in Lesotho through expanded access to HTC services and behavioral programming emphasizing evidenced-based sexual and biomedical prevention strategies.

The project will use three complementary approaches to ensure the delivery of high-quality HTC services: 1) direct provision of mobile services to men in urban and peri-urban areas of Butha-Buthe, Leribe, Berea, Maseru, Mafeteng and Mohale's Hoek districts; 2) support a local partner, LIRAC, to provide door-to-door HTC to men and

women 15-35, with an emphasis on couples, in rural and peri-urban areas of all ten districts of Lesotho; and, 3) annual "Test for Your Team" tournaments and other special events to reach men in at least one council of each of the ten districts with mobile HTC services. These mobile and community-based approaches will ensure immediate cost-efficiencies over traditional static site HTC service delivery models.
Quality assurance monitors will supervise and improve the quality of counseling and testing activities implemented by both the direct HTC service team and community-based counselors. The project's MIS infrastructure will ensure the regular collection and reporting of key indicators and inform project adjustments, as needed.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	300,000
Human Resources for Health	150,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
TB
End-of-Program Evaluation

Budget Code Information

Mechanism ID:	**13981**
Mechanism Name:	**TARGET: Increasing access to HIV counseling, testing and enhancing HIV/ADIS prevention**
Prime Partner Name:	**Population Services International**

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	HVCT	3,225,000	0

Narrative:

The project's service delivery strategy hinges on three complementary approaches: 1) direct provision of mobile services to men in urban and peri-urban areas; 2) support a local partner, LIRAC, to provide door-to-door HTC, with an emphasis on couples, in rural and peri-urban areas; and, 3) annual "Test for Your Team" tournaments and other special events to reach men. Mobile HTC services in urban areas will reach men 20-35 through workplaces, taxi ranks, shebeens and border areas. Three high-capacity teams of seasoned HTC counselors, will provide daily outreach services to urban areas of Butha-Buthe, Leribe, Berea, Maseru, Mafeteng and Mohale's Hoek districts. Emphasis will be placed upon expanding service availability in Maseru, Maputsoe and Mafeteng, which have both the highest population density and the highest HIV prevalence in the country. In addition to its core HTC services targeting men, mobile teams will provide youth-friendly HTC services to men and women 18-24 on university campuses around Maseru. The project will support LIRAC to provide door-to-door HTC services targeting men and women 15-35, with an emphasis on couples, focusing on rural and peri-urban areas. To maximize project impact and prevent counselor burnout, door-to-door HTC teams will conduct two campaigns in each intervention community over the course of the year. Each campaign will comprise an initial training/planning phase, intensive mobilization and IPC, service provision and debriefing. The project will also mobilize large urban and peri-urban congregations for HTC events spearheaded by the mobile HTC teams. Parishes not participating in door-to-door campaigns will be targeted for these intensive efforts to maximize project coverage. To ensure referral uptake, the project will hire a dedicated Referral Coordinator who liaise with referral points to build relationships and clients will be contacted to provide follow-up and track referrals. The project will also coordinate regular national- and district-level meetings between LIRAC and local service partners (including CHAL and the MoHSW), and involve local representatives of service partners in planning and feedback activities for parish-level campaigns.

Implementing Mechanism Details

Mechanism ID: 13983	**Mechanism Name: Human Resources Alliance for Africa - HRAA**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Eastern, Central and Southern African Health Community Secretariat	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 500,000	

Funding Source	Funding Amount
GHP-State	500,000

Sub Partner Name(s)

JHPIEGO	Regional Center for Quality Health Care	

Overview Narrative

The objective of this project is to improve and increase the number of human resources for health and social welfare in Lesotho. H RAA will ensure that its programmatic activities are in line with the country's Health Sector Strategic Plan, Health Services Decentralization Plan and the USG/GoL Five Year Partnership Framework on HIV/AIDS with emphasis on Goals III and IV.

The HRAA is led by the East, Central and Southern African Health Community and has five sub-partners including Jhpiego, Eastern and Southern Africa Management Institute, Regional Network for Equity in Eastern and Southern Africa, African Health Systems Development Inc and the Regional Centre for Quality of Health Care.

The HRAA partners will work collaboratively with the Ministry of Health and Social Welfare, Christian Health Association of Lesotho, Health NGOs, private sector, Regulatory Bodies, professional associations, PEPFAR Implementing Partners and development partners to achieve the following key result areas: 1. National HRH/HSS plans, policies and systems operationalized and implemented. 2. HRIS developed and the use of data for decision-making promoted. 3. Pre-service education systems for health and social welfare-related professionals, paraprofessionals and community health workers strengthened. 4. Workforce shortages addressed through improved worker recruitment, retention, and productivity, including the community/informal workforce. 5. Health professional regulatory bodies and associations strengthened (e.g., nursing councils which may register and credential health care workers, oversee continuing education, and/or accredit academic institutions).

Cross-Cutting Budget Attribution(s)

Human Resources for Health	300,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	13983		
Mechanism Name:	Human Resources Alliance for Africa - HRAA		
Prime Partner Name:	Eastern, Central and Southern African Health Community Secretariat		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	500,000	0

Narrative:

The HRAA COP 2012 activities will emphasize focus on the scale-up of HRH activities to all 10 district councils in Lesotho, following decentralization of health and social welfare services.

Districts will be supported to use the National HRH Plans and policies to develop their own specific HRH plan to strengthen the availability of health care workers (HCW) for health and HIV/AIDS programs. In addition, HRAA will also provide TA to all the 10 districts to scale-up and improve utilization of the iHRIS data for human resources decision making and monitoring of their HRH plans. Monthly HRH reports will also be submitted to the MOHSW HQ for national HRH monitoring.

Following on the development of training plans for schools and the Continuous Professional Development plan (CPD) in FY11, HRAA will support the MOHSW headquarters to develop sustainable Pre and In-service training monitoring mechanisms. The in-service monitoring system will inform decisions for CPD programs whilst the pre-service monitoring mechanism will track the progress of students from graduation to deployment.

In FY 12 HRAA will work with DHMTS to manage workforce shortages through efficient and effective recruitment, retention and productivity/ performance based financing strategies. HRAA will support all the 10 districts through capacity building training programs and workshops to implement the national retention scheme guidelines and tools for health and community health workers. In addition, HRAA will also facilitate the Development Credit Authority (DCA) consumer loans and housing for medical staff PPP program benefiting HCWs in the private, MOHSW and CHAL facilities.

In order to improve accreditation and quality assurance functions, HRAA will continue to support the strengthening of health regulatory bodies such as the Lesotho Nursing and Medical Councils through technical and financial support. In FY 12 HRAA will support districts to conduct bi-annual accreditation, quality assurance and support supervision activities in selected health facilities and training institutions.

Implementing Mechanism Details

Mechanism ID: 13987	**Mechanism Name: STRENGTHENING TB/HIV COLLABORATION IN THE KINGDOM OF LESOTHO**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Columbia University Mailman School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 3,200,000	
Funding Source	**Funding Amount**
GHP-State	3,200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Since 2009 ICAP has been implementing a nationwide TB/HIV program in close collaboration with the MOHSW. In the upcoming year special efforts will be paid to consolidate the achievements made as well as to address new challenges. Ojectives for FY 2012 are: 1: Strengthened National Capacity: support the MOHSW to strategically plan, implement and evaluate TB/HIV related activities through the development, dissemination and implementation of TB/HIV related strategic plans, policy, guidelines, models for delivering optimal TB/HIV services, training programs, performance tools and new M&E tools. ICAP will provide TA and institutional capacity building to the NTP by seconding a TB/HIV technical advisor and M&E manager. 2: Comprehensive and Quality District-Wide TB/HIV Service: strengthen DHMT capacity and role in TB/HIV service delivery with emphasis on joint clinical mentorship and supervisions. ICAP will strengthen and expand its supportive system of providing clinical

mentorship by hiring additional multi-disciplinary teams to cover each district, all public health facilities and to target key affected populations (factory and migrant workers). 3: Effective TB Laboratory Network: support the MOHSW with the implementation of the decentralization plan for sputum microscopy to 13 additional health centers as well as roll-out plan for GeneXpert, in close collaboration with other implementing partners (FIND, PIH). Objective #4: Community Mobilization: support further integration of adherence and psychosocial support within TB services and strengthen the Village Heath Worker (VHW) support system to improve TB treatment outcomes, increase uptake of ART among co-infected patients, and to increase community mobilization and awareness.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

TBD Details

(No data provided.)

Key Issues

TB

Family Planning

Budget Code Information

Mechanism ID:	**13987**
Mechanism Name:	**STRENGTHENING TB/HIV COLLABORATION IN THE KINGDOM OF LESOTHO**
Prime Partner Name:	**Columbia University Mailman School of Public Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	3,200,000	0

Narrative:

ICAP will enhance MOH stewardship and capacity at all levels to develop, manage, and evaluate health system

elements to accelerate and expand access to TB and HIV prevention, diagnostic, care, and treatment services and mitigate the impact of the TB, TB/HIV co-infection and MDR-TB epidemic.
In FY13 the main objective are to strengthen basic DOTS and improve TB treatment outcomes, strengthen TB/HIV integration with emphasis on early ART initiation, nationwide implementation of 3Is, strengthen engagement and capacity of private practitioners and address TB in high risk groups.
At national level and through the TB/HIV technical Advisor Committee (TAC) , ICAP will support the NTP with development of develop policies, guidelines, strategic plans and model of care, including a new TB strategic plan (2013-2017), an updated version of the NTP Policy and Manual and the development of a National Adherence and Psychosocial Support (APS) Protocol. ICAP will contribute to the NTP's institutional capacity by seconding a TB/HIV technical advisor and an M&E manager.
ICAP will remain crucial in the capacity building of DHMT and health facility managers (capacity to manage, supervise and to conduct operational research) as well as various cadres of health care workers, in all 10 districts. For health care workers the adopted strategy of on-site preceptorship will remain.
With the aim of improving ownership, both at DHMT and facility level, special attention will be paid to use of TB and TB/HIV related data for program planning and evaluation. This will include the roll-out of facility based M&E of TB and TB/HIV indicators, evaluation of facility based capacities to implement TB/HIV activities through the use of competency checklists and measurement of quality of care through Standards of Care (SOC).
ICAP will collaborate closely with the NTP, the Primary Health Care (PHC) Department and other partners in the development and implementation of a model of enhanced community support to strengthen DOTS with a c crucial role for VHWs. Essential components will included the strengthening of VHW supervision through VHW leads, a M&E system for VHW activities, capacity building of VHW and treatment supporters, use of SMS technology and a performance based remuneration.
Special attention will be paid to high risk groups through the hiring of specialized staff and the development and implementation of special programs/activities. A minimal package of TB and TB HIV services (TB screening, diagnosis and DOTS, IPT) will be implemented in prisons and garment factories while the roll-out of a cross-border referral system through the use of health information technology will strengthen continuum of care among Basotho mineworkers.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	0	0

Narrative:

ICAP will continue to provide support needed to improve diagnosis of TB, MDR-TB, and XDR_TB. ICAP willl support the Ministry of Health with the implementation of the TB rapid testing (Gene Xpert) for all HIV infected TB suspects in Line with the WHO guidelines and the National Gene Xpert roll-out plan. This is will include Integration of the gene xpert into the existing diagnositic protocols, Supporting FIND in the developemnt of Gene

X pert TB Diagnostic Aligorithm and the training of clinicians nationally as well as supporting its impelementation nationally .
Development EQA system for Gene Xpert, evaluation of impact on time to diagnosis and TB treatment outcomes.
ICAP support MOHSW to improve sample collection networks, reducing turn around times for testing and support implementation of quality assurance activities for TB and HIV services in the laboratories.
Specifically in this area, ICAP is being requested to strengthen quality of sputum collection for laboratory analysis through training of health care workers, development and distribution of standards of procedure(SOPs) for sputum microscopy for TB, sputum processing for culture and sensitivity, sputum transportation and reduction of turn around time for results. ICAP also will further support the ongoing job training for microscopists. Based on the results of FIND EXPAND-TB pilot project results of timely results through short messaging printers, ICAP will support the Ministry of Health to roll out the approach nationally.
Within this budget $100,000 is reserved to support the strengthening of cross-border referal for Basotho migrant mine workers affected by TB and HIV using a Private Public Partership model. The focus will be implementation of electronic data systems for TB/HIV patients from the mines linked with short message service (SMS) to track mine workers diagnosed with TB between Lesotho and South Africa. This is partnership with The Employment Bureau Agency (TEBA). This will leverage on resources from private sector (South African Mine companies) already invested in TEBA.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

The OHSS budget is planned to support 8 laboratory assistants that will support the provision of TB microscopy services and supporting laboratory activities for the initiation of ART within the TB clinics. This support will also include support for equipment including LED microscopes. They also include the decentralization of microscopy centers beyond hospitals to health centers with high TB burden. Additionally ICAP is supporting 24 positions as lay counselors whose major role is to conduct HIV counseling and testing within the TB clinics. The lay counselors also support linkages to HIV treatment and care as well as supporting adherence to both TB and HIV treatment. ICAP will work closely with the National TB program to support Monitoring and evaluation systems for TB and HIV data and ensuring that it is incorporated into the MOHSW HMIS system. This includes the support of the functioning of the Electronic TB Register (ETR) and integration of the ETR data into the national HMIS. In collaboration with WHO and NTP, ICAP will support strengthening of surveillance systems for TB through the national monitoring and evaluation system based on the new WHO guidelines. ICAP will also provide ongoing mentoring for the national TB program management of the management of other donor resources including Global fund. Mentoring will also focus on the use of program results to improve services and roll out of best practices in TB/HIV care nationally. PEPFAR will work with ICAP and MOHSW to develop to support systems of ensuring that

human resources supported for service provisions are absorbed by government and ensure continuity of services. Finally, PEPFAR will provide computers/hardware at MCC renovated health clinic sites. These computers will be part of the PPP HMIS system that will move TB data from the clinics to the district and national level.

Implementing Mechanism Details

Mechanism ID: 14026	**Mechanism Name: Construction of Regional Reference Laboratory in Leribe**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health and Social Welfare – Lesotho	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 0	
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The country has only one central laboratory and there is a need to decentralize the services and create regional reference laboratories. For rapid scale up of HIV and TB care and treatment program and achieving the targets, the laboratory infrastructure support is critical. The central laboratory support through the referral network has been a challenged due to limited transport network and logistic support. While MCC is supporting infrastructure upgrade of more than 100 health centers, construction of the national reference laboratory and blood bank, regional laboratories, blood banks, clinical laboratories and health centres at district level are not included. As services decentralize, the MOHSW has planned to establish three regional laboratories in Mafeteng, Leribe and Mokhotlong districts.

As part of strengthening the health system and implementation of HIV/AIDS treatment, care and prevention, PEPFAR Lesotho plans to support infrastructure development of health facilities including major construction and

minor renovation works for Regional and clinical laboratories, TB and HIV clinics. Through the implementing partner, CDC Lesotho will coordinate the renovations with the MOHSW from design to completion. Construction/renovation of those facilities will lead the improvement quality of care and treatment services in HIV, TB and PMTCT. With coordinated infrastructure supported by MCC and PEPFAR Lesotho, it will provide a tremendous opportunity to access women, infants, and families and bring them into care and treatment programs. Quality services are also essential to strengthen national systems for sustainable PMTCT scale-up.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Key Issues

TB

Budget Code Information

Mechanism ID:	**14026**		
Mechanism Name:	**Construction of Regional Reference Laboratory in Leribe**		
Prime Partner Name:	**Ministry of Health and Social Welfare – Lesotho**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	0	0
Narrative:			
In COP2012, PEPFAR will support the construction of one Regional Reference Laboratory in Leribe District. The purpose of the construction of the new regional referernce laboratory in Leribe Distract is to allow for badly needed laboratory services and to serve as a regional reference laboratory for the district adjoining areas. The			

demand for testing services has doubled in recent years due to the increased in burden of HIV/TB co-epidemics, the expansion of the ART services and the need for increased culture and drug-sensitivity testing (DST) which is currently. *The new Regional Reference Laboratory will provide safe and adequate working environments to increase its general testing capacity and expand the range of specialty testing including microbial/TB culture, DST, early infant diagnosis and viral load assays. It will improve quality of testing services, support operational research and trainings. The regional Laboratory will have admin and staff offices, meeting and staff room, stores, sample reception room; different clinical laboratories including molecular and TB laboratory.* *Detailed design documents of the Lab facility will be created by the contractor in consultation with Director for Laboratory Services, MOHSW. The new building will be approximately 500 square meters including associated site and utility work, and was compiled from several sources representing. The design and the construction of the building is expected to meet the required standards including function, performance, process, flow, space standards, biosafety and special requirements need for regional laboratory .* *The cost includes consultant's fees necessary to the planning and design of the buildings as well as construction of building, installation of fixed equipment, furniture and fixtures.*

Implementing Mechanism Details

Mechanism ID: 14072	**Mechanism Name: Systems for Improved Access to Pharmaceuticals and services (SIAPS)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 1,110,000	
Funding Source	**Funding Amount**
GHP-State	280,000
GHP-USAID	830,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The objective of the MSH/ SIAPS is to develop individual, organizational, and institutional capacities of in-country entities to manage key components of their national supply chains for essential public health commodities. The SIAPS project will support: 1) Governance: Support the MOHSW to establish policies, institute and implement pharmaceutical regulatory processes; strengthen the MOHSW's capacity to meet the GF's SCM requirements for disbursements of funds from Rounds 8 and 11. 2) Supply Chain Management of Commodities: Support the MOHSW to improve access to pharmaceuticals (HIV/ TB medicines and essential medicines), laboratory commodities and services, ensure good quality of pharmaceutical products and services through supporting rapid quality checks and updating the STGs. The project will support logistics for the Lesotho MBP. 3) M&E, Drug Surveillance: Support the management of ART, pharmaceutical and laboratory data through support for the Rx Solution, pharmaceutical management information system (PMIS) and laboratory logistics management information systems (LMIS). 4) Capacity Building: The PD and the SCM TWG will be supported in information based decision making; capacity of local pharmaceutical organizations will be built; NDSO's capacity for SCM will be strengthened to provide quality and essential commodities at all levels. The partner will continue to support the capacity building, pre service and in service training of pharmaceutical health personnel.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	50,000
Human Resources for Health	180,000

TBD Details

(No data provided.)

Key Issues

Child Survival Activities

Budget Code Information

Mechanism ID:	14072		
Mechanism Name:	Systems for Improved Access to Pharmaceuticals and services (SIAPS)		
Prime Partner Name:	Management Sciences for Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	230,000	0

Narrative:

1) Baseline Assessment: MSH/ SIAPS will conduct a baseline assessment of current pharmaceutical capacity, needs and issues (at all levels), human resource capacity needs for supply chain management, identify supply chain tasks and functions by level of the supply chain, detect human resource gaps in terms of skills and numbers of staff.
2) M&E, Drug Surveillance: Continue to support the management of ART, pharmaceutical and laboratory data through support for the Rx Solution inventory module (in NDSO), interphase of NDSO Rx Solution with National EMR pharmaceutical component in health facilities and MOHSW; and, implementation pharmaceutical management information system (PMIS) and laboratory logistics management information systems (LMIS).
3) Information for decision making: Support the availability and utilization of information from Rx Solution in NDSO and National EMR for SCM logistics, quantification and forecasting of need. Adapt health data collection to mHealth devices (e.g. smart phones, mobile scanners at facility level for reporting ADRs, pharmaceutical logistics data and to strengthen down-referral systems for chronically ill patients. Use PMIS and laboratory LMIS to monitor outcomes of system strengthening activities, derive lessons learned, document and disseminate findings.
4) Drug Surveillance: Revise and Track use of STGs and EML through HPTCs at all hospitals, Set up medicine utilization review programs for selected ARVs and essential antibiotics (OI utilization pattern). Establish systems for the PD, MOHSW for pharmacovigilance and tracking of ARV related events.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	880,000	0

Narrative:

1) Governance: Support the establishment of favorable pharmaceutical policies, institute and implement pharmaceutical regulatory processes; advocate for pharmacovigilance frameworks development; strengthen the MOHSW's capacity to meet the GF's SCM requirements for disbursements of funds from Round 8 and Round 11, including the establishment of the Central Logistics Office, integration of existing parallel pharmaceutical service/

supply systems and ownership and utilization of the Rx Solution. Management support will be provided through TA to the PD and sustainable staff strength building/ advocacy. The PD and Logistic office will be supported in information based decision making. Provide TA to update the NMP and NMP-SAP.
2) Supply Chain Management of HIV Commodities: Support the MOHSW to improve access to pharmaceuticals, laboratory commodities and services by improving forecasting and quantification (through the Central Logistics Office); storage and distribution of pharmaceutical, nutritional and laboratory commodities at central, district and facility levels; and, improving procurement process and quality of pharmaceutical products through supporting rapid quality checks and updating the STGs. The project will also support logistics for the Lesotho MBP.
3) Capacity Building: Build the national and district capacity to handle logistics of SCM by supporting the SCM TWG or establishing a Logistics Office in the MOHSW; build the capacity of local pharmaceutical organizations, exploring PPPs in the pharmaceutical sector. NDSO's capacity for SCM will be strengthened to provide essential commodities to every health facility. Support the capacity building, pre service and in service training of health personnel for pharmaceutical and laboratory systems management. Supportive Supervision and Mentoring will be implemented for District Councils and hospitals to adhere to MOHSW guidelines and standard operating procedures for improved patient outcomes.
4) PMTCT Acceleration: MSH/ SIAPS will support specific intervention strategies in Supply Chain Management, as outlined in the PMTCT Acceleration plan (Build National, local capacity; SCM strengthening), and establish a 'risk mitigation strategy' for stock outs.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

(This budget code focuses specific OHSS activities (under the supply chain management component of the project) for NACS Integration and PMTCT Acceleration)

MSH/ SIAPS will provide TA to improve the overall national supply chain management including logistic management information systems and provide mentorship for quantification at central, district and facility levels, as a necessary step to reduce 'stock outs' and for PEPFAR to provide HTC and PMTCT services unhindered in FY12. The MOH will be supported to provide overall coordination for this system through a central supply-chain management logistics office within the MOH PD or DDC. This office will be capacitated by IP and required to support the Family Health Division (FHD) and the MOHSW SCM TWG with quantification and forecasting of PMTCT and Nutrition products (required for the success of the PMTCT Acceleration Plan and the NACS Integration Plan), logistics for national SCM TWG meetings and developing contingency plans, in conjunction with the MOHSW and other stakeholders, for anticipated or emergent stock outs. TA will be provided to train the logistic officers in this department and eventual skills transfer to the PD of the MOHSW. Working closely with the PMTCT partner, IP will ensure that all levels of the SCM in Lesotho are strengthened to provide PMTCT and care

and treatment services. The Essential Medicines List (EML) and Standard Treatment Guidelines (STGs) will be finalized and disseminated widely to all health facilities. *Supply-chain management for ARVs, prophylaxis, Lesotho Mother Baby Pack (MBP) or Minimum Package and nutrition commodities (RUTF, fortified milk, plumpy nuts, etc.) will be supported to ensure the complete PMTCT service package can be provided to pregnant and lactating women and their infants. Support will be provided to the MOHSW to integrate its storage and delivery systems for HIV commodities and other pharmaceutical products. Logistics for prompt distribution of HIV commodities, test kits and reagents to all hospitals and health centers will be supported*

Implementing Mechanism Details

Mechanism ID: 14301	**Mechanism Name: LETLAMA**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: No
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 2,000,000	
Funding Source	**Funding Amount**
GHP-State	2,000,000

Sub Partner Name(s)

ALAFA (Apparel Lesotho Alliance to Fight AIDS)	Elizabeth Glaser Pediatric AIDS Foundation	Johns Hopkins University Insititue for International Programs
Phela Health and Communication		

Overview Narrative

The goal of the Letlama project is to improve the health of the people of Lesotho by reducing HIV incidence. The Letlama project will focus on supporting Basotho youth and adults in three main behavioral areas: 1) Increased correct and consistent condom use with all sexual partners; 2) Reduction of multiple and concurrent sexual partnering; and, 3) Increased knowledge of one's own HIV status and one's partner's status. The project will

implement evidence-based behavior change communication activities and strategies to improve linkages and referrals between communication activities and existing programs that provide HIV counseling and testing, PMTCT, and VMMC services, as well as male and female condoms. No service delivery or condom distribution activities will be directly supported by the Letlama project, beyond technical support to public sector partners to implement post-exposure prophylaxis services. The Letlama team will work closely with the public sector, community partners, and the private sector to strengthen the capacity of Basotho institutions to lead, sustain and harmonize the HIV prevention response and deliver high-quality HIV prevention services to scale, measurably contribute to the adoption of social and cultural norms, attitudes, and values that reduce vulnerability to HIV, and measurably improve the ability and motivation of Basotho youth and adults to change their behaviors through increased knowledge, risk perception, skills, and linkages to key services. Although project activities reach youth and adults of all ages, the Letlama team works specifically with young people aged 15-24 and adults 25-35.

Cross-Cutting Budget Attribution(s)

Gender: Gender Equality	100,000
Key Populations: MSM and TG	25,000

TBD Details

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**14301**
Mechanism Name:	**LETLAMA**
Prime Partner Name:	**Population Services International**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	0	0

Narrative:

The Letlama project will build the capacity of partners to design and deliver age-appropriate HIV prevention interventions to youth 15-24, including delay of sexual debut. Capacity building strategies include: formal trainings; engagement with real-world programs; and, engagement with networks of highly capable individuals and institutions. The project will also build the capacity of local coordinating authorities to play a more active role in the coordination of community-level HIV prevention programs that include abstinence and partner reduction messages. Capacity building efforts will be complemented by a multi-channel integrated campaign, designed and implemented by the Letlama team, to address the underlying social and cultural norms and practices that drive HIV and will include age-appropriate messaging to encourage the delay of sexual debut among youth and partner reduction among sexually active youth and young adults. Interactive individual and small group interpersonal communication activities will promote partner reduction amongst those who are sexually active and delay of sexual debut among youth who are not yet sexually active.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	2,000,000	0

Narrative:

The Letlama project will build the capacity of partners to design and deliver comprehensive HIV prevention interventions to youth 15-24 and young adults 25-34. Capacity building strategies include: formal trainings; engagement with real-world programs; and, engagement with networks of highly capable individuals and institutions. The project will also build the capacity of local coordinating authorities to play a more active role in the coordination community-level HIV prevention programs. Capacity building efforts will be complemented by a multi-channel integrated campaign, designed and implemented by the Letlama team, to address the underlying social and cultural norms and practices that drive HIV. Through a coordinated social mobilization effort designed to maximize local partners' coverage, and based on sound theory-based interventions, the Letlama team will increase community action and repeated exposure to key behavior change messages. Interactive individual and small group interpersonal communication activities will be implemented by Letlama partners to promote condom use, partner reduction and uptake of HIV counselling and testing services. These individual level activities will also strengthen referrals to community and health system products and services, including biomedical interventions implemented by other projects and Letlama partners. The project will also support the expansion of programs that provide post-exposure prophylaxis (PEP) to respond to cases of sexual assault, accidental needle prick, accidental surgical cut and other exposure. The project will work with the MoHSW to conduct an initial assessment of the implementation of PEP guidelines in 10 districts and identify gaps; develop of job aides; provide onsite training; develop and disseminate a register; advocate for more a confidential system for health professionals; and, ensure the availability of specific ARV components of PEP. District-level symposia will also be implemented in each district throughout the year to revitalize local commitments to HIV prevention and to galvanize local leaders to play a leading role in advocating for effective HIV prevention programming.

Implementing Mechanism Details

Mechanism ID: 16766	**Mechanism Name: Applying Science to Strengthen and Improve Systems (ASSIST)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: University Research Corporation, LLC	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: TA	
G2G: No	Managing Agency:

Total Funding: 800,000	
Funding Source	**Funding Amount**
GHP-State	375,000
GHP-USAID	425,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Even though evidence-based, simple, high-impact interventions capable of saving lives and alleviating suffering are available, many patients and clients are still not benefiting from them. Much of this implementation gap is likely related to weak health systems and processes of care delivery. These weaknesses may exist in the quality of care, including effectiveness, efficiency, patient/client-centeredness, equity, safety, accessibility, timeliness, community involvement, and inability to achieve the MDG targets.

URC, in Lesotho, will work with the Ministry of Health (at the forefront) in establishing an integrated country design to coordinate improvement activities, research and evaluation (R&E), knowledge management (KM), scale-up, sustainability, and institutionalization. This will be aimed at ensuring that planned outcomes of the Lesotho PEPFAR Program are achieved while enhancing the capability of the Government and Local Partners to implement and sustain them. URC will align evidence-based interventions in technical content areas – such as maternal, newborn, and child health (MNCH), HIV/AIDS, and health workforce – with evidence-based approaches in improvement, including collaborative improvement, human performance technology, standards, and others.

The ASSIST Strategy will be in alignment with the goals of USG and global initiatives, including the Global Health Initiative (GHI); USAID Forward; and HIV-free Survival. URC will work with the Country team and relevant PEPFAR IPs to identify and resolve gaps in programming, especially as linked to linkages between different

programs and retention in HIV Care, TB/ HIV management and HIV treatment.
URC and its partners are uniquely positioned to engage with local stakeholders to achieve PEPFAR Lesotho's aims.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	100,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms
Increase gender equity in HIV prevention, care, treatment and support
Child Survival Activities
Safe Motherhood
TB

Budget Code Information

Mechanism ID:	**16766**
Mechanism Name:	**Applying Science to Strengthen and Improve Systems (ASSIST)**
Prime Partner Name:	**University Research Corporation, LLC**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	150,000	0

Narrative:

Clinical Services and Community Programs
In PMTCT, TB/HIV, HIV Care and Treatment, URC will collaboratively work with different partners to define:

QI Gaps in care (clinical and community)
Opportunities for linkages and sustained quality health services; retention in services too
Strengths in programs (e.g quality services, best practices that are replicable, feedback, customer satisfaction, QI approaches, etc)
Quality improvement in services integration approaches

National Technical Assistance
URC will provide technical assistance to MOH to:
Build QI capacity within the MOH QI department and other programs
Own and manage existing and new QI interventions
Support QI interventions effectively at district and facility level

NACS Implementation
Improving care at the patient/provider level: Once health workers know 'what' services to provide, they still need to learn 'how' to provide these services in their context. Quality improvement (QI) is a management approach front line health workers can use to analyze and solve their own problems.
Spreading knowledge using peer-to-peer learning: To help ensure that knowledge about how to improve care that is generated at one site is spread to other sites we suggest organizing meetings where teams from multiple QI teams come together to share with each other.
Supporting a national quality management program: In addition to working directly with facilities and communities, HCI will support the MoH to strengthen a quality management system for the nutrition program

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	150,000	0

Narrative:

Clinical Services and Community Programs
In PMTCT, TB/HIV, HIV Care and Treatment, URC will collaboratively work with different partners to define:
QI Gaps in care (clinical and community)
Opportunities for linkages and sustained quality health services; retention in services too
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Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	100,000	0

Narrative:

National Technical Assistance
URC will provide technical assistance to MOH to:
Build QI capacity within the MOH QI department and other programs for PMTCT
Own and manage existing and new QI interventions
Support QI interventions effectively at district and facility level

NACS Implementation
Improving care at the patient/provider level: Once health workers know 'what' services to provide, they still need to learn 'how' to provide these services in their context. Quality improvement (QI) is a management approach front line health workers can use to analyze and solve their own problems.
Spreading knowledge using peer-to-peer learning: To help ensure that knowledge about how to improve care that is generated at one site is spread to other sites we suggest organizing meetings where teams from multiple QI teams come together to share with each other.
Supporting a national quality management program: In addition to working directly with facilities and communities, HCI will support the MoH to strengthen a quality management system for the nutrition program

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	200,000	0

Narrative:

The overall objective of this project (USAID) is to foster improvements in a range of health care processes, and to document these improvements with evidence of change in quantitative indicators of quality, based on the application of modern QI methodologies by host country providers and managers, to allow providers in another health system to design and implement a similar intervention.
GHI Principles to be addressed within URC ASSIST's scope of work
1. Addressing gender issues in country activities;
2. Addressing the integration of services through QI approaches;
3. Promoting country ownership by effectively addressing policy makers' improvement ?priorities and by making providers and managers the implementers of all QI ?activities;
4. Strengthening global health partnerships through expert support for QI activities in ?partners' programs;
5. Making the sustainability of improvements the subject of monitoring, evaluation, and ?research; and
6. Improving metrics, monitoring, and evaluation by applying these approaches to health ?care processes; by promoting research and innovation through a dedicated research program; and by the systematic testing of changes in health care processes.

Clinical Services and Community Programs
In PMTCT, TB/HIV, HIV Care and Treatment, URC will collaboratively work with different PEPFAR Lesotho partners to define:
Strengthen programs linkages
Quality improvement in services integration approaches

National Technical Assistance
URC will provide technical assistance to MOH to:
Build QI capacity within the MOH QI department and other programs
Own and manage existing and new QI interventions
Support QI interventions effectively at district and facility level

PEPFAR Deliverables
Development of Retention Action Plan for Lesotho.
Assist with Scale up of District and Facility Level Support for QI; Evidence base for PMTCT and ART Service Improvement;

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	200,000	0

Narrative:

he overall objective of this project (USAID) is to foster improvements in a range of health care processes, and to document these improvements with evidence of change in quantitative indicators of quality, based on the application of modern QI methodologies by host country providers and managers, to allow providers in another health system to design and implement a similar intervention.
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4. Strengthening global health partnerships through expert support for QI activities in ?partners' programs;
5. Making the sustainability of improvements the subject of monitoring, evaluation, and ?research; and
6. Improving metrics, monitoring, and evaluation by applying these approaches to health ?care processes; by promoting research and innovation through a dedicated research program; and by the systematic testing of changes in health care processes.

Clinical Services and Community Programs
In PMTCT, TB/HIV, HIV Care and Treatment, URC will collaboratively work with different PEPFAR Lesotho partners to define:
Strengthen programs linkages
Quality improvement in services integration approaches

National Technical Assistance
URC will provide technical assistance to MOH to:
Build QI capacity within the MOH QI department and other programs
Own and manage existing and new QI interventions
Support QI interventions effectively at district and facility level

PEPFAR Deliverables
Development of Retention Action Plan for Lesotho.
Assist with Scale up of District and Facility Level Support for QI; Evidence base for PMTCT and ART Service Improvement;

Implementing Mechanism Details

Mechanism ID: 16768	**Mechanism Name: Mentor Mothers Reducing Infections Through Support and Education (RISE)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Mothers 2 Mothers	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 400,000	
Funding Source	**Funding Amount**
GHP-State	100,000
GHP-USAID	300,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Mother to Mothers (m2m) will implement a prevention of mother-to-child transmission of HIV (PMTCT) peer education and psychosocial support project in Lesotho. Project objectives are in line with the Partnership Framework and GHI strategy. The technical approaches outlined for the Mentor Mothers Reducing Infections through Support and Education (RISE) Project are designed to have a far-reaching impact on the HIV/AIDS epidemic in Lesotho. m2m will provide peer-based PMTCT and maternal, newborn, and child health (MNCH) education and psychosocial support for pregnant women and new mothers in public health facilities and communities by employing and training mothers living with HIV who have experienced PMTCT care as "Mentor Mothers" and "Community Mentor Mothers." These Mentor Mothers will work alongside doctors and nurses, implementing partners and key community structures providing critical PMTCT/MNCH education. The Mentor Mother model of harnessing communities' capacity and introducing a new tier of trained, professionalized lay health workers has been recognized as a critical contribution to effective service delivery and strengthening health workforce capacity in the elimination of new HIV infections among children by 2015. m2m will use programmatic strategies depending on the local PMTCT/MNCH context. The program strategies are well-researched approaches to increasing utilization of PMTCT/MNCH services, through addressing barriers to uptake of prevention, care, and

treatment services and creating linkages to care and treatment. The implementation strategies include:

1. Direct Service Delivery at health facility and community level

2. Capacity Building for Governments and local implementing partners

3. Provision of technical advisory services.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	50,000
Gender: GBV	50,000
Gender: Gender Equality	50,000
Human Resources for Health	150,000

TBD Details

(No data provided.)

Key Issues

Implement activities to change harmful gender norms & promote positive gender norms

Increase gender equity in HIV prevention, care, treatment and support

Increasing women's legal rights and protection

Child Survival Activities

Safe Motherhood

TB

Budget Code Information

Mechanism ID:	**16768**
Mechanism Name:	**Mentor Mothers Reducing Infections Through Support and Education (RISE)**
Prime Partner Name:	**Mothers 2 Mothers**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	0	0

Narrative:

Not Provided

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	400,000	0

Narrative:

m2m will deliver Mentor Mother services at both the facility and in the community. Facility-based Mentor Mothers' services will include educating HIV-positive, -negative, and -unknown pregnant women and new mothers in group health talks, encouraging them to test for HIV, and providing focused education and support on an array of health issues including HIV/AIDS, PMTCT, MNCH, disclosure, safe motherhood, negotiating safer sex, family planning, infant feeding, infant testing and nutrition, as well as tuberculosis pre-screening and education, cervical cancer education and referral, neonatal male circumcision education and referral, and gender-based violence support and referral. This will be done in Group health talks with women; One-on-one interactions between the Mentor Mother and the client; Support group sessions for sharing of experiences, learning, and coping strategies; Couples interactions with female clients and their male partners; Couples support groups; Targeted client follow-up to track mothers and infants lost to care; and, Referrals to relevant maternal and child health services.
Facility-based 'model sites' are a key component of a national Mentor Mother Program. The model sites will be pivotal in supporting the capacity development of local partners by providing a platform for demonstrative knowledge and skills transfer for partners.
In select countries, m2m will implement a portfolio of strategic model sites where targeted innovations will be developed, tested and re-designed for scale-up.

In the community, m2m will pursue a three-pronged approach to build demand for care:
1. Clinical outreach through partnerships with community-based organizations and community health workers, as well as working within existing community-based structures. m2m will building new partnerships with organizations to increase community access to health services. Mentor Mothers and CHWs will collaborate with and complement each other by providing linkages between facilities and communities to support clients and provide education on PMTCT.
2. Demand creation by deploying "Community Mentor Mothers" (CMMs) to canvas communities, identifying HIV-positive, -negative, and –unknown pregnant women eligible for care and encouraging early access to care.

3. Public awareness raising through group health talks, advocacy, and information, education, and communication (IEC). m2m will develop IEC materials such as posters, brochures, and videos for Community Mentor Mothers to use as part of their outreach to women, their partners, and families to educate them on available PMTCT/MNCH care and correct misconceptions or misunderstandings. In 2013, m2m will research and develop an IEC strategy with corresponding materials to reach HIV-positive and -negative women, and their partners in a comprehensive manner. M2m will also provide technical advisory services to local implementing partners, Government of Lesotho on the implementation of the mentor mother model. Building on m2m's expertise in PMTCT care and support, m2m will contribute to national PMTCT response coordination as well as conduct a number of activities to determine the success of similar peer education programs. These activities may range from technical assistance in the development of relevant guidelines to analysis and assessment services for partners currently implementing peer education activities.

Implementing Mechanism Details

Mechanism ID: 17098	**Mechanism Name: Enhancing Strategic Information (ESI)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Institute for Health Measurement	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: Yes
Global Fund / Multilateral Engagement: No	
G2G: No	Managing Agency:

Total Funding: 650,000	
Funding Source	**Funding Amount**
GHP-State	115,000
GHP-USAID	535,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

IHM will conduct an assessment to establish HR gaps and needs for SI capacity and develop a capacity building

strategy. IHM will hold a high level meeting to discuss strategies, overall M&E developments and concerns. National target setting agenda will be established. IHM will develop a road map for Health reporting for the MDGs. IHM will continue TA to enhance and sustain data quality and ultimate institutionalisation. IHM will publish the RDQA institutionalisation experience. IHM will facilitate a DQA for HIV and AIDS and TB/HIV programs. Monitoring use of tools and sustained at all levels. Establish a protocol for introduction and management of M&E reporting tools for the MOH. IHM will provide concentrated TA for data utilisation at all levels. Quarterly reviews will be strengthened and processes to link quarterly review action items with operational plans defined. Biannual publications of HIV programs data and systematic sharing of information quarterly will be strengthened to root out various reported statistics. Hold Data Demand and Information Use trainings for district teams and Heads of Programs. Mentor MOH on populating data and linking the GIS database with the integrated HMIS and develop GIS that will map all PEPFAR Implementing partners and their activities. Contact trainings on proposal writing, data analysis for both qualitative and quantitative researches and report writing for tutors and district personnel. Train research methodologies for Health IRBs and RECs. Conduct Aetiology of STI surveillance and the HIV drug resistance EWIs.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Key Issues

Safe Motherhood

TB

Budget Code Information

Mechanism ID:	**17098**
Mechanism Name:	**Enhancing Strategic Information (ESI)**

Prime Partner Name:	Institute for Health Measurement		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	650,000	0

Narrative:

In the previous FY IHM attained much; establishing SI steering committees at both central and district levels that steer SI issues, establishing Health facilities catchment areas and populations while also conducting several M&E trainings. Established quality mechanisms including supportive supervision have increased utilisation of M&E tools and reporting. As the SI land scape changes its crucial for IHM to sustain its efforts and strengthen other portfolios as surveillance. IHM will conduct an assessment to establish HR gaps and needs for SI capacity and subsequently develop a capacity building strategy. Strategies require stewardship for sector wide by in and implementation hence IHM will hold a high level meeting to discuss strategies, overall M&E developments and concerns. National target setting agenda will be established. IHM will develop a road map for Health reporting for the MDGs.

IHM will continue TA to MOH to enhance and sustain data quality and ultimate institutionalisation. IHM will publish the RDQA institutionalisation experience in Lesotho. IHM's continued TA will prepare the MOH to commission an external body to conduct a DQA especially for HIV and AIDS and TB/HIV programs. Use of tools be sustain and monitored. IHM will continue to strengthen M&E TWGs at all levels. One clear need is to establish a protocol for introduction and management of M&E reporting tools for the MOH. IHM will provide concentrated TA for data utilisation at all levels especially at the community levels which have acquired catchment populations. Quarterly reviews will be strengthened and processes to link quarterly review action items with operational plans defined. Biannual publications of HIV programs data and systematic sharing of information quarterly will be strengthened to root out various reported statistics. Hold Data Demand and Information Use trainings for district teams and Heads of Programs.

IHM has provided TA to MOH to pioneer demarcations of health facility catchment areas and establishment catchment populations up to 2013-2014 throughout the country. IHM propose TA that will continue to mentor MOH on populating data and linking the GIS database with the integrated HMIS. There is a need to include private practitioners that are offering health services in demarcated catchment areas in the next phase of the project. IHM proposes development of GIS that will map all PEPFAR Implementing partners and their activities.

IHM's research, evaluations and surveillance portfolio will be increased in this plan period. IHM proposes to conduct trainings on proposal writing, data analysis for both qualitative and quantitative researches and report writing for tutors in Pre-service Health training institutions and district personnel. Conduct training on research methodologies for Health IRB and REC. An assessment that establishes strengths

and weakness of surveillance systems will be conducted and sustained collaboration is required to extend the effort beyond HIV surveillance only. IHM TA will undertake aetiology of STI surveillance and the HIV drug resistance EWIs.

Implementing Mechanism Details

Mechanism ID: 17123	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 17124	**TBD: Yes**
REDACTED	

USG Management and Operations

Assessment of Current and Future Staffing.

Redacted

Interagency M&O Strategy Narrative.

Redacted

USG Office Space and Housing Renovation.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Capital Security Cost Sharing			122,928	122,928
ICASS		78,745	563,718	642,463
Management Meetings/Professional Developement		5,000	15,000	20,000
Non-ICASS Administrative Costs			37,919	37,919
Staff Program Travel			324,000	324,000
USG Staff Salaries and Benefits		71,836	687,611	759,447
Total	**0**	**155,581**	**1,751,176**	**1,906,757**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHP-USAID		122,928
ICASS		GHP-State		78,745
ICASS		GHP-USAID		563,718
Management Meetings/Professional Developement		GHP-State		5,000

Management Meetings/Professional Developement		GHP-USAID		15,000
Non-ICASS Administrative Costs		GHP-USAID		37,919

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		25,000		25,000
Management Meetings/Professional Developement		5,000		5,000
Staff Program Travel		9,000		9,000
USG Staff Salaries and Benefits		36,000		36,000
Total	**0**	**75,000**	**0**	**75,000**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHP-State		25,000
Management Meetings/Professional Developement	Training	GHP-State		5,000

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Capital Security Cost Sharing		126,474		126,474

ICASS		368,000		368,000
Institutional Contractors	349,654	0		349,654
Management Meetings/Professional Developement		8,000		8,000
Non-ICASS Administrative Costs		212,597		212,597
Staff Program Travel	14,273	45,877		60,150
USG Staff Salaries and Benefits	671,449			671,449
Total	**1,035,376**	**760,948**	**0**	**1,796,324**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHP-State		126,474
ICASS		GHP-State		368,000
Management Meetings/Professional Developement		GHP-State		8,000
Non-ICASS Administrative Costs		GHP-State		212,597

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
ICASS		80,314		80,314
Management Meetings/Professional Developement		2,500		2,500
Non-ICASS		66,610		66,610

Administrative Costs				
Staff Program Travel		626		626
USG Staff Salaries and Benefits		7,235		7,235
Total	**0**	**157,285**	**0**	**157,285**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
ICASS		GHP-State		80,314
Management Meetings/Professional Developement		GHP-State		2,500
Non-ICASS Administrative Costs		GHP-State	Meetings/Conferences: $20,000; Miscilaneous equipment: $9,469	66,610

U.S. Peace Corps

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Cost of Doing Business Category Total
Non-ICASS Administrative Costs		35,108		35,108
Peace Corps Volunteer Costs		468,927		468,927
Staff Program Travel		18,260		18,260
USG Staff Salaries and Benefits		83,839		83,839
Total	**0**	**606,134**	**0**	**606,134**

U.S. Peace Corps Other Costs Details

Category	Item	Funding Source	Description	Amount
Non-ICASS Administrative Costs	other services	GHP-State	printing- $ 3,974; reproduction -	35,108

			$3,000 ; communications - $5,000	