

**LESOTHO GLOBAL FUND SUPPORT HIV/AIDS ANNUAL PROGRESS
REPORT**

JANUARY 2005

-

DECEMBER 2005

PREPARED BY GLOBAL FUND UNIT

NATIONAL AIDS COMMISSION

APRIL 2006

TABLE OF CONTENTS

	Page
Abbreviations	3
Preamble	4
Chapter 1 Background and Situation Analysis.....	5
1.1. Background.....	5
1.2. Situation Analysis.....	6
Chapter 2 Status of implementation and Challenges.....	7
2.1 PREVENTION	7
2.1.1 Youth Resource Centres.....	7
2.1.2 Adolescent Health Corners.....	8
2.1.3 Procurement of Condoms	9
2.1.4 Promoting PMTCT and VCT.....	10
2.1.5 Conduct Youth Education.....	12
2.1.6 Institutionalize HIV/AIDS into Curriculum.....	14
2.2 MITIGATION.....	15
2.2.1 Increase General awareness on Human Rights of PLWHA.....	15
2.2.2 Reduction in the reported cases by PLWHA.....	16
2.2.3 Identify and train care givers and volunteers.....	17
2.2.4 Provision of IGA.....	19
2.2.5 Guarantee education for Orphans.....	20
2.3 CARE AND TREATMENT.....	22
2.3.1 Development of Policy and guidelines.....	23
2.3.2 Training of Counsellors, Caregivers and Volunteers.....	23
2.3.3 Train Professionals on HIV Diagnosis and Management.....	24
2.3.4 Procurement of reagents, Home base care kits.....	24
2.3.5 Establishment of ART and HTC.....	25
2.3.5.1 ART Centres.....	25
2.3.5.2 HTC Centres.....	26
2.4 GOVERNANCE.....	31
2.4.1 Renovation and furnish DAC offices.....	31
2.4.2 Monitoring and Evaluation.....	31
2.4.3 Train DAC and DATF.....	32
2.4.4 Strengthen Umbrella Bodies.....	32
Chapter 3 CONCLUSION AND RECOMMENDATIONS.....	34
Chapter 4 BUDGET AND EXPENDITURE.....	36
4.1 Budget.....	36
4.2 Expenditure.....	37

ABBREVIATIONS

ART	-	ANTIRETROVIRAL THERAPY
CBO	-	COMMUNITY BASED ORGANIZATIONS
CHAI	-	CLINTON INITIATIVE HIV AND AIDS INITIATIVE
CRS	-	CATHOLIC RELEF SERVICE
DAC	-	DISTRICT AIDS COORDINATOR
DATF	-	DISTRICT AIDS TASK FORCE
FBO	-	FAITH BASED ORGANIZATION
FIDA	-	FEDERACION INTERNACIONAL DE BOGADAS
GFATM	-	GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA
GOL	-	GOVERNMENT OF LESOTHO
H.S.A	-	HEALTH SERVICE AREA
HTC	-	HIV TESTING AND COUNSELLING
IEC	-	INFORMATION, EDUCATION AND COMMUNICATION
IMAAI	-	INTEGRATED MANAGEMENT OF ADULT AND ADOLESCENT ILLNESSES
LENEPWHA	-	LESOTHO NETWORK OF PEOPLE LIVING WITH HIV AND AIDS
LCN	-	LESOTHO COUNCIL OF NON GOVERNMENTAL ORGANIZATIONS
LPPA	-	LESOTHO PLANNED PARENTHOOD ASSOCIATION
M&E	-	MONITORING AND EVALUATION
MOET	-	MINISTRY OF EDUCATION AND TRAINING
MOFDP	-	MINISTRY OF FINANCE AND DEVELOPMENT PLANNING
MOHSW	-	MINISTRY OF HEALTH AND SOCIAL WELFARE
MGYSR	-	MINISTRY OF GENDER, YOUTH, SPORT AND RECREATION
MTCT	-	MOTHER TO CHILD TRANSMISSION
NAC	-	NATIONAL AIDS COMMISSION
NGO	-	NON GOVERNMENTAL ORGANIZATION
OVC	-	ORPHANS AND VULNERABLE CHILDREN
PEP	-	POST EXPOSURE PROPHYLAXIS
PLWHA	-	PEOPLE LIVING WITH HIV AND AIDS
PMTCT	-	PREVENTION OF MOTHER TO CHILD TRANSMISSION
PR	-	PRINCIPAL RECIPIENT
SR	-	SUB RECIPIENT
VCT	-	VOLUNTARY COUNSELING AND TESTING

PREAMBLE

This is the Second Annual Report of the Global Fund support program initiated in 2004. The purpose of this report is to provide progress made in the implementation of the program highlighting successes, constraints, and challenges encountered.

The report, specifically, describes the processes undertaken to develop the capacities of the Principal Recipient, Ministry of finance and Development Planning (MOFDP) as well as the Sub Recipients, Ministry of Health and Social Welfare (MOHSW) and National AIDS Commission (NAC).

The report also describes the development processes of the M&E Plan, the development of the various instruments for use in collecting information on a matrix and indicators prepared to guide and assess the implementation processes annually.

The report is organized in the following format:

- Chapter1. Background, information, and situation analysis
- Chapter2. Status of implementation and challenges
- Chapter3. Budget and expenditure
- Chapter4. Conclusions and Recommendations

CHAPTER 1. BACKGROUND AND SITUATION ANALYSIS

1.1 Background

The Government of Lesotho signed an Agreement with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) to support the implementation HIV/AIDS and Tuberculosis programme activities In October, 2003. The agreement was for a period of two year regarded as the Phase 1 from 2004 to 2005. The support for the Phase I amounted to a total of USD12, 557,000, comprising USD10, 557,000 for HIV Programme and USD2, 000,000 for TB Programme.

A set of indicators were prepared and used as a guide to assess the implementation and performance through-out the year. These indicators comprises of five components which included Prevention, Mitigation, Care and Treatment, Governance and the Monitoring and Evaluation.

Phase I comprised of the institutional capacity building for the Principal Recipient, the overseer of the Grants the Ministry of Finance and Development Planning, through the engagement of the Technical Advisor to coordinate and work closely with the sub-recipients as part of the World Bank support. The Sub-Recipients National AIDS Commission (NAC) and Ministry of Health and Social Welfare (MOHSW) were strengthened with additional staff, specifically to build capacity for with Monitoring and evaluation at NAC by engagement of M&E advisor, M&E Officer and Data Officers at central and district level respectively, whereas MOHSW recruited the Epidemiologist, Health Informatics, and Researcher at the central and HIV/AIDS data officers at district level.

The monitoring and Evaluation Plan (M&E Plan) was developed and used as a guide to monitor, evaluate and report on progress made in terms of the GFTAM activities as defined in the approved proposal. These monitoring, evaluation, reporting and data management procedures did not only provide information for programme implementation, but also form the basis for continued disbursements, as per the performance-based disbursement system.

In addition other instruments such as Monitoring tools including the Programme Monitoring Forms were developed and are now in use by the GFATM Implementers, as part of the M&E Plan; Health Testing and Counselling Forms, PMTCT tools and ART Forms have been developed and used to collect data at all levels.

1.2 Situation Analysis

The Global Fund Grant for the support of HIV and AIDS Program is a five year program that is to be implemented in two phases. Phase I started in January 2004 to December 2005 and phase II, which has to be agreed upon is expected to start from introspective January 2006 and to be completed in December 2008.

The main goal of the program stipulated in the approved proposal is to reduce the prevalence of HIV by 6% by 2007, from 31% to 25%,

- by intensifying prevention among youth (10-25);
- strengthening community capacity;

- Mitigating the impact of AIDS among PLWAS and OVCs.
- The program also proposed to introduce ARVs and strengthen the National management structures in the delivery of HIV/AIDS services.

The Second Year of the implementation started in January 2005 was faced with the challenge to accelerate activities which had been delayed during the first year of implementation occasioned by failure to meet conditions set for the second and subsequent disbursement; measured against a set of indicators for each objectives.

The first objectives dealt with the expansion of life skills and peer education training and HIV/AIDS prevention services to adolescent and pre-adolescent young people, with specific focus on girls. Achievements in this regard included i) 359,098 young people exposed to life skills and HIV/AIDS education in schools and out of school settings; ii) 16 adolescents reproductive corners increased; iii) 7,984,304 condoms distributed to youth resource centres and adolescent health corners and to the public in general.

The second objective aimed at reducing the proportion of infants infected by establishing PMTCT programme in the 18 Health Service Areas. Achievements included i) 659 babies put on PMTCT treatment course; ii) 24,697 women attending antenatal clinics sensitized on PMTCT services; iii) 2,660 HIV infected pregnant women received complete course of antiretroviral prophylaxis to reduce the risk of MTCT after being tested positive; iv) 406 and Health staff trained on PMTCT.

The third objective was the provision continuum of care to PLWHA. Achievements included i) 30,702 PLWHA accessing community home based care support from support groups; ii) 7,493 training of health and community staff on diagnosing and managing HIV and AIDS; iii) people receiving ART treatment; iv) 19 sites with functional VCT centres put in place and people testing and counselled; v) 10,623 Orphans assisted with school fees and other basic package of care and support.

The fourth objective was to increase general awareness on the human rights of PLWHA and AIDS affected people. Achievements indicators included i) 100 PLWHA receiving advocacy training skills on their human rights; ii) 1% reduction of the reported infringements of PLWHA human rights.

The fifth objective aimed at the strengthening of HIV Coordination from central level down to the district level in all sectors in and outside government structures. The achievements indicators included i) 10 Office infrastructure constructed for District AIDS Coordinators level; ii) Lesotho Network Of People living with HIV and AIDS (LENEPHWA) established and strengthened iii) and establishment of Monitoring and Evaluation mechanisms.

To accelerate the implementation of the activities above, 42 Organizations were engaged to work together to ensure achievement of targets as set in the agreement. These included 26 Non Governmental Organizations (NGOs), five Line Ministries; four Faiths based Organizations (FBO), LENEPHWA and 9 District AIDS Task Forces (DATFS).

For the next chapters, more detailed will be discussed on specific components looking into the Specific Objectives; indicators and activities.

CHAPTER 2: STATUS OF IMPLEMENTATION AND CHALLENGES

2.1. PREVENTION

The aims of the prevention thematic area is to expand and provide necessary tools and information for the peer education within the country to meet the information needs of Basotho youth with a view to achieving HIV infection reduction, leading to the reduction of incidences recurring and reduction of morbidity and mortality.

The prevention objectives and its activities read as such; to expand and strengthen life skills education in schools and HIV/AIDS peer education training with specific focus on girls; to expand access of condoms for sexually active youth by installing condom dispensing machines in 70% of all youth friendly corners in the existing health service areas by 2007; and to reduce the proportion of infants infected by 20% by establishing PMTCT programmes in the 18 health service areas by the end of 2005.

To achieve these, the activities planned included; establish Youth Resource Centres in all ten districts; increase Adolescent Health corners in the districts; develop and disseminate Policy on Adolescent Health; develop M&E system; provide 5,000,000 Condoms throughout the Country; conduct Community Empowerment activities for the youth; integrate Voluntary Counselling and Testing (VCT) services into Adolescent and youth centres; scale up PMTCT programme in all Health Service Areas; institutionalize HIV/AIDS Curriculum in all schools including tertiary institutions; design and erect IEC billboards promoting PMTCT and VCT at the community level and conduct advocacy activities for Community leaders.

PROGRESS STATUS:

2.1.1 YOUTH RESOURCE CENTRES

The Ministry of Gender, Youth, Sports and Recreational was responsible in implementation of this activity. The objective of establishing the Youth Resource centres is to bring together the youth and train them on life skills, provide information on HIV/AIDS and any issues that the Youth may feel appropriate to build their capacity. These may include basic computer skills, counselling and testing, and services such as teenage pregnancies, Reproductive and Mental health, recreational services that could be used to help contain the problem of stigma, and discrimination.

The Ministry of Gender and Youth, Sports and Recreation (MGYSR) identified sites for the establishment of the Youth Resource Centres in Leribe, Maseru (Semonkong), Mafeteng, Berea Quthing, Qacha'snek, and Mokhotlong. The MGYSR managed to acquire existing structures in all the mentioned districts. These structures have been surveyed, and costed for renovation. In Semokong the site was acquired and construction of the new structure is on going. To date none of the above has been completed.

CHALLENGES:

- There have been delays in the construction/renovation of youth resource centres. This has caused the dissatisfaction from the GFTAM as this activity was regarded as the major strategy in responding to reduction of high infections amongst the youth population.
- Because of high costs of materials and high fees charged to construct new Youth Resource centres, the MGYSR has to resort to other alternatives of acquiring existing structures and therefore delayed the whole process.
- For future, the MGYSR should be provided with waiver to engage private contracts for renovation of additional structures as this would hasten and speed up the whole process the work.

2.1.2 INCREASE ADOLESCENT HEALTH CORNERS IN 3 DISTRICTS.

Establishment of the Adolescent Health Corners was initiated by the MOHSW in order to encourage teenage pregnant mothers, adolescents youth to utilize health facilities. The purpose was to ensure that these adolescents and young mothers should get information on reproductive health as well as any issues that may concern their health in general. When this project was initiated, already the MOHSW had in place 10 Adolescent health corners operational.

MOHSW managed to establish in additional a total of 6 Adolescent health corners, which saw the program achieving target within 18 Health Service Areas. These are found within the hospitals as well as the health clinics. This is one strategy which is assisting to provide health education on HIV and AIDS as well as reproductive health issues to the adolescent population (the teen pregnant mothers, herd-boys, initiates ect).

Peer education sessions for pregnant mothers, herd boys and adolescents in general were conducted in all the corners. At least 35,714 adolescents were provided with information on Reproductive health as well as HIV/AIDS counselling and training. Out of youth reached at adolescents health corners, at least 1,199 were tested for HIV and AIDS and 243 were found to be positive. Those positive have been referred to the ART and HTC program for further assistance as required.

In addition 103 Peer Educators have been trained in Adolescent Sexual and Reproductive Rights. As a means of extending provision of adolescent health service, 133 health staff were trained on management of reproductive issues such as survivors of sexual abuse, teenage pregnancy in order to be able to know how to handle the clients and deal with the issues. The trained staff included health workers such as Community health workers, nurses and programme managers.

The newly Adolescent health corners which were established were also equipped with medical equipment and office furniture as per request submitted.

The Adolescent Health Policy was developed and translated into local language. This document addresses adolescent health in general, with regards to sexual and reproductive health, mental aspects, substance abuse, injuries from accidents and

emotional consequences. Thus the policy will enhance provision of adolescent reproductive health programs and limit imposition of restrictions by administrators and service providers – based in their own personal beliefs – that may prohibit youth from gaining access to essential information and services.

CHALLENGES

- Majority of Family Health personnel have limited skills on reproductive health community security.
- Commitment from the Country Office which supports the Adolescent Health Programme has been lacking.
- Logistics such as transport is a hinderance for the Programme to regularly supervise and monitors the adolescents' corners country wide.
- Delay in the approval of the Adolescent policy by the Cabinet has contributed in the policy being not yet widely disseminated to all stakeholders.

2. 1.3 PROCUREMENT OF CONDOMS AND CONDOM DISPENSERS.

The youth and everyone who is sexually active are encouraged to use condoms, and therefore should rethink their sexual act and more often than not avoid engaging in the unsafe sexual act. Innovative methods of reaching youth with creative approaches to condom promotion methods also would increase the chances of condom use. By installing Condom dispensers, ensuring the available of condoms always and using other youth friendly methods of condom acquisition would make certain that youth will be better protected and reduces the spread of HIV infections.

For phase I period, at least 5,000,000 condoms and 400 condom containers were to have been distributed and installed 7,984,304 Condoms (female and Male) were distributed country wide, and this went with the installation of 308 condom containers in the targeted places such as clinics, taverns, shops, hospitals, restaurants, Bars, and filling stations and Letseng mining by an NGO who was engaged to carry out this activity.

As part of creating awareness and knowledge on the usage of condoms, education was integrated in the distribution. The distribution included house to house, and out of school youth gatherings such as bars and restaurants. The districts served included Mokhotlong Butha-Buthe, Thaba-tseka, Maseru, Qacha'snek and Quthing with their village and sub-villages. In the schools targeted, youth and teachers and traditional initiation school teachers in separate sessions, were provided with health education on issues relating to life skills, sexual abuse, and the importance of delaying sexual debut, abstinence and substance abuse.

Demographic Health Survey has also shown an increase on condom use of a 49.2% from 10 %(baseline before inception) by the youth in any given time whenever engaging in sexual act. Unfortunately the gains which were made during the year 2005 may be eroded due to very limited number of free condoms required by the general public.

In addition, UNFPA has been engaged through UNICEF to procure condoms which will be distributed to the public immediately on availability.

The main challenge faced on this activity during the implementation included:

- The poor quality condoms (bursting, smelly and very dry). These have been identified as the major reason why people are reluctant to access condoms found in some cases in the health facilities as were perceived as donations.
- Delay by UNFPA to procure condom. It has taken three months before the memorandum of understanding would be signed as well as the procurement process to be initiated. This has contributed in the limited availability of condoms in country to date.

Therefore it is recommended that quality should be of utmost importance to encourage the consistent use of condoms amongst the sexually active population as has been proven by the NGO who was able to procure a different coloured and flavoured brand of condoms, which the general public consumed and appreciated.

2.1.4 PROMOTING PMTCT AND VCT AT THE COMMUNITY LEVEL.

The Prevention of Mother to Child Transmission (PMTCT) Strategy was launched in Lesotho at 8 pilot sites in 2003 to reduce infant and child morbidity and mortality from HIV/AIDS, while VCT sites within the public and private sectors were established to encourage people from testing in order to know their status.

The Government of Lesotho through a number of organizations, MOHSW, Population Service International (PSI) and Lesotho Planned Parenthood Association (LPPA) have opened 28 Voluntary Counselling Testing (VCT) / Health Testing and counselling (HTC) country wide. From this number above, 20 sites are opened within the Health Service Areas (HSAs), four opened by PSI and four by LPPA. By end of December, 2005, 60,370 people have been counselled and tested for HIV. Out of these tested, 23,609 were found to be positive. The clients, who were tested positive and found to be in need of treatment, have been referred to the ART programmes for required support.

In order to encourage the people to go for testing and counselling so as to know their HIV status, transit advertising was undertaken as one of the strategies to widely create awareness on the services of VCT/HTC, PMTCT and the support that could be provided whenever need arises if one is HIV positive. 40 taxis and 10 minibuses with messages written on bodies moving from central, south and the northern regions were used for a period of six months. During November 2005 a "dipstick" survey was conducted to determine public awareness and reaction towards AIDS advertising on taxi's. The outcome and conclusion of the survey was as follows: 85% of respondents noticed taxi advertising; 93% of respondents were aware of the AIDS taxi advertising, and 70% of respondents understood the relevance of the message while 13% found the messages not relevant on creating awareness on the importance of testing and counselling.

On the other hand the MOHSW has embarked on a major initiative known as "Know your Status" campaign which was inaugurated on the 1st of December, 2005. The purpose is to give momentum to the achievement of the universal access to HIV testing and counselling by end of 2007. Combined with other initiatives which have been involved

towards the fight of AIDS, it is hoped that all these might turn around the HIV pandemic in the country.

To date the PMTCT program has been rolled out to 22 sites within 18 HSAs. The program was to counsel 45,000 women of PMTCT services, and put on treatment 1,600 by end of phase I. By end of phase I, the number of pregnant women who have received training and counselling on PMTCT is 24,697, and 16,308 have been tested for the HIV virus, while 2,660 have received a complete course of antiretroviral prophylaxis to reduce the risk of MTCT. Out of the women receiving treatment, at least 659 babies have been provided with the nevirapine syrup to prevent HIV infection.

Because of the low turnout of pregnant women enrolling in the PMTCT programme, a decision was reached to create awareness to the communities on the importance of PMTCT, and the services that are being provided. A community mobilization drive for PMTCT was launched. This encompasses the training of 200 TOT to drive the process, radio programs which were broadcasted in six local radio stations, 89 community mobilization sessions which were held in 94 urban and rural villages countrywide. By end of the campaign, at least 114,115 people were reached with PMTCT messages.

To further strengthen capacity for implementation for the PMTCT programme, 1328 health professionals were targeted for training through out the implementation period. To date only 406 health personnel were trained, and these included registered nurses, nursing assistants and pharmacists and community health workers. Unfortunately, Lesotho is facing a very high brain-drain of Professional health workers. This means that there is a shortage of professionals to be trained as was envisaged initially during the conception of the implementation.

Table: 1
PMTCT Service Provision in the HSAs in 2004

Years	Number of Pregnant women and Babies tested and on treatment					
	Counselled and trained	Tested	HIV Positive	Received Nevirapine	Babies on Nevirapine syrup	Nevirapine Uptake
2003 Baseline	4,130	1,201	396	149	71	37.6%
2004	5,690	5,690	2,443	1448	101	52.5%
2005	14,877	9,432	1,806	1,063	487	
Total	24,697	16,308	4,645	2,660	659	100%

Source : MOHSW, PMTCT Program

Figure 1

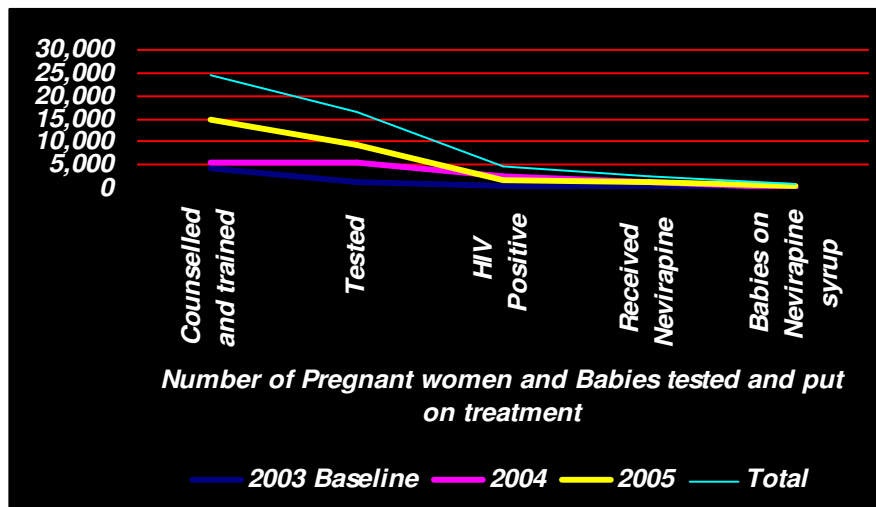


Figure 1

The graph depicts the trend since the launching of PMTCT in 2003 to December 2005 and that the uptake of PMTCT has been steadily increasing.

The major challenge encountered during the implementation by the PMTCT Programme included

- Very limited number of Maternal nurses at the antenatal clinics to register and capture data of the pregnant women attending the PMTCT services systematically. These contributed to inconsistent collection of data from PMTCT sites which resulted in data regarded as not reliable.

There is need for Vigorous strategies to be put in place to ensure that pregnant women utilizes antenatal clinics, health education provided to the family and extended system and structure as the way to advocate the utilization of PMTCT services.

2.1.5 CONDUCT YOUTH EDUCATION FOR YOUTH IN AND OUT OF SCHOOL

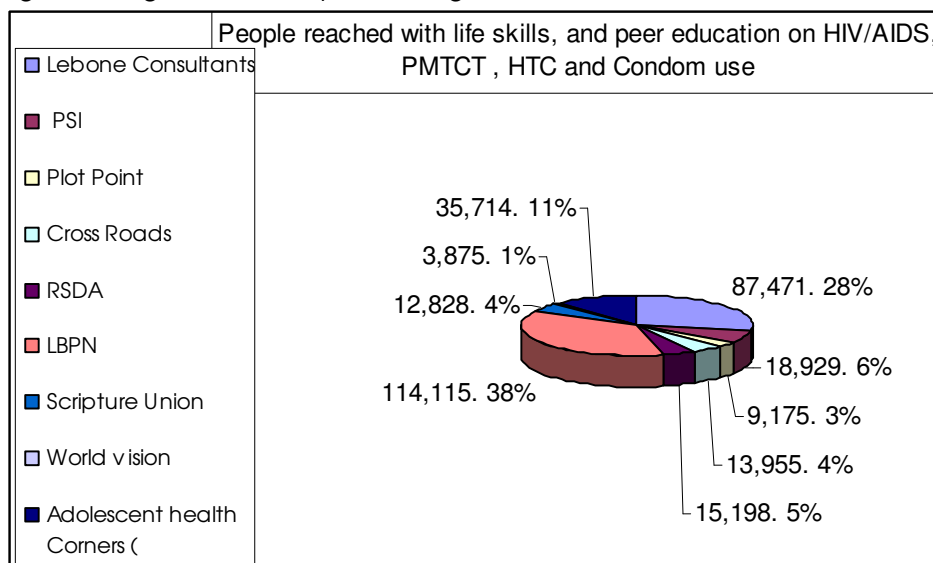
Youth education is one of the prevention strategies which can be used to curb the spread of HIV infection amongst the youth in and out of school. This can be attained through the use of peer educators, trained teachers, various methods including edutainment, talk shows, and IEC distribution with specific information targeting specific population and age group. Various Organizations were engaged to educate the youth on HIV and AIDS issues.

The first Organizations to benefit and utilized the funds for the implementation of activities under the grant was the World Vision and Ministry of Health and Social Welfare. They initiated training of peer education amongst other things. Out of 200 Peer educators to be trained, 180 Peer educators were trained (83 through MOHSW by Public Health nurses at HSAs level, and 97 by World Vision through the support of LPPA). The Intention was for the trained Peer Educators to further train other youth on issues relating to the reproductive health, HIV and AIDS. By end of the phase I some of the Peer educators

(Mafeteng Adolescent health corners) were able to train their peers on reproductive health issues including HIV and AIDS.

An increase in number of NGO implementing youth education for youth in school and out of school was accelerated to enable reaching the target set. Number of strategies were planned and devised for the acceleration and these included; conducting of edutainment activities (dramas, song theme Thuso E Teng, and production of comic strips by Plot Point) promotion of VCT/HTC , PMTCT, ART services; out of school peer education to the youth(by Rural Self-Help Development Association (RSDA)) ; targeted street-children with HIV/AIDS information and education by the Cross-Roads; targeted sex workers, miners in the districts of Leribe(Maputsoe, Maseru and Mafeteng)PS); training of Youth and sexually active population on the use of condoms and its beneficiaries by Lebone Consultants; sensitization of communities on issues of breastfeeding and PMTCT by Lesotho Breast Feeding Promotion Network (LBPN); and targeting in school youth, through the life skills training to teachers who then trained pupils on HIV and AIDS life skills by the Scripture Union). Out of the intended target of 256,080, at least 359,098 youth in and out of school were reached with peer education messages.

Figure 2: Organizations implementing Youth Education to the Youth



Source: Primary Data from Implementers NGO

The major challenge with this activity included

- Youth education activities were carried out using various strategies and even over achieved but lack of youth recourse centres as part of strategies to reach youth has been identified as one of the major important strategy which has to be achieved.

2.1.6 INSTITUTIONALIZE HIV/AIDS CURRICULUM IN ALL SCHOOLS INCLUDING TERTIARY INSTITUTIONS

The children between the ages of 5-14 years are regarded as a “window of hope” for future generation. Therefore it is important to invest in prevention strategies to ensure that they are saved from contracting HIV virus. One of the strategies identified was through the promotion of effective school programmes to curb the HIV and AIDS amongst the school age children by integrating HIV into the Curriculum from lower primary to secondary.

The Ministry of Education and training (MOET) has embarked on revising the school curriculum to integrate HIV and AIDS into school curriculum from lower primary up to the secondary level. The revised curriculum contains an approved governing framework to guide the implementation of the curriculum. To date the MOET has developed and completed a teachers training manual, learner guidelines, and an accompanying syllabus targeting primary and secondary schools, from grades 4 to form C. 80 schools including 50 Primary schools and 30 secondary schools have been selected to pilot the curriculum. About 150 teachers have been trained in order to start teaching the learners using the curriculum. It is anticipated that by beginning of the second semester, the dissemination of curriculum will be scaled up to all schools in the country.

The major challenge encountered was the delay in the buy – In to start the process to integrate HIV into school curriculum. This has at the end delayed the achievement of results. This has been quoted as one of the major challenges to be addressed very urgently in order to reach those young children at a very young tender age in order to change their behaviour.

2.2. MITIGATION COMPONENT

Over the last decade, Lesotho's OVC burden has been gradually growing, the bulk of whom have been AIDS orphans. In some rural communities, the number of orphans has exploded 20-fold in the past five years.

There is a pressing need to respond to the minimum basic needs of OVCs and to ensure they are prepared for adult life. This implies that some social services had to be scaled up to reach the most vulnerable, and that service providers, government and civil society, had to be strengthened to respond adequately and aggressively with quality interventions.

Under this thematic areas, the following objectives and indicators were to be achieved: i) To scale up the provision of a basic package of care, support and protection to 60% of orphans and vulnerable children (OVC) by 2008, and ii) to increase general awareness on the human rights of PLWHAs and AIDS-affected people in Lesotho by 40% by 2008. The performance Indicators included: i) number of registered OVC receiving basic care and support; number of OVC included in the school programme; iii) number of PLWHA receiving advocacy on their human rights; and iv) % of reduction of reported infringements of PLWHA human rights.

The activities included; conducting awareness on the human rights of the PLWHAs and AIDS-affected people in Lesotho by 40% by 2008; Identify and train of care givers and volunteers throughout the country; Guarantee primary education for Orphans and Vulnerable Children; Provide Income generating Activities to support OVCs and chronically ill; and reduce of stigma and discrimination of the PLWHAs.

PROGRESS STATUS:

2.2.1 INCREASE GENERAL AWARENESS ON THE HUMAN RIGHTS OF THE PLWHA AND AIDS-AFFECTED PEOPLE IN LESOTHO BY 40% BY 2008

The aim was of this activity was to train PLWHAs and others affected on the rights of people living with AIDS. Similar training sessions through workshops were to be held for senior civil servants, Members of Parliament, church and community leaders, and other members of the community to increase their awareness on HIV and AIDS issues and to break the silence and advocate for reduction in stigma and discrimination against people infected with and affected by HIV/AIDS.

100 people including PLWHA, senior civil servants, Members of Parliament, church and community leaders, and other members of the community were to be provided with training sessions to increase their awareness, in order to be able to break the silence and advocate for reduction in stigma and discrimination against people infected with and affected by HIV/AIDS.

A total of 70 community leaders were trained and sensitized on issues relating to OVC plight, stigma discrimination of PLWHA in the communities and the role that should be played by them to ensure that the rights PLWHA and OVC were protected. A National conference on the human rights of OVC and PLWHA followed the training sessions which were held in the districts, and the purpose of the conference was to reach a consensus on how to support and work together as church leaders, traditional leaders, the MPs, the Chiefs, Private sector, the representatives from NGOs and Government Ministries to fight the issues of discriminations for people affected and infected with HIV. 177 people attended the conference. The theme for the conference was Break the Silence on stigma and discrimination.

On the other hand, 100 PLWHA were trained and equipped with skills to advocate for their rights and to be able to handle the issues of stigma and discrimination.

Lesotho Network of People living with HIV and AIDS (LENEPWHA) was established and launched in May 2005. Furthermore, funding was provided in support of providing to the PLWHA Associations to initiate IGA for their food security and helping those who are chronically ill. So far 194 PLWHA were trained in Eco –gardening, which was followed with the supply of production materials (drum, rake, pick, spade, digging fork, hand spade, seedlings and Eco Cycle horse –pipes) to the trainees to enable them to produce food and to be able to sustain themselves.

2.2.2 Reduction in the Reported Cases by People Infringing PLWHA Human Rights

There are organizations that are already having outreach programs on the rights of women and children, and are also beginning to be concerned about the rights of people living with aids as well as the cases of abuse which goes unreported because concerned people not knowing their rights .

To address the problem of non-reporting of the abuse cases, the Federation of Women Lawyers (FIDA-Lesotho), has been appointed to help build public awareness of the legal protections available to women, children and People Living with HIV/AIDS (PLWHA). To date FIDA has managed to simplify and translate inter alia, the following Lesotho laws and legislation, and has conducted capacity-building activities centred on them:

- The Sexual Offence Act, 2003
- The Married Persons' Equality Bill 2000
- The Labor Code Amendment Act 2000
- The Children' s Protection and Welfare Bill 2004
- Development of the template for a simple Legal Will
- Translated the Land Bill, Inheritance Laws, and Marriage Laws

These documents will allow the lay public to prepare their own Wills without incurring heavy legal expenses and bearing other administrative burdens. All these activities will go a long way towards educating and empowering Lesotho society with regard to their rights, particularly those related to HIV/AIDS. 7000 copies have been printed for distribution and consumption by the public.

FIDA also launched public programs on local radio stations to promote human rights of PLWHA and plight of the OVC, and help reduce HIV/AIDS related stigma through education. Thirty four programs were conducted on seven local radio stations. The response that came as a result of these radio stations on Laws and Bills that were disseminated was very positive. This was evidence from the increased number of clients that visited FIDA to seek legal advice especially on the inheritance rights of Orphans, issues regarding child labor and administration of Estates and Wills. The latter indicated that most people were generally unaware of making and application of wills and how the Master of the High Court could assist. Since the start of the programs there has been an increase of 60% in consultation regarding the above laws, and an increase in air listener'ship which increased by 70%-80% during the period when the program was running.

Child Protection and Gender Unit and HIV/AIDS Counselling Unit (units) have also been set up in police stations countrywide to deal with reported abuse cases, and to provide

counselling services on gender sensitivity, children’s rights, and HIV/AIDS. The units are also authorized to document and collect blind data on the prevalence of the abuse for research and policy purposes. Unfortunately, during the third quarter, it became clear that such data was not being properly collected by the units. The training of staff in the units on the relevant laws governing HIV/AIDS, human rights, privacy and confidentiality will be undertaken as priority to ensure that data is collected in an ethical manner. In relation to this, USG has pledged to provide financial assistance to allow FIDA to train paralegals in six districts on the relevant human rights laws and legislation. The training has been initiated in the district of Berea and others will follow. During Phase II FIDA will receive additional funding to provide similar training in the remaining four districts, and to conduct more legal outreach and awareness programs countrywide.

2.2.3 IDENTIFY AND TRAIN CARE GIVERS AND VOLUNTEERS THROUGHOUT THE COUNTRY

The aim of this activity was to train caregivers and volunteers to take care of the sick people, as well as to care and support the Orphans at the community level.

Training of the 1000 caregivers and volunteers was one activity to be undertaken to strengthen the capacity of home based care skills to the caregivers and volunteers working at community level in order to care for the sick and OVC. 12 Organizations managed to train 5,758 caregivers and volunteers throughout the implementation of phase I. The organizations included Catholic Relief Service (CRS), CHAL, Lesotho Red Cross, Tsoanelo Orphanage, LENEPWHA, and Christian Council of Lesotho (CCL), Beautiful Gate, LANFE, Lesotho Save the Children, World Vision and the Office of the First Lady.

Table 2:

Total Number of Caregivers/Volunteers trained and patients supported

NGO	# of Volunteers and care givers trained	# of chronically ill people cared for by caregivers
Office of the First Lady	1,140	268
CRS	2,043	-
Lesotho Red Cross	1,572	7,960
World Vision	812	4778
ALE		115
10 DATF(SUPPORT GROUPS)		727
PEKA CBO		41
CCL	60	147
BEAUTIFUL GATE	73	42
LENEPWHA		194
CHAL	33	
LANFE	25	818
Total	5,758	15,080

Source : Primary data from Implementers reports

Even though the caregivers have been trained in large number, very few sick people have been assisted because of shortage and availability of home based care kits. This is

very minimal compared to the estimated at least 56,000 people living with HIV and AIDS needing care and support.

The care and support included home visits to relief to the families of the sick and using home based care kits (included in the kits are opportunistic infection drugs); provision of transport costs to the health facilities to those who are sick for collection of medication and check-up; tracking of ex workers and referring them to the nearby health facilities for treatment; provision of home garden tools and seeds to the families to produce vegetables so that the patients can be nutritionally feed and supply of food through the support of WFP to the chronically ill.

It is worth mentioning that some of the Caregivers or support groups have been proactive and tried to raise fund through stokfels and other means in order to be able to procure items to use in order to assist the sick and their families.

The major challenge that was faced during the implementation of this activity saw a large number of caregivers being trained but was not able to care and assist the sick as expected because of lack of materials to use.

2.2.4 PROVISION OF INCOME GENERATING FUNDS FOR IGA TO SUPPORT OVC.

The malnutrition crisis in most parts of the country affected about 44% of children under five years old. The aimed has been to support NGOs/CBOs/FBOs with the provision of funds to implement Income Generating Activities (IGA) in order to try to alleviate the food crisis as well as the necessary support that may be identified by the affected OVC.

91 Community Based Organizations, NGOs and District AIDS Task forces countrywide have been trained on IGA. The training focused specifically to build up the managerial, accounting and booking skills of the CBOs and District AIDS Task Forces (DATFs) in order to implement and coordinated the IGA. The intention was that these CBOs and DAFTs should then provide support to the OVC and chronically ill patients with the proceeds from the IGA. Implementation of IGAs is underway and some have already born fruitful results. The IGA identified by the CBOs for implementation included rearing of chickens (broilers and layers) and/or pigs, producing vegetables and catering, production of Vaseline using local materials, production of candles ect. To date a total of 26,531 OVC have been registered and benefited under the CBOs, NGOs and DATFs support. The support included food proceeds from the fields such as maize, wheat, cabbages, and eggs from those who reared chickens; school uniforms to the primary and secondary learners; garden tools and seeds which were provided to the older OVC; life skills and vocational training provided to some older OVC to learn skills such as knitting and embroidery, carpentry, welding, and agriculture within the local Vocational schools; and rehabilitation and repairs of the OVC houses.

Table 3: ORGANIZATIONS SUPPORTING ORPHANS FOR IGA SUPPORT

ORGANIZATION	NUMBER OF OVC	TYPE OF SUPPORT
Lesotho Red Cross	6,643	Income generating activities , school fees for those in primary and secondary school
Catholic Relief Service	9,857	Accommodation in orphanage, IGA and school fees as well as uniform for the primary and secondary level.
Christian Health Association of Lesotho	100	Uniforms provided to OVC in primary and secondary schools, as well as seeds and garden tools.
Christian Council Lesotho	166	Income generating activities proceeds benefiting OVC
Office of the First Lady	420	Provided with psychosocial support
LANFE	1,934	OVC provided with seeds and garden tools
Sisters of Charity Orphanage	56	Provided with accommodation, foods and support for schooling
PEKA CBO	119	Proceeds from fields such as vegetables supplied to OVC
Thetsane CBO	22	Eggs, vegetables supplied to Beautiful Gate to feed the Orphans.
World Vision	6,721	IGA proceeds benefiting OVC, and over 18 years OVC being trained on Vocational skills such as carpentry, knitting and embroidery, welding and agriculture.
Beautiful Gate Orphanage	73	Provided with IGAs training and provided foods parcels for vulnerable children
Mantsase Orphanage	63	Accommodation for OVC registered in and support with school fees for primary and secondary schools as well as medication whenever needed.
Tsoanelo Orphanage	108	Accommodation, day care support, medication when needed and rehabilitation and repair of the OVC houses.
Lesotho Save the Children	15	Home visits and counselling sessions, and provision of food parcels.
Lesotho Workcamps	35	A work camp for OVC conducted, provided water-tank and field allocated for ploughing to cater for OVC; and vocational training on welding, knitting carpentry and agriculture.
District AIDS Task Forces (Support Groups)	199	Income generating activities by support groups and to benefit OVC
TOTAL	26,531	

Source: Progress Reports of the Implementers

2.2.5 GUARANTEE EDUCATION FOR ORPHANS AND VULNERABLE CHILDREN

A number of Orphans and vulnerable children not in school have increased overtime because of the impact of HIV and AIDS to the families who are breadwinners and the economy in general. Various reasons for this may include children left without support due to death of the parents, vulnerable children due to parents very sick to work and not getting any income.

Five organizations, Ministry of Education and Training, Lesotho Red Cross Society, Office of the first Lady, Catholic Relief Service, and CHAL had supported the OVC with school fees and uniform from Primary school up to the high school level. By end of the phase I, at least 135,692 OVC were in school. These included 10,623 orphans who are provided with uniform and school fees at primary, secondary and high school levels, and 125, 069 registered in free education in Primary level as well as assisted with bursaries through the support of other Partners.

Table :4

Total Number of Orphans supported with School Fees from various Development Partners

District	Primary '05	Secondary A-C	High School D-E	Total number of Orphans supported with school fees
BEREA	117	655	172	827
MASERU	541	1778	329	2107
MAFETENG	254	608	278	886
MOKHOTLONG	226	414	39	453
MOHALE'S HOEK	166	415	98	513
LERIBE	269	1155	278	1433
THABA-TSEKA	61	175	28	203
BUTHA-BUTHE	112	641	86	727
QUTHING	110	573	152	725
QACHA'S NEK	233	527	133	660
	2089	6941	1593	10623

Source: Ministry of Education and Training

Figure 2:

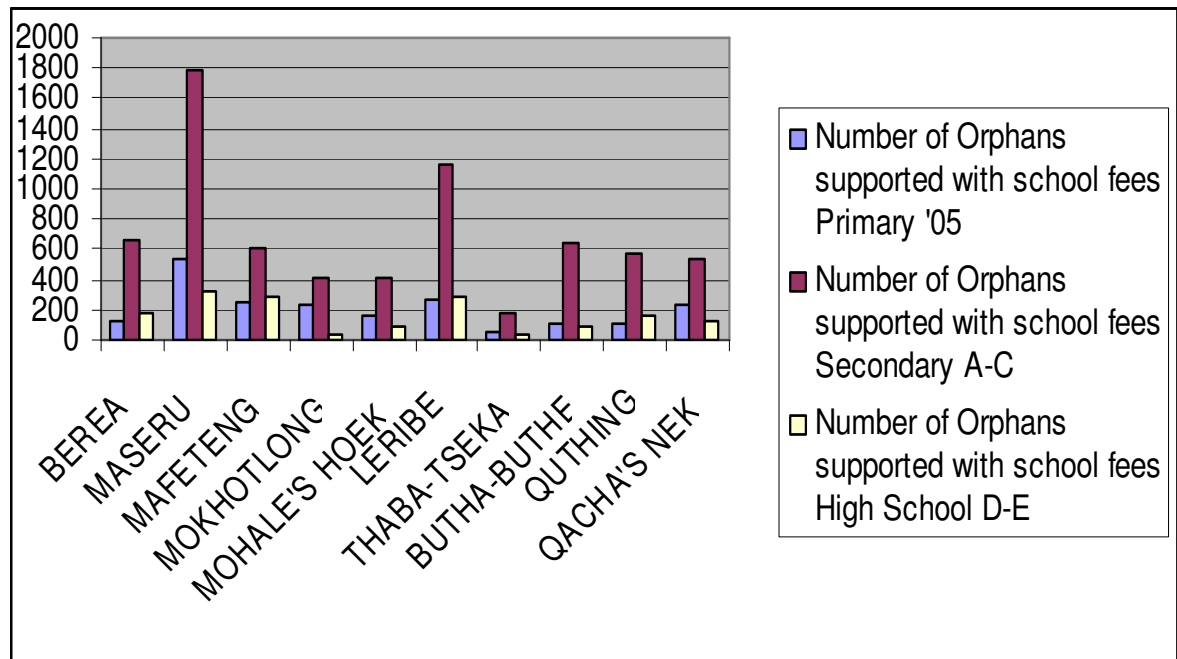


Figure 2 depicts Maseru district as being supported most, and the least district where OVC are provided with support is Thaba-tseka. The reason behind this is the number of schools found in each district, and the difficulties of the terrain which had made it sometimes impossible to reach the remote areas.

The major challenges which were encountered during the implementation by the mitigation component include:

- Unwillingness to open up by some of the PLWHA in order to be supported;
- Unreliable data supplied by organizations especially the private sector for their employees who are sometimes healthy but reported as sick, and sometimes this comes with unrealistic expectations from both the employer and the employee alike;
- Registration of OVC in some instances was found to be cumbersome because of illiteracy of guardians, sometimes double registration and the children whose parents are still alive and working;
- The sustainability of training and ensuring that skills acquired by the OVC at vocational schools are used;
- Delays in the disbursement payment request to the Implementers which resulted in the delay of the initiation of the projects;
- Most of the caregivers trained was discovered were not fully aware of their responsibilities to the OVC, but only taking care of chronically ill patients;

- Most of the communities' leaders did not fully comprehend the issues of inheritance of OVC as very important, therefore the reason for more sensitized community awareness trainings on the rights and plights of OVC;
- The Home based Care kits are still very limited as most of the procured home based care kits are being controlled by Public Health nurses and provided to the community health workers trained by them, while the support groups which were not trained by the MOHSW are being left out from being the provided with the kits;
- Training of communities on the collection of data using tools has been found lacking, and this may lead to unreliable data collected by the communities.
- Sometimes it was difficult for Programmes (Engaged for a short period) to gain a slot on Radio Lesotho.
- A much needed holistic approach to caring for orphans and still achieving necessary targets is required. Many of the OVC needed psychosocial support and mentoring along with food, clothing , shelter and education.
- The children in the mountain areas are some of the poorest and have a greatest need, but because of terrain it has been in some cases very difficult and costly.

2.3 CARE AND TREATMENT COMPONENT

As outlined in the proposal, comprehensive clinical care and support for people living with HIV/AIDS (PLWHAs) has been regarded as critical to the improvement of their quality of life. Therefore PLWHAs should have access to the treatment of opportunistic infections coupled with psychosocial counselling and palliative care, and the services should be made available both in the homes and communities as well as in the health facilities providing a continuum of care.

Major Objectives of this component included: to provide Continuum of Care services to 80% of PLHWAs in Lesotho by 2008; to provide Antiretroviral ARV Therapy to 50% of the PLHWAs by 2008 and to establish Voluntary Counselling and Testing (VCT) services in all the 10 Districts by 2008. The indicators for performance measurement included: number of health providers trained on diagnosing and management of HIV and AIDS in order to provide care and support to PLWHA; number of patients receiving ARV treatment; number of sites with VCT services; and number of people tested for HIV and counseled.

PROGRESS STATUS:

2.3.1 DEVELOPMENT OF POLICY GUIDELINES AND PROTOCOLS AND MONITORING TOOLS

The second year saw development, and adaptation of monitoring tools for collection and collation of data finalized and operationalized by all the ART sites, PMTCT, GFATM Implementers, and all HIV Testing and Counselling (HTC) centres. Improved collection of data has been released since the end of quarter two in the second year of implementation. The tools included ARV registers, supervisory checklists PMTCT forms, HTC forms and Program Monitoring and evaluation reporting forms which were printed and distributed to all the HSAs.

The MOHSW managed to print and disseminate National Antiretroviral Guidelines to all Health Service Areas as well as the Private sector clinics.

Health personnel operating the facilities were trained on the use of the national antiretroviral guidelines, and tools for collection and collation of data. Additional refresher courses are envisaged for the existing and newly deployed personnel in the Health facilities.

2.3.2 Training of Counsellors, Caregivers and Volunteers

The purpose of this activity was to train Counsellors to create a pool of counsellors throughout the Country so that access to free quality HIV testing and counselling services is available whenever is required.

Through the Directorate office, different categories of staff have been trained and empowered with counselling skills, and these included 2,052 people drawn from various organizations. The participants were the Human Resource personnel from MOHSW,

basic and community counsellors from line ministries, Nursing Assistants, basic counsellors and lay counsellor, students from NUL, Community Home based Care givers, Community health workers and church leaders. The development skills provided included provision of HIV and Testing and counselling; Provision of psychotherapy, adherence counselling; family and community; spiritual and nutritional counselling; home based care, palliative care and psychosocial care and support.

On other hand, the Office of the First Lady trained additional 90 volunteers in 4 constituencies on counselling; in the districts of Leribe, Mophale'hoek and Mafeteng; which made the people trained as counsellors to a total of 2,142 country wide.

In addition MOHSW provided a comprehensive training to 70 Counsellors (13 Professional counsellors, 35 community Counsellors and 24 Basic Lay Counsellors) and these have since been deployed in Health facilities to operate and provide services to the established HTC centres in all ten Health Service Areas.

2.3.3. TRAIN PROFESSIONAL HEALTH PERSONNEL ON HIV DIAGNOSIS AND MANAGEMENT OF THE ARVS

There has been a need to train staff so that HIV/AIDS patients could be treated with ARVs. The Global fund resources were used to train medical doctors, nurses, laboratory technicians, pharmacists and professional counsellors starting with the hospitals where the program were rolled out first. Training for medical personnel (those responsible for prescribing for patients in the health facilities) had focused on appropriate management of ARVs, following the guidelines and protocols that would be developed by the health authorities in Lesotho under this program.

258 health professionals including doctors, nurses, pharmacists, laboratory technicians and laboratory technologists and counsellors were trained in management and diagnosis of HIV/AIDS/STI/PEP and in syndromic management protocols, which included drug management and non drug management of STI. The training included training of trainers by IMAAI. The purpose of the training was to equip the health personnel with management and diagnosis skills to care and support the PLWHA in all Health facilities down to the community level.

2.3.4 PROCUREMENT OF REAGENTS, HOME BASED CARE KITS AND LABORATORY SUPPLIES

The intention was to provide the Support Groups, and Community workers with the Home based care kits in order to give support and care to those who were sick at the community level. On the other hand, reagents were to be procured and provided to the Central laboratory and the established ART Sites.

3000 Home - based care kits were procured by NDSO. A distribution list including the ten Government hospitals was prepared and provided to NDSO for distribution by Directorate HIV/AIDS/STI of the MOHSW.

HOME BASED CARE KITS DISTRIBUTION LIST

Health Service Area	Number of HBCK distributed
Mokhotlong	104
Butha-Buthe	306
Leribe	396
Berea	355
Mafeteng	255
Mohale'shoek	225
Quthing	105
Qacha'snek	217
Thaba-Tseka	171
Directorate HIV/AIDS STI/Maseru QUEEN II	263
Office of the First Lady	377
Total Kits delivered by NDSO	2,776

The purpose of procuring the home based care kits was to provide the support groups and community health workers with kits in order to care and support the chronically ill. Due to the delay in the procurement of kits which were distributed in January, 2006 data of how many support groups and community health workers have been provided is not yet been made available.

ABBOTT has been selected to provide the Ministry of Health and Social Welfare with the required reagents for all the facilities. Reagents were procured and distributed to all health facilities.

2.3.5 ESTABLISHMENT OF ART AND HTC

HIV Testing and Counselling services have been offered in the public and private sectors, Non-Governmental Organisations (NGOs), Community Based Organisations (CBOs) and Faith Based Organizations (FBOs). It is an entry point for prevention, care and support for individuals and the community.

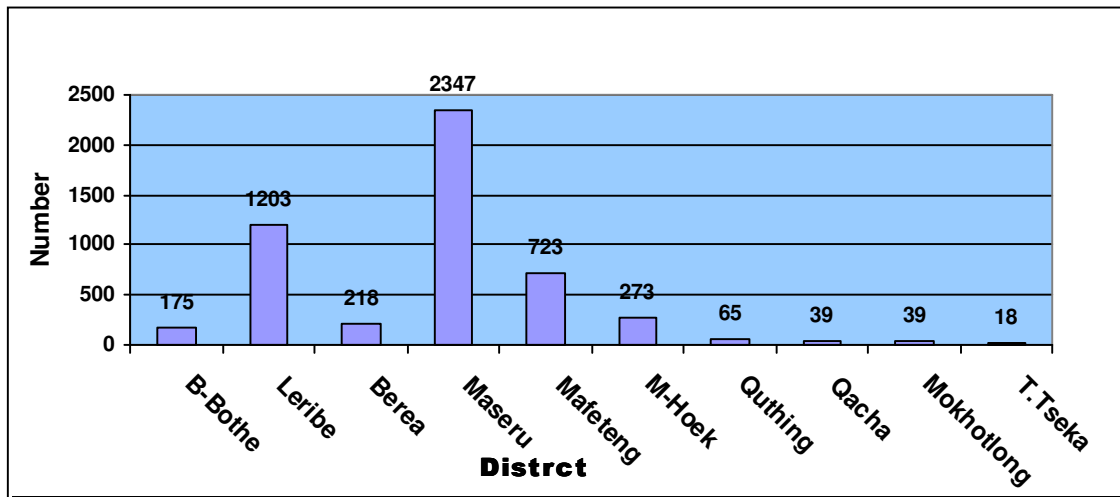
Treatment, Care and Support for HIV infected individuals has been a focus for the Government Policy. Budget allocated from the GOL and GFTAM has been made available to treat with Antiretroviral therapy (ART) Basotho who developed AIDS.

2.3.5.1 ART Centres

The aim in the establishment of ART centres was to provide ARV treatment to 3,100 HIV patients by end of phase I. This was followed by estimated 3x5 target of 28,000 PLWHA by WHO that at least 28,000 patients are in need of ART by end of December, 2005. By December, 2005, it was estimated that there were 14,717 PLWHA who have been enrolled in the national HIV and AIDS Chronic Care, and at least 8,684 patients were on ART treatment. Following the launch of paediatric treatment in Lesotho, there were already 264 children who were also accessing ART by end of 2005. End of phase I witnessed 19 ART established and making possible for accessibility of ART treatment by those who needed the treatment. Although the 3x5 target was not achieved, the

number of people on ART has increased tremendously since the initiation of the programme.

**Figure 3: Number of Patients on ART by Districts in 2005
(Baseline 3000 on treatment by the end 2004)**



Source: MOHSW, Directorate HIV/AIDS/STI

The established ART sites have been refurbished and renovated. Furniture, medical equipment and computers was also procured and distributed to all sites.

The Clinton HIV/AIDS Initiative (CHAI), Central Laboratory and the STI, HIV and AIDS Directorate have conducted a laboratory network assessment countrywide has been completed. The laboratory network gaps have been identified and some of them have already been addressed. For example Lesotho had only one CD4 in 2004 and now the national CD4 coverage has increased to 8 CD4 count machines. The Health Delivery System needs will be addressed with the support of Global Fund Round 5.

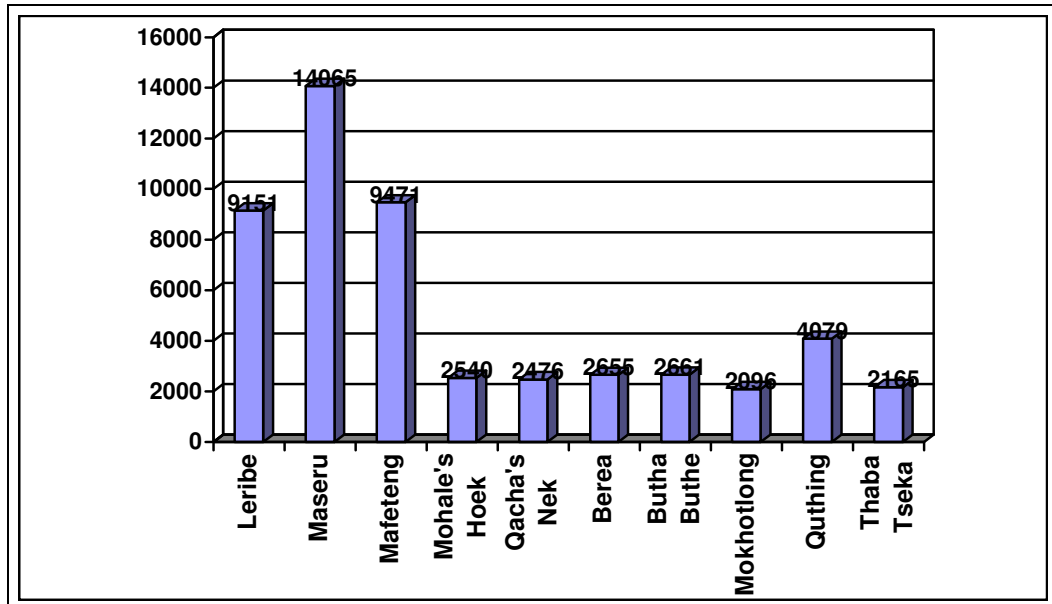
2.3.5.2 HTC Centres:

HIV Testing and Counselling (HTC) services have been offered by the public sector, private sector and NGOs. This is a service which is an entry point for prevention, care and support for individuals and the community.

From June 2004, emphasis has been made on the improvement of the delivery of the HTC services. During the implementation period achievements have been accomplished through ; creation of Information Management Systems for VCT for better follow-up and tracing, revision and translation into Sesotho of the National HTC guidelines for an appropriate understanding and expansion to the lowest level of the community and mentoring of HTC Counsellors in all sites throughout the country for quality assurance.

The table 5 presented below reflect the response that has been noted since the placement of the counsellors with the District Hospitals. Figure 4 reflect a good response from the public which may be attributed ART services provided within the hospital.

Figure 4: Total Number of Clients Pre-test Counselling Jun 04 – Dec 05



Source : MOHSW, Directorate HIV/AIDS/STI

The HTC services offered in the country aim at increasing the number of people who know their HIV status. One tool to gauge the success of the intervention is to compare the number of clients who received the Pre-test Counselling session with the number of clients who were tested.

Table 5: HTC Results from all Districts in Lesotho

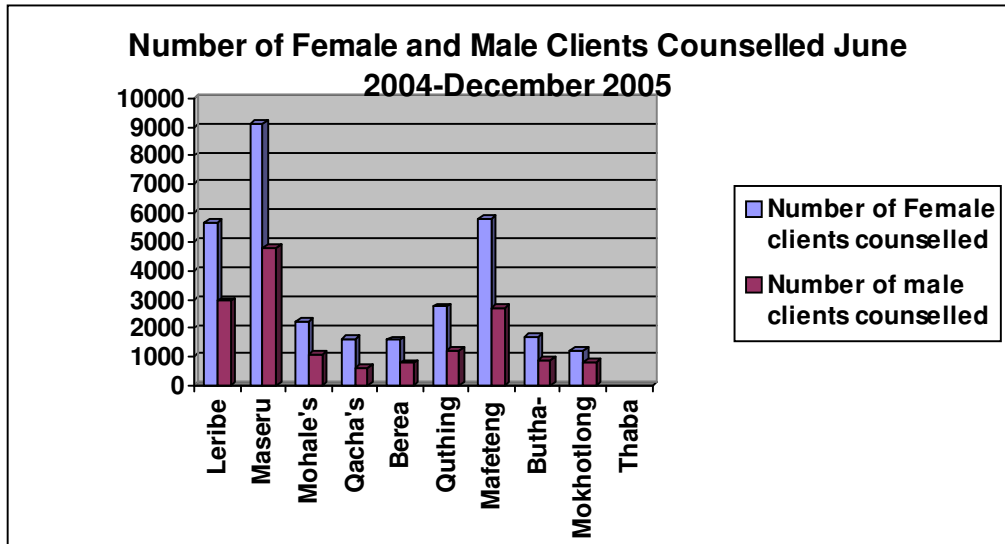
Districts	LRB	MSU	MFT	MHK	QNK	TY	BB	MKG	QTN	TT	Total
Clients Pre-test counselled	9151	14062	10068	3824	2476	2655	2661	2096	4079	2165	51953
Clients tested	8558	13337	8612	3636	2276	2383	2607	2040	3973	2142	48306
Clients Post-test counselled	8489	13298	8606	2816	2276	2383	2607	2047	3972	2142	47401
Total HIV positive	4632	3993	3704	1899	776	1062	1076	659	1941	795	19849

Total HIV negative	3973	7657	4805	1710	1507	1321	1431	1388	2032	1347	26611
---------------------------	-------------	-------------	-------------	-------------	-------------	-------------	-------------	-------------	-------------	-------------	--------------

Source: MOHSW, Directorate HIV/AIDS/STI

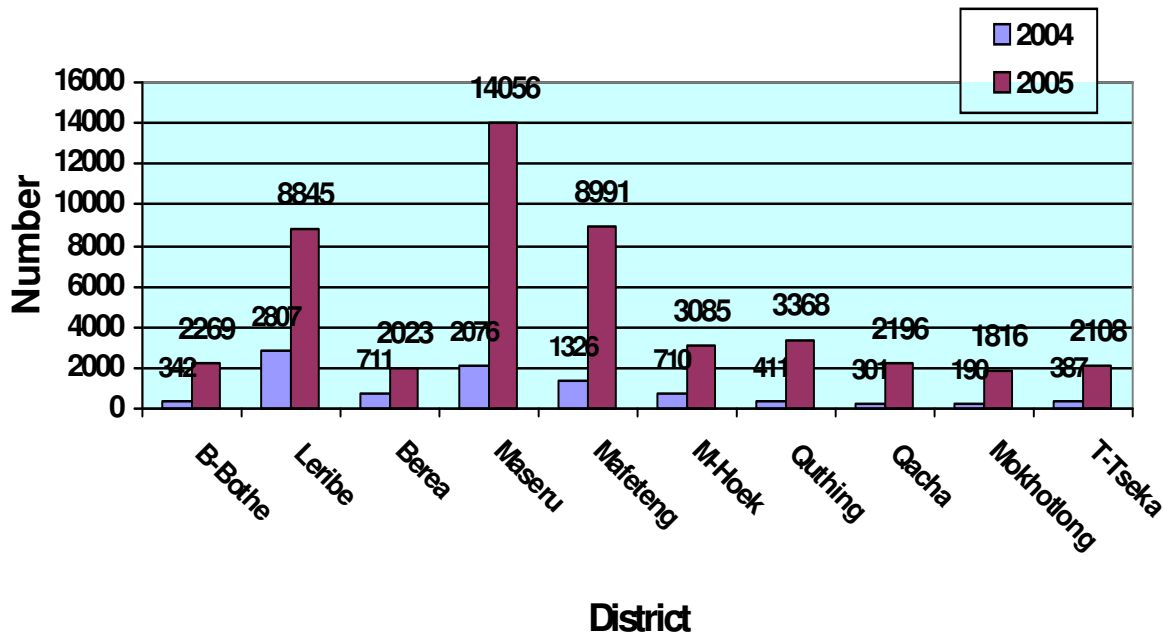
The above charts indicate that most of the people who received pre-test counselling subsequently opted for an HIV test. The results show that a significant number of Basotho are using the HTC facilities. This depicts a steady increase in the people who are voluntarily approaching the HTC sites for testing and could be attributed to the fact that the efforts have been made by the counsellors to sensitize the communities about HTC services. Another contributing factor is that the number of health talks and workshops on this topic has also increased the community's awareness to the pandemic. Finally the formation of support groups, adequate referral systems, adherence counselling and provision of antiretroviral treatment have also contributed in decreasing the stigma attached to HIV and AIDS.

Figure 5:



The statistics that compare male and female clients are available from all the districts except Thaba-Tseka; however the available numbers depict a clear picture of the inequality of attendance in terms of gender. There are more females than males frequenting the VCT/HTC centres.

HIV Testing by District 2004 -2005



The above table show that the number of people tested countrywide increased in all districts in 2005. The best results observed are in Maseru, Mafeteng and Leribe districts where the numbers increased by seven-fold. This could also be due to the fact that the three districts are part of the ART piloting sites.

The total number of patients who tested and HIV positive by the end of December 2005 were 19 849 clients. The total number of patients who tested HIV negative were 26 611 clients. These statistics included clients tested through Government ministries, PSI Clinics, LPPA HTC sites and District Government HTC centres.

The Main challenges during the implementation include:

- Delays in the provision of furniture and medical equipment for the ART sites and HTC;
- Delays in the procurement and distribution of Home based Care Kits to the support groups and community health workers;
- Provision of Home based Care Kits to Public Health nurses, who on the other hand, are distributing KITS only to the MOHSW Trained Community Health workers and leaving out the other support groups who are caring for chronically ill patients at community level.
- Turnover of staff operating the ART sites has contributed to the not properly used Monitoring tools for collection and collation of statistical data of ART Patients.
- Insufficient funding for logistics

- Inadequate infrastructure countrywide to provide these services
- Problems with referrals due to high influx of patients at ART service centres
- Inadequate human resource capacity to manage HIV/AIDS interventions at all levels
- Poor follow up due to lack of transport with the hospital facilities for STI, HIV and AIDS interventions
- Need for expansion to all health centres countrywide
- Drug adherence and literacy
- Coordination and harmonisation of community based programmes (this includes standardising CHBC training, regular provision and replenishment of home based care kits and support to the care givers through the care of cares program)
- Constant supply of drugs to manage Opportunistic Infections, Sexually Transmitted Infections and Antiretroviral drugs.

2.4 GOVERNANCE COMPONENT

The area of focus for this component was the enhancement and strengthening of NAC coordination mandate of all HIV/AIDS implementing structures at all levels. This included capacity building for NAC to ensure adequate coordination, development of policy and legal framework as well as guidelines for implementing agencies. This included technical assistance to Monitor and Evaluate programmes; strengthening of human resources, and infrastructure; and ability to provide technical support and overall institutional leadership and management for all participating agencies including PLHWA, District AIDS Taskforces (DATFs), Community Based Organizations (CBOs), GOL ministries, NGOs and private sector.

The objectives to be attained during the second year included: to operationalise and strengthen NAC Coordination Mandate in the implementation of the National HIV/AIDS Strategic Plan by 100% by 2005; to establish and/or strengthen HIV/AIDS Coordination Units in all Public Sectors, and at least 80% Private and NGO Sectors at the Central level by 2008; and to strengthen the Capacity of the District HIV/AIDS Coordination Mechanism in all the sectors in and outside Government by 2007.

PROGRESS STATUS:

2.4.1 RENOVATE AND FURNISH 10 OFFICES FOR DISTRICT AIDS COORDINATORS

The deployment of 10 District AIDS Coordinators (DACs) came a time when no office accommodation was catered for and ready for use by the DACs at the district level. A decision was reached that in the interim the DACs would be housed within the District Administrators offices while other means were being worked out. Ministry of Works and Public Works through Building Design Services was mandated to build the offices in all ten districts.

Even-though there have been delays in the initiation of the implementation, three places have been completed and offices ready for use by the DACs. These are in Mokhotlong, Qacha'snek, Berea, Mhale'shoek, Maseru and Butha-Buthe. For the rest of the sites, at least 90% of construction has been completed.

The construction of these offices has come at the right time as NAC has also engaged and deployed District Data Officers who will benefit from the offices.

2.4.2 MONITORING AND EVALUATION

NAC has successfully established a Monitoring and Evaluation Unit to monitor and evaluation programmes at the National Level. Monitoring and Evaluation Advisor, and Monitoring Officer were engaged during the implementation. Unfortunately the Advisor left the position, but recruitment process for replacement has been completed. The Monitoring and Evaluation working Group was also constituted during the second quarter of the second year, and had managed to identify the National core list of indicators on HIV and AIDS. A concept for the establishment of a decentralised m&e mechanism and access resources to support the development of the new national m&e

plan for Lesotho was developed for support under the World Bank. This has since been approved by the World Bank.

On the other hand, training was held for various organizations on the Country Response Information System (CRIS), as per operational plan by MEWG (at the end of the training the participants produced a bulletin using data from their respective programme activities).

A training of the recipients of the Global Fund support was conducted for various Participants which included the private sector (even the smaller local NGOs/CBOs that are not particularly Global Fund recipients), the public sector and all the recipients of Global Fund support during the next quarter. In addition to the training expectation was that, materials such as a training manual and brief leaflet have been produced for future reference and use respectively.

The Ministry of Health and Social Welfare has developed a comprehensive M and E plan for the health sector response. In this process the M&E of the HIV and AIDS programme will be incorporated into the M&E of the overall health sector response to HIV/AIDS.

As the management of each intervention needs to be a success, the STI, HIV and AIDS Directorate is strengthening its Monitoring and Evaluation division to respond to the increasing demand of the variety of interventions being implemented. Three more staff members have been employed as from January 02, 2006 to strengthen the capacity of this unit. Additionally, 10 HIV and AIDS Officers to be employed at district level is on going.

All tools for ART and other HIV interventions have been designed, printed and distributed in all relevant facilities. The M & E Unit has been empowered by Consultants with the support of the World Bank, UNAIDS M&E Adviser and WHO HIV and AIDS Officer.

2.4.3 TRAIN DACS AND DATF TO DEVELOP COMPREHENSIVE WORK-PLANS THAT INTEGRATE ISSUES OF PREVENTION, MITIGATION AND CARE AND SUPPORT

The District AIDS Task Forces (DATFs) worked without implementation plans for a very long time since their establishment. The DATFs were provided with skills in the development of strategic planning and budgeting, which was followed by needs assessments, and thereafter the development of the HIV district Strategic Plan and costed action plan. These will be used for resource mobilization by the District AIDS Coordinators as well as NAC to forward to development partners for support of the district activities.

2.4.4 STRENGTHEN THE UMBRELLA BODY OF NGOS TO COORDINATE AND IMPLEMENTATION OF HIV AND AIDS ACTIVITIES AT THE COMMUNITY LEVEL.

The Lesotho Council of NGOs (LCN) has been strengthened to coordinate HIV/AIDS activities by engaging a HIV/AIDS Coordinator, for a period of two years. The office was also provided with a 4x4 Toyota Vehicle as well as office equipment. By end of third quarter, the HIV and AIDS Coordinator left the LCN, and this left a big gap in the HIV and AIDS coordination of NGOs.

The major challenges under this component included:

- Delays in the construction of DACs offices which has resulted in most of them working not in a very conducive environment because of overcrowding within the District Administrators offices;
- The resigning of the Monitoring and Evaluation Advisor affected some of the activities;
- The absence of the HIV and AIDS Coordinator at NGO umbrella body has set back the progress attained during the initial implementation;
- The Strategic plans developed by the DATF need to be revised encompassing the findings from the joint review responses and the reviewed HIV and AIDS National Strategic Plan .

CHAPTER 3. CONCLUSION AND RECOMMENDATIONS

The delays in the first year of the implementation , 2004 - which resulted in little progress being achieved were mostly due to the delays in the development of acceptable Monitoring and Evaluation plan and the Procurement Supply Management plan, as a result a moratorium was placed on the disbursement of funds by the Global Fund Secretariat in the second and third quarters. The funds by end of October 2004 were long depleted and therefore stalled and hindered progress significantly to carry out the implementation of activities in Lesotho. Consequently, the set targets for the first year, were not attained.

The second year saw the acceleration of activities and many implementers playing major role in ensuring improvement in the implementation. This has resulted in 82% of HIV and AIDS results being attained and disbursement of funds being improved.

The challenges facing a country like Lesotho, ravaged by the twin epidemics of HIV/AIDS and TB, are enormous, yet one cannot overstate the great momentum that has been created by the Global Fund grant. The grant has helped to complement the efforts in HIV/AIDS mitigation, prevention, care, treatment, and have also had a very positive impact on increased effectiveness and functioning of overarching governance processes.

In conclusion it should be emphasized that the value of the Global Fund grants to Lesotho is far reaching at multiple levels. In addition to supplying much needed financial resources, the Global Fund grants have catalyzed and improved donor commitment and synergy, creating a more supportive and enabling environment for ensuring quality national HIV/AIDS and TB programs in Lesotho. All donor contributions, financial and technical, have been strategically designed to complement the role and priorities of the Global Fund Programs. The Global Fund grants have also stimulated a very visible increase in high-level political commitment

Recommendations by Thematic Areas

Coordination Level

1. Commitment toward of the Global Fund implementation is needed especially from all level of sectors to ensure compliance of the contract agreement.
2. Concerted effort towards monitoring and supervision of the grant needs to be provided by the Lesotho CCM to ensure that implementation goes according to the schedule.

Care and Treatment

3. The Lesotho CCM should facilitate the additional resources especially to ensure larger scale roll out of ART programme, however the country needs to overcome the shortage of funds to ensure that more patients are being placed on ARV treatment.
4. Involve the private sector in the management of HIV and AIDS interventions in partnership with the Government of Lesotho
5. Improve the infrastructure at district level and health centre level to meet the

demands of the number of patients within the catchments area.

6. Expansion of HIV testing and counselling services to all health centres countrywide (CHAL, Red Cross and Government of Lesotho).

Mitigation

7. It has been evident that people are eager to learn about their rights, and children's rights especially OVC. It therefore recommended that
 - Legal education over radio and easy materials should not be a once activities, but should be an on going process;
 - The laws that have social impact should be discussed with the people at all levels, so that they can own the laws;
8. There is a high need for provision of psychosocial support of the OVC
9. Coordination with NGOs, Government Departments, local authorities and other agencies should be strengthened and thus strengthen the referral process for the benefit of OVC.
10. Assist communities more with selection criteria of OVC and verification of OVC data should be intensified

PREVENTION

11. With regard to condom distribution, it is recommended that because of the high demand on procured flavoured male coloured condoms and latex and polyurethane female condoms, funds be made available to procure more.
12. To train more peer educators as it has been seen that there is a high demand for counselling even for social problems not related to HIV and AIDS.
13. With regard to the Program Monitoring Tools, it is recommended that the tool to include the support groups, Primary school students, the shepherds, mother in laws, daughters in laws and institutions served.

CHAPTER 4 : BUDGET AND EXPENDITURE

4.1. BUDGET

4.1. PHASE I budget signed between MOFDP and GFTAM October 2003 for the years 2004 to 2005.

Planned Program Budget

(USD)

		Year 1					Year 2	Total Phase 1
		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total	Total	
1	GOVERNANCE	100,500	332,000	258,250	255,750	946,500	1,080,000	2,026,500
2	MITIGATION		78,000	600,000	602,000	1,280,000	1,800,000	3,080,000
3	PREVENTION	88,000	196,000	566,000	110,000	960,000	1,000,000	1,960,000
4.	CARE AND SUPPORT	97,500	379,000	244,000	270,000	990,500	2,500,000	3,490,500
	GRANT TOTAL	286,000	985,000	1,668,250	1,237,750	4,177,000	6,380,000	10,557,000

4.2 The expenditure for the two years according to the thematic areas was attained as follows.

FINANCIAL REPORT 2004 -2005 PHASE I GLOBAL FUND

ITEM	Year 1	Q5	Q6	Q7	Q8	Total Phase I
CARE AND SUPPORT						
CONSTRUCTION AND PROCUREMENT	173,513	80,012.47	36,112.63	125,872.08	174,249.37	
RECRUITMENT	336,381.55	84,156.94	105,692.21	106,660.52	290,943.02	
TRAINING	26,890.13	71,291.95	20,005.19	79,939.17	52,752	
M&E	1,827.44	0	0	0	0	
ADMINISTRATION	70,392.70	0	0	0	0	
Sub-total	609,004.82	235,461.36	161,810.03	312,471.77	517,944.39	1,836,692.37
MITIGATION						
CONSTRUCTION AND PROCUREMENT		0	0	0	2,385.55	
RECRUITMENT	72,000	437,476	0	445,035.54	463,417.81	
TRAINING	566,742.05	600,000	0	0	0	
M&E						
ADMINISTRATION						
Sub-total	638,742.05	1,037,476	0	445,035.54	465,803.36	2,587,056.95
PREVENTION						

	YEAR 1	Q5	Q6	Q7	Q8	TOTAL PHASE 1
CONSTRUCTION AND PROCUREMENT			150,511.74		452,645.50	
CONSULTANCY AND RECRUITMENT		353,093.17	246,076.15	263,364.95	149,739.55	
TRAINING	60,395.01	35,292.79	40,595.02	23,744.40	108,126.23	
M&E	810	-	1,025.02	815.39		
ADMINISTRATION						
Sub-total	61,205.01	388,385.96	287,696.19	287,924.74	710,511.28	1,735,723.18

GOVERNANCE						
CONSTRUCTION AND PROCUREMENT	149,396.16	66.95	0	259,636.18	142,433	
RECRUITMENT	34,978.28	34,624.71	38,967.02	71,592.03	150,942.93	
TRAINING	12,903.74	0	26,301	14,024.81	46,902.03	
M&E	510	0	0	0	0	
ADMINISTRATION	26,821.92	0	56.1	0	10,862.73	
Sub-total	224,610.10	34,691.66	65,324.12	345,253.02	351,140.69	1,021,019.59

Monitoring and Evaluation						
ITEM	YEAR1	Q5	Q6	Q7	Q8	TOTAL PHASE 1
CONSTRUCTION AND PROCUREMENT		-	-	-		-
CONSULTANCY AND RECRUITMENT		-	-	-	-	-
TRAINING		5,142.18	4,013.15	49,303	34,117	
ADMINISTRATION		-	-	-		-
SUB TOTAL		4,013.15	49,302.85	34,117		87,433
SUB TOTAL NON HEALTH GOODS						7,269,792.09

HEALTH PRODUCTS : CONDOMS, HOME BASED CARE KITS, REAGENTS AND DRUGS

ITEMS	Q5	Q6	Q7	Q8	TOTAL
Home based care kits				391,525	391,525
reagents			83,434.84	100,328.25	183,763.09
Drugs		83,417.76		938,737.53	1,022,155.29
Condom containers	58,333				58,333
Condom	100,000			231,932.48	331,932.48
SUB TOTAL HEALTH PRODUCTS					1,987,708.86
Grand Total = NON HEALTH GOODS + HEALTH PRODUCTS					9,255,633.95

