# The UN COVID-19 Response and Recovery Multi-Partner Trust Fund
# (UN COVID-19 MPTF)

## Proposal Title: UN support to control spread and minimize the social-economic impact of COVID-19 in Lesotho

## Amount: $1,000,000

## I. Immediate Socio-Economic Response to COVID19

The Kingdom of Lesotho is a mountainous and landlocked country, covering 30,555 square kilometres, wholly surrounded by South Africa. It is classified as a lower middle-income country (LMIC) with a Human Development Index of 0.518 and ranking 164 out of 189 countries It is one of the most unequal countries with a Gini -Co-efficient of 44.6. Lesotho has a population of 2 million people, most of whom reside in the rural areas. Lesotho has a very young population with 45.3% under 20 years of age. The country is mountainous, making accessibility and delivery of services very difficult. Due to its geographic location and socio-economic situation, Lesotho is highly dependent on South Africa for most of the consumer goods and services.

The country is facing multiple and complex socio-economic challenges, that include persistent and high poverty, unemployment, economic and social inequalities, poor health and limited quality health services, poor quality of education and training, limited environmental protection and resilience, and uncertain political environment that affects country stability and effective governance. Over one million people (49.7 percent of Lesotho's population) live below the national poverty line. Hunger and poverty are more pervasive among people living in rural areas, female-headed households, the less educated, the unemployed, large families, and children. Unemployment is estimated at 32.3 percent, with unemployment among youth estimated at over 40 percent.

Although still very low, Lesotho's has achieved notable progress in critical health indictors in the past ten years; including child and maternal mortality, HIV and AIDS and TB. Life expectancy at birth has increased by almost 8 years for both men and women from 45 years in 2010 to 52 years since 2018. Neonatal, infant and under-5 mortality was reduced from 77 to 34 per 1,000 live births; infant and under-5 mortality rate is 59 and 85 per 1,000 live births, and maternal mortality reduced from 1,155 to 1,024 deaths per 100,000 live births. Lesotho has also stabilized infections of HIV/AIDS with incidence rate estimated at 1.1%. TB incidences remain high at 611 per 100, 000 people. At least 13% of the population is undernourished and 33 percent stunted. Almost 70 percent of Basotho have access to clean water sources, but only 40% have access to basic and healthy sanitation services. However, safe hygiene and sanitation practices at community level is limited, with only 18% of the population washing hands with soap and water at critical times.

Further, Lesotho health system is weak and fragile, and the country has traditionally relied on South Africa to provide secondary and tertiary level health services. The country has a three-tier public health delivery system with the lowest tier composed of 211 health centers; 2nd tier with 2 specialized hospitals, 18 general hospitals, 4 primary hospital and the 3rd tier having one tertiary hospital. There is a growing presence of private health facilities in the country, especially in the urban areas, that highly complements the quality and delivery of national health services. The system also includes a network of over 6,000 village health workers, with each serving about 40 households. Overall, Lesotho's health system suffers an acute shortage of human resources, with only six nurses, one physician and a pharmacist per 10, 000 people. Access to health services is difficult for many people, especially in rural areas. Medical and health laboratory services are limited.

Women are more likely to be poor, unemployed, face gender-based violence and have a higher prevalence of HIV than their male counterparts across the country. Gender Based violence against women in Lesotho is rated at 86% and with increased reports during emergency situation due to increased household vulnerabilities and socio-economic deprivations. Various categories of population including adolescent boys and girls, women, elderly women, people with disability, men, people leaving with HIV/AIDS and elderly men have previously been exposed to protection and GBV risks.

Climate change and environmental degradation represent a great threat to poverty reduction and to achieving Sustainable Development Goals (SDGs). In the past ten years, Lesotho has experienced successive climate shocks such as recurrent droughts, dry spells and floods, which have negatively affected communities and households' livelihoods, with serious consequences for people's food security. On annual basis, more than a quarter of the population, especially those residing in the rural areas, is declared to be vulnerable and in need of food and humanitarian assistance.

*Lesotho national response to COVID-19*

As of 21 April 2020, Lesotho has no confirmed case of COVID-19, following detection and testing of 21 suspected cases. Despite this, Lesotho is considered more vulnerable to the pandemic due to its socio-economic interdependency with South Africa and the weak health system. The country is also ranked highly vulnerable in terms of Infectious Disease Vulnerability Index (at or below 40). As a result, the country is already implementing some public health interventions aimed at prevention and control for the disease, including a country-wide lockdown for non-essential services and movements. The Government of Lesotho has also established a National Emergency Command Centre (NECC), led by a high-level cabinet sub-committee and supported by a multi-stakeholder national rapid response team and technical subcommittees to provide oversight, coordination and leadership to the national response. The country has developed an integrated National COVID-19 Response Plan and a Health Sector Preparedness and Response Plan with consolidated estimated budgets of US$64 million. In collaboration with partners, the UN and private sector, the Government of Lesotho is actively mobilizing resources and technical support for the nation response.

*UN Support to national response*

Under the leadership and coordination of the UN RC and in line with principles of 'Delivering as One', the UN Lesotho has established a response team, that is aligned to the UNDAF pillars, to support the national response to COVID-19. The UNCT has appointed WHO as a lead representative of the UN and to ensure coordinated UN response in the national task force. Based on the UN Contingency Plan, the UNCT has developed the response strategy that aligned to the agency comparative advantages, aimed at safeguarding the achievements and progress towards the Sustainable Development Goals (SDGs) and providing an integrated support towards national readiness, response and recovery from the

COVID-19. By adopting the "One Health Approach" and "Whole-of-Society Approach", the UN support will focus on strengthening national coordination and leadership, national emergency response, health systems to ensure inclusive and equitable access to facilities by all. It will facilitate community engagement and participation for resilience building and social cohesion and address emerging socio-economic challenges to minimize impact and potential vulnerabilities due to the COVID-19.

# II. Solutions proposed

The purpose of this proposal is to support the Government of Lesotho to scale up national readiness and response operations for COVID-19 by addressing critical gaps in the National Response Plan. The UN proposes an integrated response to strengthen the national response system to ensure inclusive and decentralized response to the COVID-19 and ensure continuity of critical health services to slow down the transmission, reduce morbidity and mortality from the pandemic and other related socio and economic effects among men, women and children, through the following solutions:

### Output 1: Strengthened coordination, planning and monitoring at national, district and community level

Through the expertise and leadership of the WHO on the response to health pandemics, and based on its convener role, the UN will actively advocate for leadership and coordination between the national and district coordinating mechanisms to harmonize a multi-sectoral and inclusive national response, through the following interventions:

- Enhance linkage between Ministry of Health (MOH) and Disaster Management Authority (DMA), and facilitate inclusion of wider stakeholders (religious leaders, women and girls, people with disabilities and youth*)* in the decision-making processes and coordination mechanisms for COVID-19 response
- Develop and support adaptation of standard operating procedures (SOPs) and build capacity of national and district command structures on coordination functions, management of the pandemic and establish a chain of command and communication channels on national response.
- Facilitate digital technology for rapid response and interventions, delivery of related essential services (SRHR, ART, Vaccinations, maternal)

### Output 2 Enhanced disease surveillance for rapid case detection and management, investigation, tracing and monitoring of contacts

With lessons from the current indicator-based surveillance system, the UN will support the government of Lesotho to upgrade and improve sensitivity and coverage of the national disease surveillance to generate real-time data on priority diseases, specifically COVID-19 through:

- Capacity building and adopt generic surveillance guidelines for different stakeholder groups including village health workers (VHWs), health facility workers, rapid response teams, traditional healers, civil society organizations and media houses to improve the national surveillance system.
- Adopt innovative strategies and digital technologies for collection and analysis of decentralized and sex and age disaggregated data on COVID-19 response and coping strategies
- Generate information, knowledge and evidence to update the continuum of care and facilitate evidence-based decision making and planning.
- Develop technology-based innovations to enable community-level surveillance, screening and reporting of suspect cases.
- Develop laboratory capacities for specimen collection, transportation and processing for detection of COVID-19 infections.

### Output 3: Strengthened mechanisms and measures for infection prevention and control at health facility

and in community settings

Collaborating with the civil society and community-based organisations, the UN will implement an effective infection prevention and control (IPC) system, which includes quality messaging and provision of critical water, sanitation and hygiene services and supplies in priority settings including health facilities, communities and high-risk public areas, to establish healthy environments and lessen transmission of COVID-19. Priority interventions include:

- Strengthening COVID-19 information pathways and dissemination of information related to control and prevention of COVID-19 using local platforms to influence behaviour change and safe practices in communities and health facilities.
- Strengthening/setting up Infection, Prevention and Control (IPC) committees at health facility and community levels, strengthening linkage between communities and health facilities.
- Build capacity of IPC committees on COVID-19 preparedness, response and recovery, through trainings targeting particularly health care workers, community health agents and community leaders.
- Support continued access to critical infection prevention and access services and supplies (including water, waste management, soap, handwashing facilities) in critical institutions (health facilities, earmarked isolation/quarantine centres), high risk public places (such as markets, points of entry and public transport); high risk communities and vulnerable groups (such as poor urban neighbourhoods, communities without access to WASH services).

Output 4: Continuity of other essential health services maintained

Working with the health facilities, civil society and community-based organization, private sector and community leaders, the UN will adopt digital technologies and best practices from prior emergency programmes, including the El-Nino drought to monitor and ensure continued delivery of essential health services including SRH services to prevent reversals in existing gains in health response, by:

- Supporting assessment and monitoring of existing health services delivery against t minimum standards required during emergencies and determine gaps.
- Support provision of community-based integrated essential health services such as antiretroviral medicines, family planning and reproductive services through outreaches and mobile clinics prioritizing hard to reach areas, PLHIVs, women and girls of reproductive age, orphans, returned migrant populations and other key population groups.
- Adopt digital applications, text and tele-messaging for hard to reach districts for delivery and continuity of a comprehensive package of other essential health services.

## III. What is the specific need/problem the intervention seeks to address?

Despite not having a confirmed COVID-19 case, Lesotho is more vulnerable to the COVID-19 due to its fragile health system and the socio-economic linkages with South Africa. The country has established the national and district level coordination mechanisms to provide overall coordination and leadership on the national response. However, gaps still exist to ensure achievement of an inclusive and integrated response, due to limited capacities for coordination and linkages between national and district structures, lack of equipment and facilities for surveillance, detection and monitoring, limited communication and awareness especially within the key communities and population groups, and lack of continuity of critical health services.

### (i) Coordination, planning and monitoring

At national level, there is no clear coordination between the National Emergency Command Centre and the Ministry of Health as a lead Ministry in the national response, resulting in ambiguity of roles and

national communication on the pandemic. This has further resulted in fragmentation and duplication of efforts across the different sectors.

Further, there is limited information flow between district coordination structures, the national level, and the community level. There is limited capacity to respond and support district-based interventions. As a result, the response is dominated by the central level structures and weak at subnational and community levels, thus weakening national response mechanisms and inclusivity. There is also limited participation of other population groups, including civil society, religious leaders, local authorities, women and youth groups, which are critical for an inclusive engagement and effective national response.

### (ii) Surveillance, rapid response teams and case investigation

Implementation of event and community-based surveillance is currently ad hoc despite its criticality for enhancing the sensitivity and responsiveness of the disease surveillance system for Lesotho. A large pool of health workers especially at primary health facility level are inadequately skilled in data management and do not use health facility data for decision making and planning which is critical for preparedness and response to health-related emergencies including COVID-19.

Different community level structures which include VHWs (mostly mid to elderly women, peer educators who are young people), traditional healers and other community leaders have not been oriented on COVID-19 to facilitate screening of suspected cases, , contact tracing and subsequent reporting and referral through the health care delivery system for testing and management.

The country has only tested 23 suspected cases for COVID-19 due to lack of in-country testing capacities that include lack of testing kits, limited screening suspect cases in health facilities, and limited skills of laboratory staff for conducting the required tests. Other gaps in surveillance are shortage of basic screening equipment at the points of entry and in remote health facilities.

### (iii) Prevention and control of COVID-19 infections

While a lot of information on COVID-19 has been disseminated through mass media, there is limited engagement of engagement of community health agents and leaders and health workers. As a result, majority of population especially in the rural communities have limited or inaccurate information to prevent and control infections and facilitate adoption of safe measures for early identification and reporting of suspected cases.

There are critical public places in the country where people gather in large numbers such as health facilities, isolation/quarantine centres, public places (public transport, markets etc), points of entry and in high risk communities which lack essential prevention and control supplies (water, waste management, handwashing facilities, soap and sanitizers). This could lead to rapid transmission of the virus should there be people infected.

Another problem is limited practice of regular washing of hands with soap and water where only 18% of the population washes hands with soap and water at critical times making them more vulnerable to COVID-19.

Finally, there is a limited capacity and linkages of IPC committees who are critical for the care of sick patients due to COVID-19 and other health conditions at health facility and community level which

weakens the country's ability to prevent and manage cases of COVID-19.

### (iv) Continuity of essential health services

A protracted COVID-19 pandemic is likely lead to a breakdown and overstretching of the already weak health system, and limit access to essential and lifesaving health services especially in the poor rural areas.

Anecdotal data indicates that the country is witnessing an increase in GBV cases against women as perpetrators and survivors are forced to be in one place with the current restrictions of movement. There is also no plan to provide psychosocial and mental health support to vulnerable groups especially for those affected by gender-based violence, chronic illnesses, loss of economic activity and overwhelmed frontline workers.

There are also indications that over 15,000 PLHIV are not accessing critical ART drugs since the country put in place the measures to address COVID-19. Further, access to services such as TB treatment and support to chronic conditions such as hypertension and diabetes has been affected. This could lead to further health risks, and exacerbate the existing socio-economic challenges, including unwanted pregnancies, indirect morbidity and mortality.

## IV. How does this collaborative programme solve the challenge? Please describe your theory of change.

IF the Government of Lesotho has decentralized the national health response to COVID-19, strengthened leadership and coordination between the national and district level command for the disease and empowered communities, including women and youth groups, to effectively participate in the implementation of the national response, THEN the country will attain system readiness and partnerships to ensure effective and inclusive national response to COVID-19, reduce the risk of explosive infection rates and enable effective management of suspect and confirmed cases. This will be achieved by adopting innovative programmes, data and digital technology solutions to (i) enhance coordination, planning and monitoring of the national response, (ii) facilitate rapid response for surveillance, investigation and case management, (iii) promote infection prevention and control, and (iv) enable continuity and delivery of critical health and non-health services.

*(i) Coordination, planning and monitoring*

To establish an integrated and effective national response, the UN will enhance the national response, by strengthen national leadership and capacities for coordination, planning and monitoring for COVID-19. This will facilitate community inclusive, integrated and multi-stakeholder response. Based on the international best practice for national response in crises situation and health pandemics, the UN will advocate and build capacities of the national structures to effectively manage the pandemic and ensure community engagement by strengthening linkages between the Ministry of Health and the Disaster Management Authority, and facilitating wider participation in the national response to include women and girls, youth, people with disabilities and traditional leaders. The UN will ensure inclusive community engagement, advocacy and adherence to human rights in the national and district level response for social coherence and public accountability. This will enhance credibility of the national leadership, enhance community trust and facilitate collaborative solutions towards the national response.

Through the office of the Resident Coordinator and working with the national leadership for the national response, the UN will identify gaps in the national leadership and coordination of COVID-19

response and help establish management practices and effective chain of command and communication on the response. UNDP and WHO will collaborate to roll-out digital technologies that connect the national, district and community platforms and mobilise private sector support to facilitate speedy adoption. This capacity will include communication and information channels from the community, district and national levels. It will also include procurement and supply of digital technology for DRRTs for delivery of key response interventions and capacity building in the use of those technologies.

It is anticipated that the capacity to coordinate at district and community level will need further technical support and handholding. The UN will thus place coordinators at district level for this continuous support, to also enhance data collection and collation. It is expected that with the training, digital technologies and district coordinators, the districts and communities will have the requisite capacities to coordinate the response at decentralised level. Linkages and communication with the national level will also be strengthened.

The UN will also exploit the digital technologies, and data innovations, including big data and artificial intelligence to generate, collect and analyse decentralised and disaggregated data to understand the emerging issues and impact of the pandemic on different population groups, including women, youth and children. The UN will work with the Bureau of Statistics and Ministry of Health to establish internal capacities for monitoring social and tradition media to generate intelligence on the response, including health, emerging vulnerabilities and related socio-economic issues. This will, in turn, facilitate early identification of contacts, establishment of response mechanisms, and elimination of associated risks. Digital systems will be useful for improving reporting systems across the different levels and availability of real-time data to inform decision making and monitor the scale of and extent of the outbreak in the country.

*(ii) Surveillance, case detection and investigation*

Given the increasing risk of infection in the country, Lesotho will need to establish capacities for detection, monitoring and investigating suspected cases to avoid potential surge in infections. The UN will work with the Ministry of Health to strengthen the integrated disease surveillance system and improve existing systems to generate real-time community alerts and events; and enable capturing and response, leading to early identification and detection of suspected cases. The UN will further empower the village health workers with skills to further investigate, facilitate home quarantine and self-isolation in line with the national guidelines and effectively manage arising sensitivities and discrimination due to COVID-19. This will improve the national response and management of cases by putting in place necessary public health measures to prevent further spread of the disease within communities.

In addition to the equipment procured through WHO and UNDP, the UN will build national laboratory capacities, by engaging international experts and personnel to manage the specimen collection, transportation and processing of COVID-19 infections. This will be complemented by rolling out digital technology solutions for surveillance to also enhance reporting of suspect cases. This will further enhance decision-making and facilitate continuum of care in the response.

*(iii) Prevention and control of COVID-19 infections*

To ensure effective prevention and control of the COVID-19 and facilitate adherence to the national prevention strategies, the UN will support implementation of infection prevention and control systems at critical public places including health facilities, high risk and open space. Different UN agencies will collaborate to develop and disseminate quality messaging targeting some cultural and social norms that may perpetuate the infection among different population groups. The UN will work with local media

practitioners, social media influencers and community leaders to enable effective dissemination of key messages and to target populations including women and girls.

The UN support will also facilitate access to water, safe sanitation and hygiene services, and promote healthy waste management in public spaces, community and household levels. This will promote behavioural and culture change, encourage safe practices and establish healthy environments to slow transmission. This intervention entails availability of adequate and appropriate personal protective equipment, proper use and disposal of such equipment, sustaining WASH services and supplies in health facilities, isolation/quarantine centres, high risk communities and public places, adherence to standard precautions for health settings and adequate hand washing facilities for health care workers, patients and those visiting the health facility.

The UN will support establishment of relevant committees and facilitate linkages between the communities and health facilities. In collaboration with WHO, UNICEF will build capacities of the IPC committees, particularly targeting the health care workers, community health agencies and men-, women- and youth-led community organisations. This intervention will contribute to the project outcome by reducing and avoiding infections and deaths of health workers and the general public who encounter the health facilities.

(iv) *Continuity of essential health services and systems*

Maintaining essential health services during the COVID-19 crisis is critical for avoiding indirect morbidity and mortality associated with failure to provide key health services that include immunisation for vaccine preventable diseases; sexual, reproductive, maternal, new born and child health which are critical in maintaining the rights, well-being and health of women and girls; provision of medication for chronic diseases (hypertension, diabetes, HIV; TB including mental health); responding to and providing care for emergency health conditions and support services (laboratory, radiography and blood bank services).

Working with the academia and the Ministry of Health, the UN will support assessment of the health facilities to determine gaps in delivering key essential services during the time of COVID-19, consistent to the minimum standards for providing essential services in emergencies. In collaboration with the Ministry of Gender and Youth, Sports and Recreation, and other partners, the UN will also support an assessment of the COVID-19 impact on women and girls and use existing platforms for collating information and related data.

The UN support will further ensure continued provision of essential services including continuation of clinical management of rape and other GBV related incidences, vaccinations for preventable diseases; maternal and reproductive health; provision of medication for chronic diseases including mental health; HIV and AIDS; emergency health conditions and support services (laboratory, radiography and blood bank services. The UN will adopt innovative solutions including digital solutions, text and tele-messaging for hard to reach communities and support development of comprehensive packages for other essential services.

# V. Documentation

- The UN has supported the Government of Lesotho to develop the UN Contingency Plan for COVID-19 and this is posted on the WHO partner portal.

- In collaboration with the World Bank, the UN is supporting the Government of Lesotho to undertake a socio-economic impact analysis to determine a multisectoral impact and establish mechanisms for recovery beyond the COVID-19.
- UN is supporting the Ministry of Gender and Youth, Sports and Recreation to assess the ipact of COVID-19 on gender.

# VI. Target population

The target population to be reached by the project is described and quantified in the table below. These beneficiaries have been analysed by the UN in Lesotho since there is no other national document that provides such analysis.

| Outputs or potential impacts | Target Beneficiary | Estimate number |
|---|---|---|
| Outcome: COVID-19 transmission and mortality reduced and/or prevented in Lesotho | • Population living in Lesotho over the period of the COVID-19 crisis (males and females of all ages and conditions) | 2 million |
| *Output I. Coordination and planning strengthened at national and district level for an integrated "whole-of-society" response to COVID-19* | • DMA,<br>• Ministry of Health and<br>• national and district level command centres, community leaders<br>• The general public received well coordinate response | 200,000 |
| *Output II. Imported and locally transmitted cases of COVID-19 rapidly detected and contact tracing and monitoring enhanced.* | • Health care workers, including laboratory staff,<br>• village health workers,<br>• community leaders<br>• General population living in Lesotho in all categories including the most vulnerable | 200,000 |
| *Output III. Strengthened measures and mechanisms for infection prevention and control at health facility and in community settings* | • Male and female health workers in public and private health facilities<br>• community health agents and leaders in high risk areas across the country<br>• General population in Lesotho in high risk communities including those seeking health services in health facilities | 150,000 |
| *Output IV. Priority essential health services maintained during COVID-19 outbreak* | • The general public receiving prioritized services such as: childhood vaccinations; maternal and reproductive health services; clients receiving medication for chronic diseases including mental health; HIV and AIDS emergency health conditions and support services (laboratory, radiography and blood bank services) | 50,000 |

# VII. Who will deliver this solution?

UN Lesotho. Under the leadership of the UN Resident Coordinator, the UN Lesotho will collaborate and mobilise internal and external expertise to ensure effective support to the national response to COVID-19. In this case, the UN support will be delivered through the WHO, UNICEF, UNDP and UNFPA. The UN RC will provide coordination support and ensure accountability for results and resources through the relevant UNDAF results group. The UN RCO will also establish an oversight committee comprising the key government ministries, including Ministry of Health, Ministry of Gender and Youth, and the UNCT to facilitate inclusive decision-making and ownership of the project results.

UNICEF: At global level, UNICEF, in collaboration with WHO, has already developed several frameworks and guidance on COVID-19. UNICEF Lesotho has been working with the government on national response on 3 key pillars: Coordination, planning, and monitoring; Risk communication and community engagement and Infection prevention and control (IPC). On this programme, UNICEF will contribute significantly to Output 3 on Infection Prevention and Control and continue supporting WHO on Output 1 on Coordination, Planning and Monitoring. UNICEF has extensive in-country technical expertise and programming experience in WASH, C4D and Health, which are essential for these two outputs. The project will benefit from UNICEF's long-term relationship with the Ministry of Health, Ministry of Water and Community-Based Organizations. The UN Trust Fund will allow UNICEF to continue supporting the national COVID-19 response. The Trust Fund will also help UNICEF support better prioritization and alignment of Lesotho's COVID-19 Response Plan and provision of quality technical assistance.

WHO has developed several guiding documents on preparedness and response to COVID-19. At country level, the documents will be used for guiding the implementation of the project. WHO will lead the response coordination and monitoring, surveillance and case management. WHO will also collaborate with the other agencies in the areas of infection prevention and control and further play a major role in guiding the country in defining the contents and mechanisms for continuing essential services during these critical times. The oversight mechanism will be in line with the existing mechanism for managing emergencies (zero reporting, situational reporting, quarterly end of project reporting).

UNDP has established the Accelerator Lab programme, which is aimed at unearthing local innovations and solutions for emerging and existing development challenges. In collaboration with local youth innovators, academia and private sector, UNDP is leading development of innovative technological solutions aimed at accelerating surveillance, case monitoring and management. UNDP has also collaborated with the Government and local NGOs to roll-out water dispensers and develop key messages for critical population groups. Based on previous programmes on data, UNDP will also engage and build capacities of the Bureau of Statistics and the academic sector to generate, collect and analyses data and generate evidence to inform decision and policy -making in the context of COVID-19.

UNFPA is the lead agency in GBV response in emergency and has supported and developed guiding tools that will assist in the implementation of the project to ensure women and girls will receive the requisite protection in emergencies and ensure continuation of SRHR services for all. Over the previous emergency situations and the current CERF response UNFPA has developed partnerships with NGO and those will be instrumental in the implementation of the project. For purposes of this project UNFPA will work closely with UNAIDS in the implementation to ensure that PLHIV are not left behind.

# VIII. COVER PAGE

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| Contacts | Resident Coordinator or Focal Point in his/her Office<br>Name: Salvator Niyonzima<br>Email: Salvator.niyonzima@one.un.org<br><br>Position: Resident Coordinator<br>Other Email: bandar@who.int<br><br>Telephone: +266 22228000<br>Skype: |
| Description | The purpose of this proposal is to support the Government of Lesotho to scale up national readiness and response operations for COVID-19 by addressing critical gaps in the National Response Plan. The UN proposes an integrated response to strengthen the national response system to ensure inclusive and decentralized response to the COVID-19 and ensure continuity of critical health services to slow down the transmission, reduce morbidity and mortality from the pandemic and other related socio and economic effects. This will be achieved by adopting innovative programmes, data and digital technology solutions to:<br>(i) enhance coordination, planning and monitoring of the national response,<br>(ii) facilitate rapid response for surveillance, investigation and case management,<br>(iii) promote infection prevention and control, and<br>(iv) enable continuity and delivery of critical health and non-health services. |
| Universal Markers | Gender Marker: *(bold the selected; pls select one only)*<br>a) Have gender equality and/or the empowerment of women and girls as the primary or principal objective.<br>b) **Make a significant contribution to gender equality and/or the empowerment of women and girls**;<br>c) Make a limited contribution or no contribution to gender equality and/or the empowerment of women and girls. |
| Fund Specific Markers | **Human Rights Based Approach to COVID19 Response** *(bold the selected)*:<br>**Yes**/No<br>Considered OHCHR guidance in proposal development UN OHCHR COVID19 Guidance<br>Considered OHCHR guidance in proposal development UN OHCHR COVID19 Guidance |
| | **Fund Windows** *(bold the selected; pls select one only)*<br>**Window 1: Enable Governments and Communities to Tackle the Emergency**<br>Window 2: Reduce Social Impact and Promote Economic Response |
| Geographical Scope | **Regions: Africa**<br>**Country:** Lesotho |

<table>
<tr><td></td><td></td></tr>
<tr><td>Recipient UN Organizations</td><td>WHO, UNICEF, UNFPA , UNDP<br>1. Ms. Anurita Bains<br>Country Representative<br>UNICEF<br>E-mail: abains@unicef.org<br>2. Dr. Richard Banda<br>Country Representative<br>WHO<br>E-mail: bandar@who.int<br>3. Ms. Betty Wabunoha<br>Resident Representative<br>UNDP<br>E-mail: betty.wabunoha@undp.org<br>4. Dr. Marc Derveeuw<br>Country Representative<br>UNFPA<br>E-mail: derveeuw@unfpa.org</td></tr>
<tr><td>Implementing Partners</td><td>Ministry of Health, Ministry of Gender, Ministry of Water, Ministry of Police, National University of Lesotho, Ministry of Development Planning, Lesotho Red Cross, Gender Links, Lesotho Planned Parenthood Association, LENASA.</td></tr>
<tr><td>Programme and Project Cost</td><td><table>
<tr><th>Budget</th><th>Agency</th><th>Amount</th><th>Comments</th></tr>
<tr><td>Budget Requested</td><td>WHO</td><td>$523, 320</td><td>Output 1, 2, 3, 4</td></tr>
<tr><td></td><td>UNDP</td><td>107, 000</td><td>Output 1, 2, 3</td></tr>
<tr><td></td><td>UNICEF</td><td>260, 000</td><td>Output 3</td></tr>
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<tr><td></td><td>Duration (In months): 6 months</td></tr>
<tr><td></td><td>End Date: 31st December 2020</td></tr>
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# IX. Results Framework

| Window 1: Proposal Outcome | | | | | Outcome Total Budget USD |
|---|---|---|---|---|---|
| | *Outcome:* COVID-19 transmission and mortality reduced and/or prevented in Lesotho through community engagement and health systems strengthening | | | | USD1,000,000 |
| | | Baseline | Target | Means of verification | Responsible Org |
| Outcome Indicator [Max 2500 characters] | 1.1. International Health Regulations (IHR) capacity and health emergency preparedness. | 12% IHR core capacity index | 20% | End of project report | WHO, UNICEF, UNDP, UNFPA |
| | 1.2. COVID-19 associated mortality maintained below 10% | 0 | <10% | End of project report | WHO, UNICEF, UNDP, UNFPA |
| Proposal Outputs | 1. Strengthened Coordination, planning and Monitoring of COVID-19 National Response at national and community level | | | | |
| | 2. Enhanced disease surveillance for rapid case detection and management, tracing and monitoring | | | | |
| | 3. Strengthened measures and mechanisms for infection prevention and control at health facility and in community settings | | | | |
| | 4. Continuity of other essential health services maintained | | | | |

| | Output Indicators | Baseline | Target | Means of verification | Responsible Org |
|---|---|---|---|---|---|
| Output I | Strengthened Coordination, planning and monitoring of COVID-19 National Response at national and community level | | | | |
| Proposal Output Indicators | 1.1.1. Availability of a functional National and district Coordination Structures | 0 | 1 national<br>10 district coordination centres | Quarterly reports | WHO, UNFPA |
| | 1.1.2. Referral system for care of COVID-19 in place and functional | | | Quarterly reports | WHO, UNDP |
| | 1.1.3. Extent[1] to which data is used to to inform policy decision, disaggregated by source:<br>(a) traditional health register<br>(b) digital technologies (big data and artificial intelligence) | (a) 1<br>(b) 0 | (a) 3<br>(b) 2 | Quarterly reports | WHO, UNDP |
| Output II | Enhanced disease surveillance for rapid case detection and management, tracing and monitoring | | | | |
| Proposal Output Indicators | 1.2.1. Proportion of confirmed COVID-19 cases reported to WHO within 24 hours disaggregated by district, community, gender and age | 0 | 100% | Situational reports | WHO, UNDP |
| | 1.2.2. Proportion of self-quarantined travellers monitored disaggregated by district, community, gender and age | TBD | 80% | Situational reports | WHO |
| | 1.2.3. Number of epidemiological and situational reports produced and shared | 0 | 30 | Weekly reports | WHO, ? |
| Output III. | Strengthened measures and mechanisms for infection prevention and control at health facility and in community settings | | | | |
| Proposal Output Indicators | 1.3.1. Number of people reached with quality COVID-19 messaging and information at health facility and community levels (disaggregated by gender and age) | Total = 0 | Total 150,000 (M: 50,200, F: 52,300, C: 47,500) | Situational reports | UNICEF, UNDP, WHO, UNFPA |
| | 1.3.2. Number of operational IPC committees at (a) hospital, (b) health facility and (c) community levels | (a) 0<br>(b) 0 | Total 100<br>a. 50<br>a. 50 | Situation report | WHO, UNICEF |
| | 1.3.3. Number of people (disaggregated by gender) trained on IPC | (a) 0 | 500<br>(a) 200 health workers | Situational reports | WHO, UNICEF |

[1] Scale: 0 – none; 1 – minimal; 2 – advanced; 3 – fully

| | Output Indicators | Baseline | Target | Means of verification | Responsible Org |
|---|---|---|---|---|---|
| | (a) health care workers and<br>(b) community health agents and<br>(c ) leaders.) | (b) 0<br>(c) 0 | and<br>(b) 200 community health agents and<br>(c) 100 leaders | | |
| | 1.3.4. Number of people accessing WASH services at ( health facilities, isolation/quarantine centres, high-risk communities and open spaces (disaggregated by gender and age) | 0 | 50,000 (M: 16700; F: 17500; C: 15800 | Situation Reports | UNICEF, UNDP |
| | 1.3.5. Proportion of hospitals with functional triaging at OPD | 4.5% | 100% | Situational reports | WHO |
| Output IV | Continuity of essential health services[2] maintained | | | | |
| Proposal Output Indicators | 1.4.1. Proportion of people (disaggregated by type of services, gender and age) continuing to receive essential health services and key messaging | 0 | 70% | Situational reports | WHO, UNFPA, UNICEF |
| | 1.4.2. Proportion of public health facilities supported to continue to provide essential health services | 0 | 90% | Situational reports | WHO |
| | 1.4.3. Proportion of public health facilities delivering integrated outreach services as part of essential health services | 25% | 50% | Quarterly reports | WHO, UNFPA |

[2] Essential health services include family planning (FP) , MNCH, PMTCT, psychosocial support (PSS) clinical management of rape and GBV and multi-month dispensing of medicines for the chronically ill individuals.

# X. SDG List

| Sustainable Development Goals (SDGs) [select max 3 goals] | | | |
|---|---|---|---|
| ☐ | SDG 1 (No poverty) | ☐ | SDG 9 (Industry, Innovation and Infrastructure) |
| ☐ | SDG 2 (Zero hunger) | ☐ | SDG 10 (Reduced Inequalities) |
| ☒ | SDG 3 (Good health & well-being) | ☐ | SDG 11 (Sustainable Cities & Communities) |
| ☐ | SDG 4 (Quality education) | ☐ | SDG 12 (Responsible Consumption & Production) |
| ☒ | SDG 5 (Gender equality) | ☐ | SDG 13 (Climate action) |
| ☒ | SDG 6 (Clean water and sanitation) | ☐ | SDG 14 (Life below water) |
| ☐ | SDG 7 (Sustainable energy) | ☐ | SDG 15 (Life on land) |
| ☐ | SDG 8 (Decent work & Economic Growth) | ☐ | SDG 16 (Peace, justice & strong institutions) |
| ☐ | SDG 17 (Partnerships for the Goals) | | |

Relevant SDG Targets and Indicators

| Target | Indicator # and Description | Estimated % Budget allocated |
|---|---|---|
| **Target 3.d.** Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks | 3.D.1. International Health Regulations (IHR) capacity and health emergency preparedness. | **52%** |
| **Target 3.3.** By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat, hepatitis, water-borne diseases and other communicable, diseases | 3.3.1 Number of new HIV infections per 1,000 uninfected population, by sex, age and key populations<br>3.3.2 Tuberculosis incidence per 1,000 population | **4%** |
| **Target 3.7.** By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes | 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods | **4%** |

| Target | Indicator # and Description | Estimated % Budget allocated |
|---|---|---|
| **Target 5.6.** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences | | |
| **Target 6.2.** By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations | 6.2.1 Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water | **36%** |

# XI. Risk

| Event | Categories | Level | Likelihood | Impact | Mitigating Measures | Risk Owner | |
|---|---|---|---|---|---|---|---|
| Unprecedented global demand, supply disruption and export bans on the sale of essential/critical medical equipment, laboratory consumables, pharmaceutical and non-pharmaceutical commodities making it hard for the country to access them. | *Operational* | *3* | *6* | *5* | Develop a PPE plan and guidance tools to ensure optimization of available stocks and clarity of PPE usage guidelines in different settings<br><br>Support the government to assess stocks and establish proactive supply plan to enhance continuity of essential services.<br><br>Continue advocacy with policy makers, national regulatory authorities, pharmaceutical sector on the guideline development, standards, promotion of local production and innovation on items such as hand sanitizers, gowns, face shields | Global industry | |
| Unstable political situation leading to unconducive environment for a robust community-based response | *Political* | *2* | *3* | *5* | Liaise with institutions working on political reforms to get updates as the situation evolves so as to adapt the response accordingly<br><br>Engage technical teams within ministries and key institutions ensure programme continuity<br><br>Utilize trusted channels (e.g. community leaders, family doctors, social influencers) for information transmission | Lesotho Government | |
| Limited exposure, capacity and skills to exploit digital technology platforms for disease control and management | *Technological* | *2* | *3* | *3* | Develop capacities of key stakeholders and provide the necessary technical support to enhance use of digital technologies in the COVID-19 response | | |

# XII. Budget by UNDG Categories

| Budget Lines | Fiscal Year | Description [OPTIONAL] | Agency WHO | Agency UNICEF | Agency UNFPA | Agency UNDP | Total USD |
|---|---|---|---|---|---|---|---|
| 1. Staff and other personnel | 2020 | | 139,000 | 66,000 | 0 | 0 | 199,000 |
| 2. Supplies, Commodities, Materials | 2020 | | 83,000 | 71,190 | 20,000 | 0 | 183,000 |
| 3. Equipment, Vehicles, and Furniture, incl. Depreciation | 2020 | | 35,000 | 0 | 0 | 50,000 | 85,000 |
| 4. Contractual services | 2020 | | 105,000 | 30,000 | 0 | 50,000 | 185,000 |
| 5. Travel | 2020 | | 25,000 | 15,000 | 11,000 | 0 | 55,000 |
| 6. Transfers and Grants to Counterparts | 2020 | | 90,000 | 60,800 | 65,805 | 0 | 234,120 |
| 7. General Operating and other Direct Costs | 2020 | | 12,000 | 0 | 5,700 | 0 | 17,700 |
| **Sub Total Programme Costs** | | | **489,084** | **242,990** | **102,505** | **100,000** | **934,579** |
| 8. Indirect Support Costs * 7% | | | 36632 | 17,010 | 7,175 | 7,000 | 65,421 |
| **Total** | | | **523320** | **260,000** | **109,680** | **107,000** | **1,000,000** |

** The rate shall not exceed 7% of the total of categories 1-7, as specified in the COVID-19 Response MOU and should follow the rules and guidelines of each recipient organization. Note that Agency-incurred direct project implementation costs should be charged to the relevant budget line, in line with UNSDG guidance.*