



LESOTHO

UNGASS Country Report

**STATUS OF THE NATIONAL RESPONSE TO THE 2001
DECLARATION OF COMMITMENT ON
HIV AND AIDS**

January 2008 - December 2009



Acknowledgements

This report was developed by the National AIDS Commission (NAC) in collaboration with the Ministry of Health and Social Welfare (MOHSW). Additional technical support was provided by the UNAIDS country office and Armstrong Associates Consulting. Many organisations and individuals were involved at various levels in the development of the report. On behalf of the Board of Commissioners, I would like to express our gratitude to all. We acknowledge the support of the UNGASS Core Team, comprising representatives from MOHSW, the Global Fund Coordination Unit, UNAIDS and NAC. The team worked tirelessly to ensure that the final form of this report achieved the highest standard of completeness and accuracy. We must equally acknowledge the contributions of the UNGASS Forum Members for their guidance, and the M&E Technical Working Group for assisting with data collection and analysis. We thank the MOHSW and the Christian Health Association of Lesotho for facilitating access to staff in the Ministry and to hospitals, and other partners for the completion of the National AIDS Spending Assessment. We also thank those stakeholders, ranging from sex workers and prisoners to senior representatives of line ministries, who participated in the NCPI survey, the focus groups and panel discussions, and the final stakeholder validation workshop. We are indebted to those stakeholders who took part in the process of selecting and documenting best practices. Last, but not least, thanks are due to the NAC staff which supported all aspects of the report development process.

With kind regards,

A handwritten signature in dark ink, appearing to read 'Thabo Makeka', written over a light blue horizontal line.

Advocate Thabo Makeka
Chair, Board of Commissioners
National AIDS Commission

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LIST OF ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ALE	Association of Lesotho Employers and Business
ANC	Antenatal care
ART	Antiretroviral treatment
ARV	Antiretroviral
BCC	Behaviour change communication
BIPAI	Baylor Paediatric AIDS Initiative
CARE	Co-operative for African Relief Everywhere, Inc.
CCM	Country Coordination Mechanism
CD4	T-helper cells (part of the immune system that is destroyed by HIV infection)
CDC	Centers for Disease Control (US)
CGPU	Child & Gender Protection Unit
CHAI	Clinton HIV & AIDS Initiative
CHAL	Christian Health Association of Lesotho
CIET	Centro de Investigación de Enfermedades Tropicales
CPT	Cotrimoxazole prophylaxis
CSO	Civil society organization
CRIS	Country Response Information System
DFID	Department for International Development (UK)
DNA	Deoxyribonucleic acid
DSW	Department of Social Welfare
EDF	European Development Fund
EGPAF	Elizabeth Glazer Paediatric AIDS Foundation
EU	European Union
FAO	Food & Agriculture Organization (UN)
GFATM	Global Fund to Fight AIDS, TB and Malaria
GFCU	Global Fund Coordination Unit
GOL	Government of Lesotho
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH (German Technical Corporation)
HIV	Human immune-deficiency virus
HPSU	Health Planning & Statistics Unit
HTC	HIV testing and counselling
ICAP	International Center for AIDS Care & Treatment Programs, Mailman School of Public Health, Columbia University, New York, NY.
JICA	Japanese International Cooperation Agency
KAP	Knowledge, attitudes, practices
LCGP	Lesotho Child Grants Programme
LCN	Lesotho Council of NGOs
LCS	Lesotho Correctional Services
LDF	Lesotho Defence Force
LDHS	Lesotho Demographic and Health Survey
LENEPWHA	Lesotho Network of People Living with HIV & AIDS
LIRAC	Lesotho Inter-Religious AIDS Consortium
LMPS	Lesotho Mounted Police Services
LCN	Lesotho Council of NGOs
M&E	Monitoring & evaluation
MCA	Millennium Challenge Account

MCC	Millennium Challenge Corporation
MDR-TB	Multi-drug resistant tuberculosis
MOET	Ministry of Education & Training
MOFDP	Ministry of Finance & Development Planning
MOGYSR	Ministry of Gender, Youth, Sports & Recreation
MOHSW	Ministry of Health & Social Welfare
MOJHRCS	Ministry of Justice, Human Rights & Correctional Services
MOLE	Ministry of Labour & Employment
MOLGC	Ministry of Local Government & Chieftainship
M2M	Mothers-2-Mothers (UK)
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NCPI	National Composite Policy Index
NGO	Non-governmental organization
NOCC	National OVC Coordinating Committee
NTP	National TB Programme
NUL	National University of Lesotho
OVC	Orphans & vulnerable children
PACT	People Achieving Change Together (US)
PCR	Polymerase chain reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PIH	Partners in Health (Boston, MA)
PLWHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
PR	Principal Recipient
PS	Principal Secretary
PSI	Population Services International
PSM	Procurement & supply management
RSA	Republic of South Africa
SADC	Southern African Development Community
STI	Sexually transmitted infection
TB	Tuberculosis
TDF	Tenofovir
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	US dollar
UNFPA	United Nations Population Fund
USG	United States Government
WHO	World Health Organization
XDR-TB	Extreme drug resistant tuberculosis

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**LESOTHO UNGASS COUNTRY REPORT:
STATUS OF THE NATIONAL HIV & AIDS RESPONSE
2008 TO 2009**

1.0 PROGRESS ON CORE INDICATORS & REPORT SUMMARY

Lesotho's progress in responding to the HIV epidemic since the last UNGASS reporting period is shown in Table 1 below. Details on these achievements are explained in the summary that follows.

Table 1: Progress on Core Indicators

UNGASS Indicators	2005	2007 ¹	2009	Universal access targets 2010
National Commitment				
1.Domestic and international AIDS spending by categories and financing sources.	NA	Public Expenditure: 2005-06: M 58,921,026 2006-07: M 55,779,134 External Expenditure: 2005-06: M 83,298,401 2006-07: M 122,627,478	Public Expenditure: 2007-08: M 150,053,982 2008-2009: M 355,066,269 ² External Expenditure: 2007-08: M 252,970,071 2008-2009: M 268,617,087	NA
2. Percentage of donated blood units screened for HIV in a quality assured manner.	100%	100%	100% ³	NA
3. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.	16%	31% (CD4<350) 42% (CD4<200)	51% ⁴ (CD4<350)	80% (CD4<350)
4. Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission.	5.9%	31%	71%	80%
5. Percentage of estimated HIV-positive incident TB cases that received treatment.	No available data.	24.4%	27.6% ⁵	NA
6. Percentage of women and men aged 15-49 who received an	No available data.	Male: 4.8% Female: 6.3%	Data pending from 2009 DHS.	80%

¹ Data sources and technical details for the 2007 results column can be found in the Lesotho 2007 UNGASS report available at http://data.unaids.org/pub/Report/2008/lesotho_2008_country_progress_report_en.pdf

² NAC. 2010. Provisional 2008/2009 National AIDS Spending Assessment Results. PowerPoint presentation. See Section 6.0 for additional details, especially note 77.

³ Lesotho Blood Transfusion Service. Annual Report 2009.

⁴ MOHSW. 2010. Output from STI/HIV&AIDS Directorate and HPSU for 2009 UNGASS report. See section 4.5.1 below.

⁵ MOHSW. 2010. Output from National TB Programme for 2009 UNGASS report. See section 4.5.2 below.

UNGASS Indicators	2005	2007 ¹	2009	Universal access targets 2010
HIV test in the last 12 months and who know the results.		All: 5.5%		
7. Percentage of most-at-risk population that have received an HIV test in the last 12 months and who know the results.	No available data.	No available data.	No available data.	NA
8. Percentage of most-at-risk populations reached with HIV prevention programmes.	No available data.	No available data.	73% ⁶	NA
9. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child.	25%	No available data.	Data pending.	80%
10. Percentage of schools that provided life skills-base HIV education within the last academic year.	No available data.	No available data.	88% ⁷	100%
11. Current school attendance among orphans and among non-orphans age 10-14.	1:1	1:1	Data pending from 2009 DHS.	NA
12. Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Male: 18% Female: 26%	Male 18% Female 26%	Data pending from 2009 DHS.	80%
13. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	No available data.	No available data.	WSW: 6.3% MSM: 3.8% ⁸	NA
14. Percentage of young women and men who have had sexual intercourse before the age of 15.	Male: 27% Female: 15%	Male 27% Female 15%	Data pending from 2009 DHS.	Male: 13.55% Female: 7.55%
15. Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	Male: 21.1% Female: 7.2%	Male: 21.1% Female: 7.2%	Data pending from 2009 DHS.	NA
16. Percentage of adults aged 15-49 who had more than one	Male: 48% Female: 50%	Male: 48.6% Female: 41.9%	Male: 50.5% Female: 37.5% ⁹	NA

⁶ There are 11 key populations identified in the revised NSP. Interventions are underway for 8 of the 11 groups. See section 4.4 below.

⁷ MOET. 2010. Output for 2009 UNGASS report. 1443 of a total of 1641 schools were implementing the curriculum at December 2009.

⁸ UNDP/NAC. 2010. A cross-sectional assessment of population demographics, sexual practices, HIV risk status, and human rights contexts of sexual minorities in Lesotho. Maseru, LS: UNDP/NAC. p. 13, 17. Question asked respondents to choose most at-risk sexual behaviour from a list of five options. 8/212 MSM and 15/240 WSW answered correctly.

⁹ MOHSW. 2010. HPSU preliminary output from 2009 LDHS for 2009 UNGASS report.

UNGASS Indicators	2005	2007 ¹	2009	Universal access targets 2010
sexual partner in the past 12 months who report the use of a condom during their last intercourse.				
17. Percentage of female and male sex workers reporting the use of a condom with their most recent client.	No available data.	No available data.	No available data. ¹⁰	NA
18. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	No available data	No available data	48.2% ¹¹	NA
19. Percentage of injecting drug users who reported the use of a condom at last sexual intercourse.	No available data.	No available data.	No available data.	NA
20. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected.	No available data	No available data	No available data.	NA
21. Percentage of young women and men aged 15-24 who are HIV infected.	Both male and female: 10% Male: 6% Female: 14%	Both male and female: 18.7.	Data pending from 2009 DHS.	NA
22. Percentage of most-at-risk populations who are HIV infected.	No available data.	No available data	Inmates: 17% ¹² MSM: 11.6% ¹³ WSW: 7.1%	NA
23. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	82%	74.4%	80% ¹⁴	100%
24. Percentage of infants born to HIV-positive mothers who are also HIV-positive.	25%	15%	Data pending from UNAIDS.	NA.

¹⁰ 100% of sex workers interviewed for the report stated that at the start of negotiations with clients they always insist on condom use; sometimes there is agreement not to use condoms depending on the client; some sex workers are forced by clients not to use condoms (see section 4.4 below).

¹¹ UNDP/NAC 2010, op. cit. note 9, p17. 95/194 of MSM respondents used condoms every time with a male partner.

¹² MOJHRCS/LCS. 2009. Report of the Assessment of the LCS HIV&AIDS Situation. Maseru, LS: LCS. Self-reported prevalence rates (sample= 2,700 male inmates).

¹³ UNDP/NAC 2010, op. cit. note 9. p13,16. Self-reported rates for MSM (sample=190) and for WSW (sample=208).

¹⁴ MOHSW. 2010. Output from Health Planning and Statistic Unit for 2009 UNGASS report. 39,256/39,609 (original cohort) still on treatment after 12 months. 146/183 ART sites reporting.

1.1 PROFILE OF THE HIV&AIDS EPIDEMIC IN LESOTHO

The estimated adult HIV prevalence rate for 2008 was 23.6 % (range=21.3 %, 25.8 %). This was an increase of 0.4% from 2007. In 2008, there were approximately 21,000 new adult HIV infections in Lesotho. There were approximately 12,000 AIDS-related deaths. The annual number of AIDS-related deaths has been declining since 2005. The most recent estimates show that there are approximately 260,000 HIV-positive adults (15-49 years) in Lesotho. There are an estimated 21,000 HIV-positive children (0-14 years) bringing the total HIV-positive population to approximately 280,000.

The understanding of the HIV epidemic in Lesotho has improved significantly since 2007. Increases in both data quality and technical capacity have resulted in a more accurate and greater range in the country's ability to model the trends and impacts of the epidemic. The following are the main drivers and contextual factors fuelling the HIV epidemic in Lesotho:

Immediate drivers:

- Multiple and concurrent sexual partnerships;
- Low levels of consistent and correct condom use;
- Poverty and unemployment;
- Challenges for adolescents and youth to change patterns of sexual behaviour;
- High rates of alcohol use; and,
- Low rates of male circumcision.

Contextual factors:

- Social and cultural factors affecting women and girls;
- Social and cultural inhibitions around open discussion of sex and sexuality; and
- Income inequalities and income disparities.

1.2 PROGRESS IN RESPONDING TO HIV & AIDS

While challenges remain in the way of meaningfully reducing HIV prevalence in Lesotho, progress has nevertheless occurred and, on several core indicators as indicated in Table 1 above, momentum has built to the extent that early signs of significant change are visible. These developments are summarized in the following sections.

1.2.1 Prevention

Behaviour Change Communication (BCC)

Between 2008 and 2009, the MOHSW and its partners expanded the scale and scope of BCC interventions. During this period, youth peer education programs (including life skills training), faith-based programs, sports-based programmes, edutainment were implemented across the country. In 2009, Lesotho joined the Southern African 'One Love' initiative addressing multiple and concurrent sexual partnerships. The MOHSW and NAC launched a new National BCC Strategy in 2009. In 2010, a national operational plan for BCC will be developed along with a national prevention strategy incorporating the BCC component.

Male Circumcision

Following initial work completed in 2007, including a rapid assessment and cost-effectiveness analysis, a full situational analysis on male circumcision in Lesotho was completed in 2008. The study found that 48% of men aged 15 to 59 were circumcised with the highest rates in the 20 to 24-year-old age group. Most circumcisions (67%) had taken place as a result of participation in traditional initiation schools. Ritual circumcision is not complete medical circumcision and does not achieve the same preventative impact in relation to HIV transmission. The scaling-up for medical male circumcision is proceeding. Guidelines, protocols, a site assessment tool, M&E tools and a counselling package are close to finalization. These will be introduced to the wider health sector in 2010.

Prevention of mother-to-child transmission of HIV (PMTCT)

Lesotho's PMTCT programme was launched in 2003. Since then, there has been a continuous effort to scale-up and strengthen the programme to reach as close as possible to 100% of HIV-positive pregnant women and to ensure that services are available in the villages and communities where these women reside. Between 2007 and 2009, significant progress was made in making PMTCT services available at the health centre level. A national scale-up plan was approved in 2007 and implemented over the 2008 and 2009 period. PMTCT coverage rates have increased from 6% in 2005 to 71% in 2009.

Condom Promotion and Distribution

Between 2004 and 2009, over 32 million condoms were procured and distributed using both governmental and non-governmental channels. To improve the effectiveness of condom distribution and promotion activities, a Condom Technical Working Group was established in 2008. The group has collaborated in the completion of a situational analysis and a national condom strategy.

HIV testing and counselling (HTC)

As a result of the implementation of the two-year Know Your Status campaign between 2006 and 2008, the number of individuals in Lesotho seeking HTC has increased significantly from year to year. 70% of the population (1,316,461 are 12 years and above) is considered to be sexually active and/or eligible for HTC. For this group, approximately 787,813 or 70% had undergone HTC by the end of 2009.

Workplace Programmes

During the reporting period, NAC commissioned situational assessments of public and private sector workplaces to better understand the state of workplace policy and programme development related to HIV and AIDS. To address the gaps in workplace programmes for the public sector, NAC conducted a series of training sessions to capacitate government ministry focal points with basic HIV and AIDS competency and to provide them with technical skills to support workplace policy and programme development. In 2008, the Ministry of Labour and Employment issued national guidelines for workplace programme development in the private sector.

1.2.2 Addressing Key Populations

Within the general population of Lesotho, there are specific sub-groups which are at greater risk of HIV transmission. The needs of these sub-groups have not been fully studied and, consequently, not fully included within the country's prevention efforts. This situation is changing though. Interventions are underway or planned for uniformed services, inmates, people with disabilities, sexual minorities, commercial sex workers, adolescents and youth (15-24 years), migrant labourers, and herd boys.

1.2.3 Treatment, Care & Support

Provision of antiretroviral treatment (ART) to adults and children

The expansion of access to ART to the health centre level in each district of the country has resulted in a significant increase in the rate at which HIV-positive men, women and children have been enrolled on ART. At this time, 180 of 216 ART service points have been accredited and accreditation of the remaining 36 sites is underway. At the end of 2009, there were a total of 62,190 adults and children receiving ART, representing 51% of the total estimated need (122,818).

Management of TB/HIV co-infection

The GOL has made significant progress in strengthening collaboration and coordination between the HIV and TB programmes. A national TB/HIV Coordinating Committee has been established along with a Technical Working Group within the MOHSW. These bodies have supported the development of a revised TB/HIV policy manual and strategic plan. They have also supported the development of revised TB/HIV monitoring and evaluation tools. Health care workers in all facilities have been trained on TB/HIV co-infection management. In 2009, 78% of individuals diagnosed with TB were also tested for HIV. Of those tested, 76.5% were found to be HIV positive and 27.6% were enrolled in ART.

Community and home-based care

The provision of a continuum of care and support services has always been an important component of Lesotho's HIV chronic care strategy. Since 2006, increasing numbers of community health workers have received incentives to motivate them to provide consistent, high quality services. Home-base care services have been expanded to include adherence monitoring for HIV and TB treatment, PMTCT support, and identification of children who may be suffering from the consequences of HIV infection but not yet diagnosed.

1.2.4 Impact Mitigation

Support to Orphans & Vulnerable Children (OVC)

Data from the 2006 population census indicates that there were an estimated 221,403 OVC (from all causes) in Lesotho during that year. For 68% of all OVC, HIV&AIDS is the major factor causing orphanhood and vulnerability. An essential package of support is being delivered to OVC by the MOHSW and its partners. The Department of Social Welfare, in collaboration with UNICEF and EU, has piloted a cash grant programme to address children's vulnerability at the household level. The Child-Help Line is expanding. Child and Gender Protection Units, run by the Lesotho Mounted Police Service in each district, have been strengthened. The Office of the Master of the High Court, the statutory body protecting children's inheritance, has been decentralized to all districts. Orphan registration has been piloted and birth registration expanded through the Ministry of Local Government and Chieftainship.

Addressing the needs of women and girls

In 2007, the Ministry of Gender, Youth, Sports & Recreation issued a *National Action Plan on Women and Girls and HIV&AIDS: Facing the Future Together 2007-2011*. The impetus to develop the plan was the evidence of the reality in Lesotho that women and girls are disproportionately affected by the HIV epidemic. Community-level activities are ongoing to sensitize women and girls and their communities to their legal and human rights in Lesotho.

Preventing stigma & discrimination against PLWHIVs, OVC and other vulnerable groups.

NAC continues to support non-governmental partners to work at the community level to provide education and awareness about the damaging effects of stigma and discrimination and the protections that are in place for those who are victimized by it.

1.2.5 Leadership, Management & Coordination

Leadership

Through its coordination structures and technical committees, NAC continues to provide leadership on behalf of the GOL within the multi-sectoral HIV response. Leadership has also been demonstrated on a number of fronts including the National Assembly, faith-based organisations and civil society in general. The GOL continues to finance the response and the MOHSW provides the necessary leadership within the health sector. The members of the HIV and AIDS parliamentary portfolio committees toured the country in 2009 reviewing HIV and AIDS services and listening to the views of communities as part of their oversight function.

Advocacy, policy & legislation

During the reporting period, NAC reviewed and facilitated alignment of a number of sectoral policies. Comprehensive stakeholder consultations on the draft AIDS bill were undertaken alongside dissemination of the SADC Model Law on HIV and AIDS. Drafting of the bill will be finalised in 2010 for ultimate tabling before Parliament.

Coordination & management of the multi-sectoral response

Since the last reporting period, NAC has been strengthening its role in coordination by convening national partnership fora on a quarterly and annual basis. Using district level technical officers, NAC has expanded and strengthened its ability to collect and share information on district and local level interventions. NAC has also been providing financial and technical support to umbrella bodies to ensure that these organizations are able to provide coordination and support to their members at district and local levels.

1.3 NATIONAL M&E SYSTEMS

While Lesotho has achieved a great deal of progress in many other aspects of its response to HIV, improving the extent and the quality of strategic information that is required to plan and implement effective and relevant interventions has not always kept pace. In 2008, an assessment of the national M&E systems and structures was undertaken. The review has informed a national plan of action to strengthen M&E capacities and systems. In 2009, the Lesotho Output Monitoring System for HIV & AIDS (LOMSHA) was launched as an integrated data collection and analysis tool for the entire multi-sectoral response to HIV.

1.4 FINANCIAL MANAGEMENT AND RESOURCE MOBILIZATION

The resource envelope for the national HIV & AIDS response has increased by 140% since 2007, while the increase that has been registered between 2008 and 2009 is 24%.¹⁵ Growth has occurred largely in the GOL budget contribution. Between 2008 and 2009, the GOL contribution to HIV & AIDS grew by 56%, which is an increase of 132% since 2007. For development partners, their contribution has increased by 6% since 2008 and 154% since 2007. The private sector contribution has declined by 16% and 43% respectively.

1.5 CONTRIBUTIONS FROM DEVELOPMENT PARTNERS

Lesotho's national response to HIV and AIDS receives significant support from its development partners. These include the UN Country Team, Global Fund, PEPFAR, USAID, CDC and other USG Partners, Millennium Challenge Account, Clinton HIV and AIDS Initiative, World Bank, European Union, Irish Aid, GTZ, DFID, and JICA, among others. There are a number of smaller external contributions to individual projects and agencies in Lesotho. These funders include the Canada Fund for Local Initiatives, the Canadian International Development Agency, the Mennonite Central Committee, the Swiss Development Corporation, the Government of China, and the UK-based Prince's Fund.

¹⁵ NAC 2010, op. cit. note 2. For the 2008/2009 assessment, hospital costs for HIV&AIDS treatment were included. These totalled LSL 121,265,468. When these are added to the 2008/2009 public contribution to HIV&AIDS expenditure, the national recurrent budget share rises to LSL 355,066,269 and total spending on HIV&AIDS to LSL 626,954,165. The hospital costs are removed in this table for purposes of trend analysis with other assessment results in years when these costs were not included.

2.0 BACKGROUND

2.1 INTRODUCTION

In 2001, representatives from 189 nations across the globe gathered in New York City for the United Nations General Assembly Special Session on HIV & AIDS (UNGASS). At the end of the session participating countries, including Lesotho, ratified the Declaration of Commitment on HIV&AIDS.¹⁶ As parties to the Declaration, nations agreed to submit biennial reports on their respective efforts to respond to HIV & AIDS at country level. The reporting process began in 2003. The Government of Lesotho (GOL) submitted UNGASS reports in 2005 (also covering the 2003 reporting period) and 2007.¹⁷ This 2009 UNGASS report details the progress made in addressing a population-wide, hyper-epidemic of HIV since the beginning of 2008. There have been major achievements and important progress within the national HIV & AIDS programmes during this period. These position the national response to gain sufficient strength and momentum to achieve the country's universal access targets within the next UNGASS reporting period from 2010 to 2012. This report reflects the views of a wide range of stakeholders. It serves as a high-resolution portrait of Lesotho's efforts to address its HIV epidemic and to preserve and protect the health and well-being of its people.

2.2 DEVELOPMENT OF THE 2009 UNGASS REPORT

Lesotho's 2009 UNGASS report was developed by the National AIDS Commission (NAC) in collaboration with the Ministry of Health and Social Welfare (MOHSW) with support from the UNAIDS country office. Representatives from government, civil society, the private sector and development partners participated in the development process. Data was primarily sourced from the MOHSW, other line ministries, NAC and UN-supported data banks on HIV & AIDS and development indicators. Data collection procedures included document review, key informant interviews, survey, and stakeholder panels. In addition, focus groups were convened with representatives from key populations. Data analysis procedures included variance analysis, trend analysis, (including curve fitting), frequency analysis, and standard qualitative analysis procedures, in particular thematic analysis using coding.

The development of the report was guided by a Core Team including statisticians, epidemiologists, monitoring and evaluation experts, and individuals trained in quantitative and qualitative research techniques. A stakeholder steering committee, the UNGASS Forum, reviewed drafts of the report and provided assistance with the interpretation of findings from the data. A stakeholder validation workshop was held near the end of the preparation process to ensure equal representation of all viewpoints and to validate the findings and conclusions of the report. Finally, the report was presented to His Majesty's Cabinet for review and approval before submission to UNAIDS.

The report is subject to standard limitations. Data from key informant interviews and focus groups was taken at face value with no independent tests for accuracy or validity. Not all representatives

¹⁶ For the text of the Declaration see <http://www.ua2010.org/en/UA2010/Universal-Access/Official-Papers/Declaration-of-Commitment>

¹⁷ Lesotho's UNGASS reports are available at: naids.org/en/KnowledgeCentre/HIVData/CountryProgress/2007CountryProgress.asp

from important stakeholders were available to fully participate in the report preparation process. Consequently, some aspects of the report may represent only partial views from these different entities. Focus groups were conducted mainly in Sesotho. Summaries were prepared and then translated into English and, for that reason, some of the specificity and nuance of the focus group data may have been lost.

2.3 NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

The National Composite Policy Index (NCPI) questionnaires gather the views of the governmental, non-governmental and development partner stakeholders with respect to all of the key components of an effective national response to HIV&AIDS. For the 2009 UNGASS report, the questionnaires were self-administered. Of the 30 questionnaires 21 were completed and returned. Respondents were then invited to panel discussions to explore the results, to provide additional observations on the state of the national HIV response, and to reach consensus on the overall ratings of Lesotho's progress with respect to HIV&AIDS. These final ratings are included under the different components of the country's response as they are discussed in the relevant sections throughout the report. Comparisons are made with NCPI findings in previous years where data was available.

3.0 HIV&AIDS IN LESOTHO AT 2009

3.1 LESOTHO COUNTRY PROFILE

The Kingdom of Lesotho, located in the eastern part of Southern Africa, is a land-locked country completely surrounded by the Republic of South Africa (RSA). It has been an independent, democratic nation since 1961. Lesotho is governed by a constitutional monarch. The Kingdom covers an area of 30,350 km² and has a population of 1,876,633 million.¹⁸ 51% of the population is female; 23% of the population lives in urban areas clustered along the northern borders with RSA. 77% of the population lives in rural and remote mountainous areas. The population growth rate declined between 1996 and 2006, from 1.5% to 0.08%. Lesotho currently has the lowest growth rate in the southern African region. The impact of the HIV epidemic is a major factor in the decline in population growth. The life expectancy for Basotho is 44.9 years. 58% of the population is under the age of 19. The country is at 154 of the 182 countries listed in the Human Development Index (Swaziland is 142; Botswana 125; Namibia 128; and RSA 129).¹⁹ 43.2% of the population lives on less than USD 1.25 per day; 68 % lives on less than USD 2 per day. Lesotho continues to experience high rates of maternal mortality and early infant death although the GOL has recently launched an intensive effort to address this.

Lesotho is very sensitive to shocks in both the natural and the economic environment. Other than imports from RSA, the main food source for the rural population is subsistence farming and cattle and sheep herding. Changing climate patterns have caused severe drought in the southern regions of the country. Lesotho was the only country in Southern Africa to harvest less in 2009 than in 2008.²⁰ The Lesotho Vulnerability Assessment Committee (LVAC) estimated that between 400,000 and 450,000 people would require some form of humanitarian assistance before the harvest in April 2010.²¹ 20% of all children are considered underweight for age and 13% of the population is under nourished.²² The main sources of revenue for Lesotho are remittances from Basotho employed in RSA, revenues from the Southern African Customs Union (SACU), and royalties from the export of natural resources, in particular water and diamonds. The RSA mining sector, the Government of Lesotho, and the textile manufacturing sector are the three main sources of employment.²³ Retrenchments from the mining sector are ongoing. Revenue projections from SACU for 2009/10 were over estimated by some union members by as much as 50%. This is causing the GOL among others to require severe fiscal restraint measures within the 2010 national budget. The global credit crisis at the end of 2008 resulted in reduced orders for textile products. One factory group required government assistance to avoid bankruptcy in 2009. Another ceased operations leaving 2,600 individuals out of work in an area where stable, full-time employment opportunities are extremely limited.

¹⁸ GOL. 2009. Lesotho 2006 Population and Housing Census. Maseru, LS: MOFDP/BOS.

¹⁹ UNDP. 2009. Human Development Report. Geneva, CH: UNDP. Available: http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_LSO.html

²⁰ See <http://www.wfp.org/countries/Lesotho>

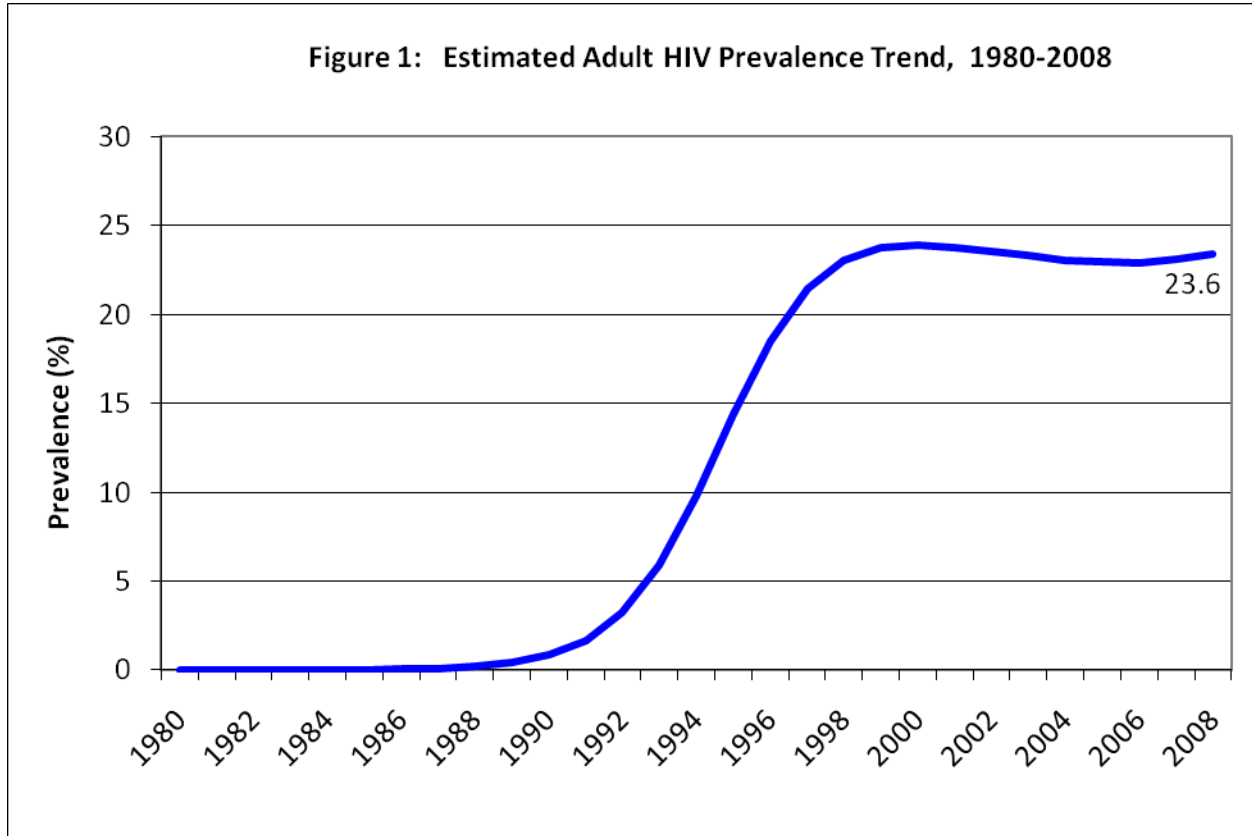
²¹ GOL. 2008. Lesotho Food Security and Vulnerability Monitoring Report May 2008. Maseru, LS: Office of the Prime Minister.

²² WFP. 2007. Lesotho Food and Nutrition Fact Sheet. Geneva, CH: WFP.

²³ GOL. 2008. Statistical Yearbook. Maseru, LS: MOFDP/BOS.

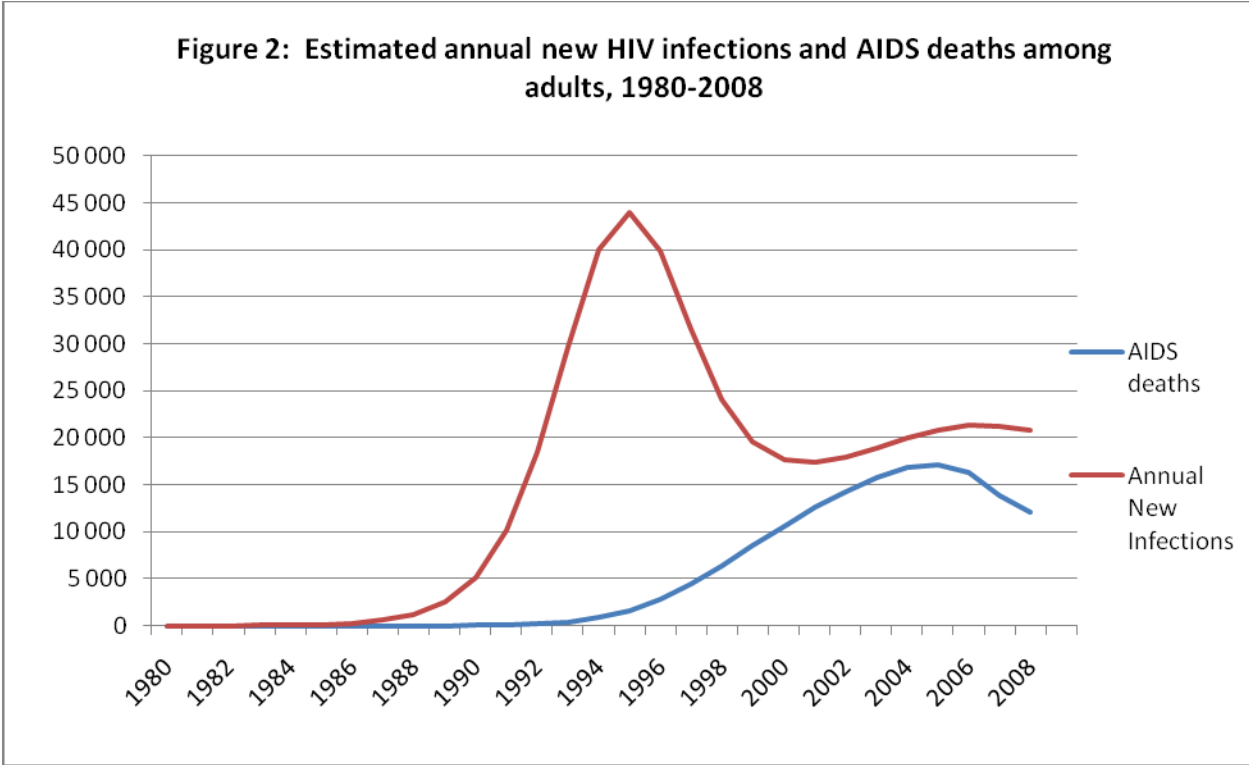
3.2 STATUS OF HIV&AIDS IN LESOTHO

The estimated adult HIV prevalence rate for 2008, the most recently available estimate, was 23.6 % (range=21.3 %, 25.8 %).²⁴ This was an increase of 0.4% from 2007, as shown in Figure 1 below. The national prevalence rate appears to be stabilizing; however, more data points are required for subsequent years before this trend can be confirmed.



Changes in HIV prevalence are usually explained by the relationship between the number of deaths annually and the number of new infections as shown in Figure 2 below.

²⁴ GOL/UNAIDS. 2009. National HIV and AIDS Estimates for Lesotho. Maseru, LS: MOHSW. All data in this section comes from this source unless otherwise indicated.



The total number of HIV-positive individuals in any one period declines when the number of AIDS deaths exceeds the number of new infections. In 2008, there were approximately 21,000 new adult HIV infections in Lesotho. There were approximately 12,000 AIDS deaths. The annual number of AIDS deaths has declined since 2005. The increasing number of HIV-positive adults and children receiving anti-retroviral therapy (ART) is the most likely cause of this trend. The number of HIV-positive individuals still alive as a result of ART has an influence on HIV prevalence as it will continue to push up the prevalence rate despite the decline in AIDS deaths. The apparent leveling of the HIV prevalence rate in Lesotho is affected by this trend as well as by the ongoing, unacceptably high annual rate of new HIV infections.

The estimated number of HIV-positive adults in the country is shown in Table 1 below.

Table 2: Estimated HIV-positive Adults 2008

	Estimated HIV-positive adults in 2008	Estimated new adult infections in 2008	Estimated annual AIDS deaths in 2008
Male	110,000 (90,000-130,000)	10,000	5,000
Females	150,000 (130,000-170,000)	11,000	6,000
Total	260,000 (230,000-290,000)	21,000	11,000

This most recent estimate shows that there are approximately 260,000 HIV-positive adults (15-49 years) in Lesotho. Not shown on the table are the estimated 21,000 HIV-positive children (0-14 years) bringing the total HIV-positive population to approximately 280,000. These figures also show the ongoing disproportionate impact of HIV as 57.7% of all HIV-positive adults are female while only 42.3% are male.

3.3 EPIDEMIC DRIVERS

The understanding of the HIV epidemic in Lesotho has improved significantly since the submission of the 2007 UNGASS report. Increases in both data quality and technical capacity have resulted in improvement in the GOL's ability to model and anticipate the trends and impacts of the epidemic. In 2009, a study was released by the GOL on the national prevention response and the primary modes of HIV transmission in the country.²⁵ Additional sub-studies were also made available which together confirmed the following as the main drivers and contextual factors fuelling the country's HIV epidemic:²⁶

3.3.1 Main drivers:

- *Multiple and concurrent sexual partnerships:* A number of cultural, social and economic factors cause high levels of multiple and concurrent sexual partnerships (MCP) meaning that individuals may have two or more ongoing sexual relationships.²⁷ For men, having different concurrent partners can be a measure of masculinity and sexual virility. For women, having different partners can assist with various social or economic needs. A high frequency of concurrency leads to highly interrelated sexual networks. Such networks are easily permeated by HIV once one partner begins to infect another.²⁸
- *Low levels of consistent and correct condom use:* Recent work with youth (15-24 years) has shown continued reluctance to use condoms in sexual relationships, particular for adolescents who are in the early stages of becoming sexually active.²⁹ For the general population, social meanings around condom use, among other factors, limit the effectiveness of this intervention. Insisting on condoms in sexual relationships can be interpreted as signifying sexual infidelity or lack of trust. Female condoms are not consistently available in all parts of the country denying women equality in relationships with respect to the ability to negotiate condom use.
- *Poverty and unemployment:* The search for employment and the struggle to maintain a sufficient source of income leads to high rates of migration, both across Lesotho and to neighbouring RSA. Spouses spend long periods of time living apart. Women are often left in homes and

²⁵ See GOL. 2009. Lesotho HIV Prevention Response and Modes of Transmission Analysis. Maseru, LS: UNAIDS/NAC/MOHSW.

²⁶ See, in particular, Kimane I, Ntimo-Makara M, Lebuso M. 2009. Study on Sexual and Reproductive Health Issues and HIV in the Context of Youth People in Lesotho. Roma, LS: NUL-CONSULS; and NAC. 2009; Gender and Multiple Concurrent Partnerships in Lesotho. Maseru, LS: NAC.

²⁷ In 2007, 24% of adults in Lesotho reported more than one sexual partner at the same time. The regional SADC rate was 17%. See CEIT. 2008. Survey of HIV&AIDS related knowledge, attitudes & practices. Lesotho 2007. Summary of results. PowerPoint Presentation. May, 2008. Maseru, LS: NAC.

²⁸ See SADC. 2006. Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa Report. Gabarone, BT: SADC Secretariat.

²⁹ See GOL 2009, op.cit. note 22.

villages to care for families and to search for additional income. This may involve engaging in sexual relationships in order to receive additional support for practical needs like food, transport or social protection (transactional sexual relationships).

- *Challenges for adolescents and youth to change patterns of sexual behaviour:* Although the Ministry of Education and Training (MOET) and its partners have implemented life-skills training and HIV peer education programmes in schools, and the Ministry of Gender, Youth, Sports & Recreation (MOGYSR) has established district youth resource centres as focal points for similar programmes for youth out-of-school, a high proportion of adolescents and youth are still not reached by these interventions. A large proportion of adolescents do not attend high school or are unable to pursue tertiary-level qualifications. In addition, many high school and tertiary level graduates are unable to find meaningful work. This has contributed to sharp increases in HIV prevalence as these young men and women become sexually active, marry and have children within an environment where meaningful opportunities to pursue life goals are extremely difficult to find.³⁰
- *High rates of alcohol use:* In the modes of transmission analysis, it was found that alcohol consumption often precedes sexual activity in many different types of relationships. Alcohol consumption is widely known to interfere with decision-making regarding safer sexual practices.³¹
- *Low rates of male circumcision:* Approximately 40% of males in Lesotho are circumcised as adolescents or adults.³² This is done mostly as part of participation traditional initiation schools. Ritual circumcision is not complete circumcision and therefore does not give the same preventative effect as full medical circumcision.

3.3.2 Contextual factors:

- *Social and cultural factors affecting women and girls:* Although recognition of the rights and entitlements of women and girls has changed significantly within the legal system in Lesotho, these changes have not yet influenced ongoing social and cultural practices regarding female roles in marriage and sexual relationships. Many women and girls, particularly in rural areas, are not yet able to make their own decisions in terms of how and when they participate in relationships with men. In many instances, sexual initiation for adolescent girls takes place with older men who have a higher likelihood of being HIV-positive (inter-generational sexual activity). Finally, Lesotho, like other neighbouring countries, continues to experience high rates of gender-related violence. This is no doubt influenced by ongoing perceptions of women as of lower social status than men and duty bound to provide for husbands or partners in whatever way this is demanded.
- *Social and cultural inhibitions around open discussion of sex and sexuality:* Reticence between parents and children, and teachers and learners to openly discuss sex and sexuality is an entrenched part of Basotho culture. While this is changing, for some groups, such as adolescents and young adults,

³⁰ See GOL. 2009. *Op. cit* note 30.

³¹ Ibid.

³² GOL/WHO/UNAIDS. 2008. Male Circumcision in Lesotho: Situational Analysis Report. Maseru, LS: MOHSW.

the ongoing difficulty of open discussion about sexual relationships increases vulnerability to HIV infection, STIs and unplanned pregnancies.

- *Income inequalities and income disparities:* There are ongoing, intractable challenges related to significant differences in income and wealth. A high proportion of Lesotho's population is living in poverty. Other challenges besides HIV prevention may overwhelm individuals and families as they struggle to address daily needs for food, shelter and livelihood.

While challenges remain in the way of meaningfully reducing HIV prevalence in Lesotho, and successfully mitigating the impacts of the epidemic on the country and its people, progress has nevertheless occurred and, on several core indicators, momentum has built to the extent that early signs of significant change are visible. These developments, along with other successes and challenges, are explained in this report throughout the sections that follow.

4.0 PROGRESS IN RESPONDING TO HIV & AIDS 2008 - 2009

4.1 OVERALL ACHIEVEMENTS SINCE 2007

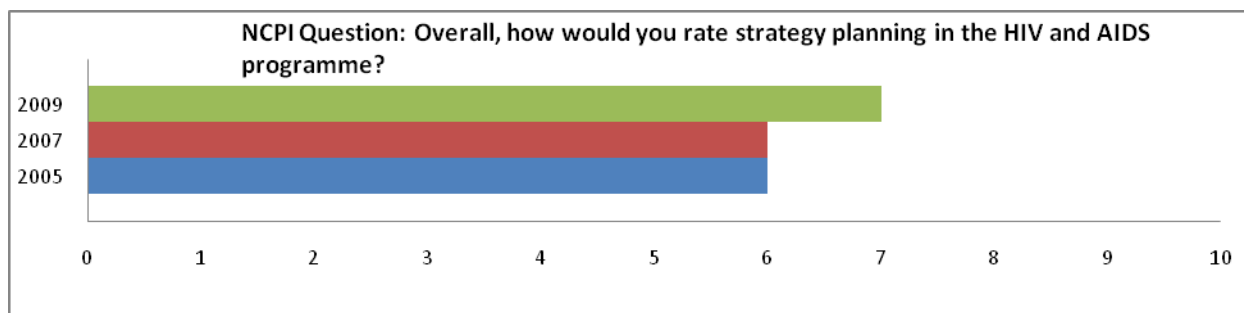
The most significant achievements during this UNGASS reporting period are:

- The approval of three additional Global Fund grants to assist the country to reach its universal access targets for HIV and to meet the country's goals for its national strategy on TB;
- The completion of a modes of transmission analysis to provide more evidence for the development and implementation of effective HIV & AIDS interventions;
- The roll-out of a life-skills curriculum in primary and secondary schools aimed at equipping children and adolescents with knowledge and skills to avoid HIV infection and to make informed, healthy decisions about their own growth and development.
- The provision of over 20,000 high school bursaries per year to vulnerable or orphaned adolescents to keep them in school and to motivate them to use educational achievement as a way to address their life situation and to prevent HIV infection.
- The increasing number of sexually active adolescents, youth and adults who regularly undergo HIV testing and counselling (HTC).
- The full decentralization of antiretroviral treatment (ART) and tuberculosis (TB) treatment to almost 200 health centres in local communities across the country and the significant increase of adults and children on ART that has resulted from this.
- The progress in coverage of the national prevention of mother-to-child transmission (PMTCT) programme at the health centre level, and the increasing proportion of pregnant women who undergo HIV testing and who participate in the PMTCT programme.

More details on these achievements are discussed below under each major component of the national HIV&AIDS response.

4.2 REVISION OF THE NATIONAL HIV & AIDS STRATEGIC PLAN 2006-2011

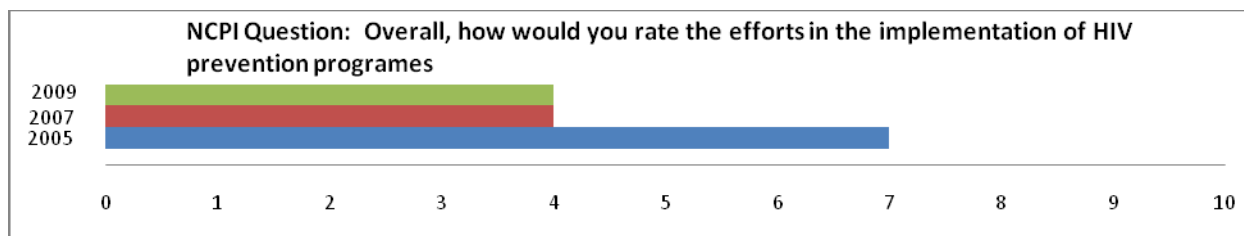
The National HIV&AIDS Strategic Plan 2006-2011 (NSP) underwent a mid-term review in 2008. The review process engaged all partners, including government, civil society, development partners, PLWHIVs and members of key populations.



The strategy was revised to become a results-based plan with specific, quantifiable targets under each component. This included the universal access targets set in 2006. The results are categorized by type, including output, outcome and impact. In addition, primary and secondary priorities are clearly indicated. This has facilitated the translation of the strategy into annual operational plans. It has also helped clarify the roles and responsibilities of each of the sectors in relation to the different components of the strategy. The revised NSP covers all sectors with specific, ear-marked resources that align with the expected results as well as the different levels of prioritization.

4.3 PREVENTION

Lesotho has continued to strengthen and expand its capacity for HIV prevention. In response to improvements in the quality and range of strategic information regarding the HIV epidemic, the country is continuously intensifying its prevention efforts.



For the 2008 to 2009 reporting period, stakeholders were not all in full agreement on the impact of these intensified efforts. The non-governmental and the private sectors indicated during the NCPI panels that they were not fully engaged in national prevention efforts. All stakeholders also noted the absence of a national prevention policy and national prevention strategy to improve coordination and to increase the effectiveness of current and planned interventions.

4.3.1 Behaviour Change Communication (BCC)

Between 2008 and 2009, the GOL and its partners expanded the scale and scope of BCC interventions. A theatre and dance troupe toured the country entertaining and educating adolescents and youth on HIV prevention. A year-long radio drama was aired and a feature film, *Kau la pobo*, was launched telling the story of how a small rural village in Lesotho addressed the impact of HIV on the community. Youth peer education programs were implemented through Youth Resource Centres and through community partners in each district. One organization, the Action Group in Sports Against AIDS, held workshops and sports tournaments to engage active young people regarding HIV. Through the Lesotho Inter-religious AIDS Consortium (LIRAC), faith-based

organizations used the Sunday Pack, an HIV resource kit for faith communities, to address BCC issues within church congregations. Catholic Relief Services (CRS), World Vision (WV) and the Lesotho Catholic Bishops Conference collaborated on a baseline knowledge, attitudes and beliefs survey to inform their joint, faith-based programmes on HIV & AIDS.³³ While the survey revealed that there were adequate levels of basic knowledge about HIV and AIDS amongst church goers, it also found that few churches had specific HIV programmes. Most churches with HIV programmes focussed on supporting OVC rather than the more complex area of HIV prevention sexual relationships. Nevertheless, 89% of respondents indicated that having multiple and concurrent sexual partnerships (MCP) outside of marriage was not acceptable.

In 2009, Lesotho joined the Southern African 'One Love' initiative addressing MCP.³⁴ The campaign uses billboards, educational materials, radio and television slots, community dialogue tools and an interactive website to engage men and women in reflection and discussion on their emotional and sexual relationships. A new National BCC Strategy was launched in 2009.³⁵ A health sector policy on comprehensive HIV prevention, drafted by the MOHSW in 2009, will be finalized and launched in 2010. The MOGYSR, NAC and UNICEF worked together to support the development of an HIV prevention programme for young people by young people.³⁶ This programme will implement the adolescent-and-youth-focussed component of the new BCC strategy. There have also been community dialogues on MCP facilitated by a number of different NGOs including the Communication for Change Project (C-Change). Challenges still remain for BCC activities, including fragmentation, under-developed technical skills in designing BCC strategies and materials, lack of consistency on standards and messages, and incomplete coverage of interventions for all target audiences. In 2010, a national operational plan for BCC will be created along with a national prevention strategy incorporating the BCC component. A substantial increase in funds for BCC interventions will be available starting in the same year to ensure swift and comprehensive implementation of the strategy and the operational plan. Also in 2010, NAC will undertake a study on sexual networks in Lesotho with support from the UNAIDS Programme Acceleration Fund.

³³ CRS/WVI/USAID/PEPFAR. 2009. Lesotho Faith-Based HIV Prevention Campaign: Baseline Survey Report April 2009. Maseru, LS: CRS.

³⁴ See <http://onelovesouthernafrica.org/> for further details.

³⁵ GOL. 2009. Behaviour Change Communication in Lesotho: National Behaviour Change Communication Strategy 2008-2013. Maseru, LS: MOHSW/NAC.

³⁶ GOL/UNICEF. 2009. Communication for Social Behaviour Change: Operational Framework for Young People. Maseru, LS: MOHSW.

4.3.2 Male Circumcision

Following initial work completed in 2007, including a rapid assessment and cost-effectiveness analysis, a full situational analysis on male circumcision in Lesotho was completed in 2008.³⁷ The study found that 48% of men aged 15 - 59 years were circumcised with the highest rates in the 20- to 24-year-old age group. Most circumcisions (67%) had taken place as a result of participation in traditional initiation schools. Ritual circumcision is not complete medical circumcision and does not achieve the same preventative impact in relation to HIV transmission. A minimum 52.2% prevalence of complete medical circumcision is required to have a significant effect on reducing HIV transmission. This requires that 34,798 circumcisions be performed in 2009 rising to 44,164 annually by 2015 in order to achieve the minimum coverage rate. Provision of circumcision would have to increase by a factor of 7 in order to achieve these targets. This would require an additional investment of M125.9 million Maloti (USD 17 million) over 12 years or approximately M9 million (USD 1.2 million) annually. The scaling-up for male circumcision is proceeding. Guidelines, protocols, a site assessment tool, M&E tools and a counselling package are close to finalization. These will be introduced to the wider health sector starting in 2010. Nine hospitals have been assessed and equipment and consumables procured to support the roll-out of the scale-up plan.

4.3.3 PMTCT

Lesotho's PMTCT programme was launched by the Prime Minister in 2003 after its piloting in the same year at Government of Lesotho hospitals and Christian Health Association of Lesotho hospitals (CHAL). Since then, there has been a continuous effort led by the MOHSW to scale-up and strengthen the programme to reach as close as possible to 100% of HIV-positive pregnant women and to ensure that services are available in the villages and communities where these women reside.

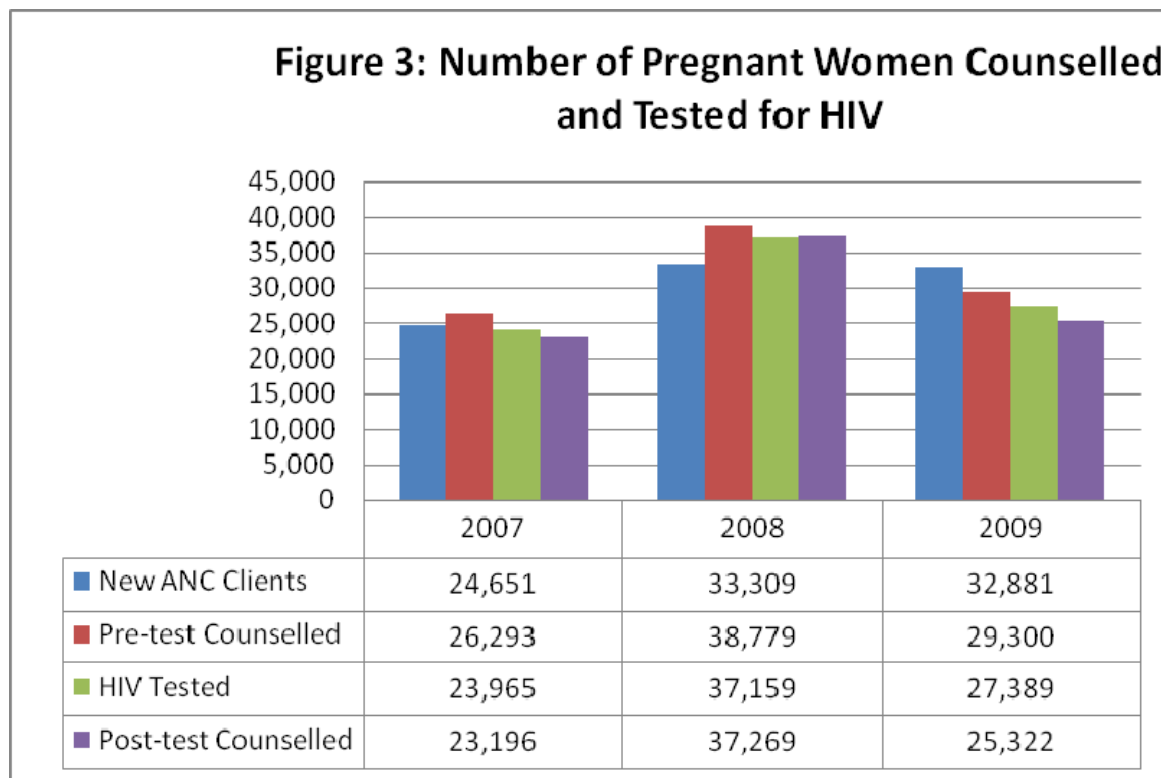
³⁷ GOL/WHO/UNAIDS 2008, op. cit. note 32.

Table 3: Annual PMTCT Statistics 2004-2009

	2004	2005	2006	2007	2008	2009
# of facilities providing PMTCT	9	22	37	136	180	186
# of new ANC Clients		9 700	11 952	24 651	33 609	35 420
# of clients pre-test counselled	2 764	10 684	13 047	26 293	38 779	29300
# of clients tested	2 764 (41.2%)	5 459 (51%)	9 277 (71%)	23 965 (91%)	37 159 (89%)	27389
# of clients post-test counselled	2377 (86%)	4913 (89%)	7 168 (77.2%)	23 196 (96.8%)	37 265	25322
# of clients HIV positive	845 (6.3%)	1 489 (11%)	2 592 (19.2%)	5 539 (43.3%)	8 581	9798
# of clients who received ARV prophylaxis	421	779	2 005	2799	6 083	4625
# of clients who received HAART	–	26	219	1167	1 361	4221
# of clients who received ARV Prophylaxis & HAART	421 (49.8%)	805 (54.1%)	2224 (85.8)	3966 (71.6%)	7 444 (86.7%)	8846 (90.3%)
# of deliveries				17 656 (35.3%)	23 143 (48.7%)	19323
# of HIV positive mothers delivering live births				3 584	5 183 (42.5%)	4613
# of babies who received ARV prophylaxis			1 839	2 767 (94.3%)	4 888 (94.3%)	4240 (33.9)
HIV test uptake	40%	51%	71%	91%	95%	93%
% of HIV infected pregnant women who received ARVs to reduce the risk of MTCT	3.1%	5.9%	16.5%	31%	58.2%	71%

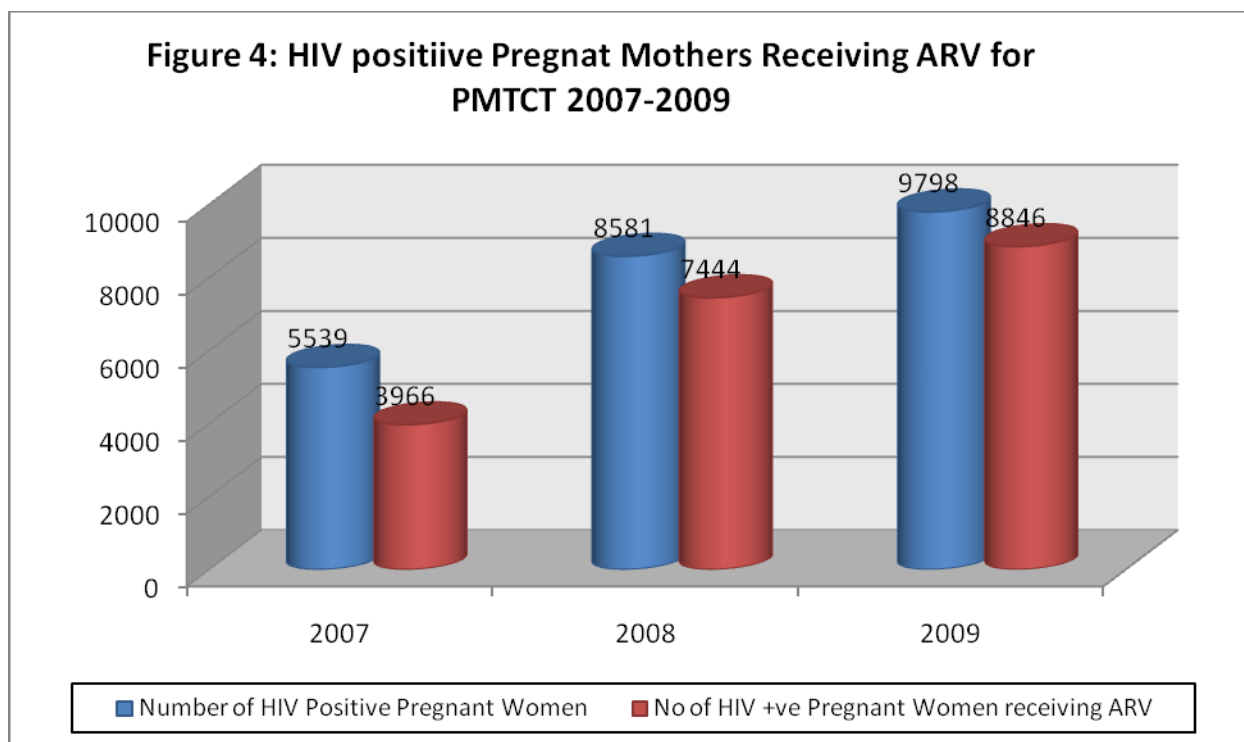
2009 ANC (83%) reporting completeness

Figure 3: Number of Pregnant Women Counsellled and Tested for HIV



Between 2008 and 2009, significant progress was made in making PMTCT services available at the health centre level. A national scale-up plan was approved in 2007 and implementation is continuing.³⁸ The programme expanded from 180 health facilities providing PMTCT in 2008 to 186 by 2009. This was mainly the results of expanded training and decentralisation of PMTCT interventions to health centres. PMTCT services are largely provided by nurses, who have been trained in Intergrated Management of Adults and Adolescents Illnesses (IMAI) and are able to assess pregnant mothers and initiate prophylaxis regiments and Highly Active Anti-Retroviral Therapy (HAART) if indicated. The national PMTCT guidelines were revised and updated to incorporate changes in best-practice, in particular those in relation to the care and support of HIV-exposed infants. The new guidelines also support the PMTCT+ approach which encourages greater male involvement in all stages of the reproductive cycle and the use of PMTCT as an entry point to address HIV within the context of the whole family. Different partners are assisting the MOHSW in the PMTCT programme, including ICAP, EGPAF, BIPAI, CHAI, Mothers-2-Mothers and the Global Fund.

³⁸GOL. 2007. PMTCT Scale-up Plan. Maseru, LS: MOHSW.



The PMTCT coverage rate has increased from 6% in 2005 to 58.2% in 2008 and 71% in 2009. HIV testing and counselling is a routine component of antenatal care (ANC) services at hospitals and health centres. After a group counselling session, individual HIV tests are performed. This has resulted in over 90% of women attending ANC clinics undergoing an HIV test.

Although over 90% of pregnant women attend ANC clinics for at least one visit, too many women do not return for additional visits and still give birth outside of health facilities.³⁹ Consequently, they may not know their HIV status and be unaware of PMTCT interventions. Ongoing training of Community Health Workers is helping to address this. So is the effort to make a minimum PMTCT package available to all women on their first ANC visit. There are larger, more complex factors affecting utilization of maternal and child health services in Lesotho, including staffing and the accessibility of local health centres. The MOHSW is addressing these with support from development partners. Sero-prevalence rates amongst young pregnant women have remained stable between 2007 and 2009.⁴⁰ The prevalence rate for the 15 - 24 year-old age group was 18.7% and 19.7% respectively. HIV prevalence remains the highest in the 20 - 35 year age group, ranging from 27.8% to 45.2% nationally.

4.3.4 Condom Promotion and Distribution

Between 2004 and 2009, over 32 million condoms were procured and distributed using both governmental and non-governmental channels.⁴¹ There is incomplete information about what happens with condoms once they are collected by sexually active adolescents, youth and adults.

³⁹ GOL 2008, op. cit. note 23.

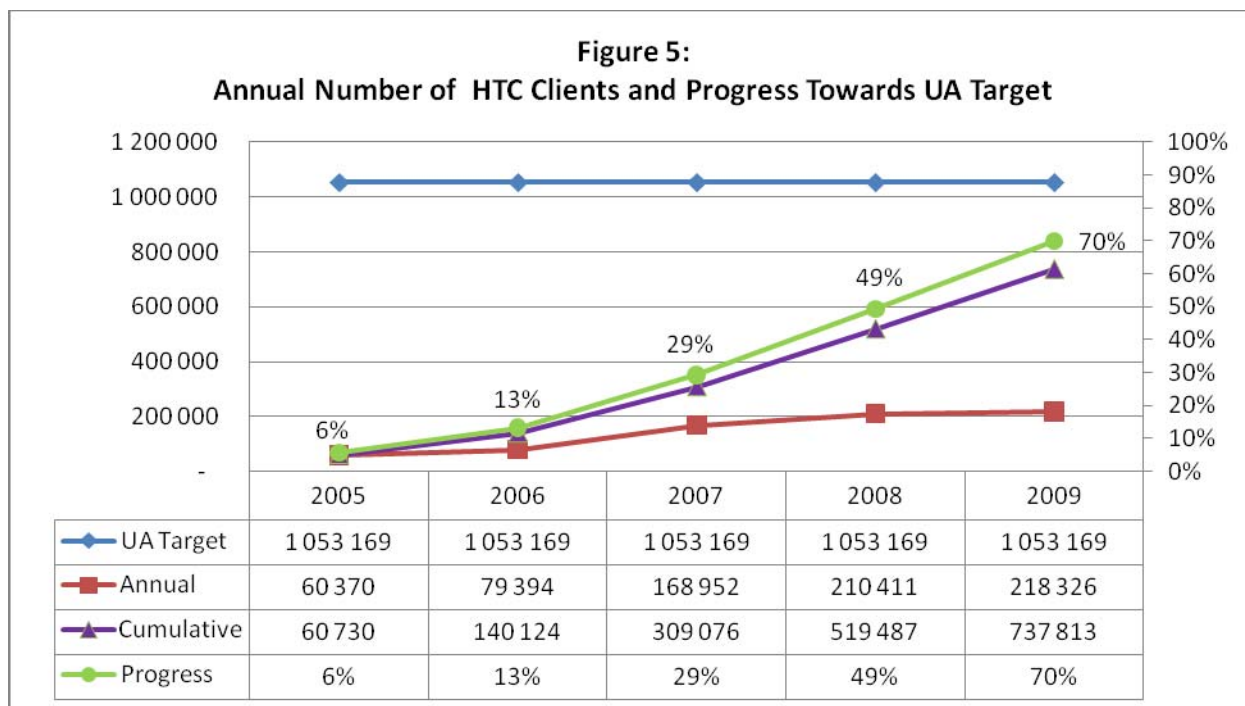
⁴⁰ GOL. 2010. Lesotho 2009 Sentinel Survey Report. Maseru, LS: MOHSW. Other data in this section on prevalence originates from this report.

⁴¹ MOFDP/GFCU. 2010. Global Fund Round 2 Grant:Strengthening Prevention and Control of HIV & AIDS and TB in Lesotho: Final Report. Maseru, LS: MOFDP.

Findings from a regional knowledge, attitudes and practices (KAP) study conducted in 2007 and released in 2008 indicated that 48.6% of men and 41.9% of women who had more than one sexual partner in the previous year used condoms. The results of the modes of transmission analysis showed that adolescents and youth continued to be reluctant to use condoms, particularly when they first start to become sexually active.⁴² To improve the effectiveness of condom distribution and promotion activities, a Reproductive Health Commodity Coordinating Committee was established in 2008 made up of representatives from MOHSW, line ministries, UN agencies, PSI, NAC and other partners. The group has collaborated in the completion of a situational analysis and drafting of a national condom strategy. One of the priorities of the draft strategy is improving the procurement and supply management process as coverage of condom distribution and consistent availability of condoms is not complete across all regions of the country. The situational analysis will form the basis for guiding the development of Condom Programming Policy.

4.3.5 HIV testing and counselling

As a result of the implementation of the two-year Know Your Status (KYS) campaign between 2006 and 2008, the number of individuals in Lesotho seeking HIV testing and counselling (HTC) has increased significantly from year to year. In 2007, 47% of adults (15-49) perceived that they could be at risk of HIV infection.⁴³ The perception has helped to improve demand for HTC. By the end of 2009, 737,813 individuals had undergone HTC representing approximately 70% of the proportion of the population that is eligible to receive HTC (1,316,461 are 12 years and above).⁴⁴



⁴² See GOL 2009, op cit. note 25, Chapter 3: KYE Synthesis.

⁴³ CIET 2008, op cit. note 27.

⁴⁴The data is the number of HIV tests performed. At the moment, data cleaning cannot pick individuals who may test more than once in any given period. The HTC promotion programme encourages sexually active individuals to undergo HIV testing at least once per year. For estimate of sexually active population, see GOL 2009, op. cit. note 18.

The national HTC policy was revised in 2009 to incorporate many of the modalities used in the KYS campaign to create demand for HTC and to make it available at the community and household level.⁴⁵ The KYS brand has also been maintained to support the MOHSW's efforts to achieve the universal access target for HTC. HTC services are available at every access point in the national health care system, either through HTC counsellors or trained health care providers. Training manuals for HTC counsellors have been revised to increase the counsellors' skills base in advising individuals about HIV prevention strategies. Mobile HTC clinics have been procured to increase access to HTC in remote areas. Despite this increase in the frequency of HTC amongst the population, knowledge of ways to prevent HIV transmission, whether one is HIV-negative or HIV-positive, has not yet been internalized to the extent that sexual behaviour is changing and HIV transmission is declining. Clearly HTC can only be effective as a prevention strategy when it is paired with other prevention interventions, especially BCC.

4.3.6 Workplace Programmes

During the reporting period, NAC commissioned situational assessments of public and private sector workplaces to better understand the state of workplace policy and programme development related to HIV & AIDS.⁴⁶ The assessment showed that not all line ministries had put in place appropriate interventions. In some cases, policies and programme designs had been drafted but not yet completed, approved, or implemented. To address these gaps, NAC conducted a series of training sessions to capacitate ministry focal points with basic HIV & AIDS competency and to provide them with technical skills to support workplace policy and programme development. Following the training, NAC provided support for the development of workplace programmes in 11 line ministries. The remaining ministries will receive support in 2010. As an additional measure to strengthen public sector HIV&AIDS workplace interventions, the Ministry of the Public Service issued a model public sector HIV & AIDS workplace policy.

Within the private sector, the assessment revealed inconsistent efforts across workplaces to address HIV & AIDS and to put in place policies and programmes to safeguard business interests while at the same time protecting and promoting the health of the workforce. The Ministry of Labour and Employment (MOLE) issued guidelines in 2008 to assist the private sector to develop workplace policies and programmes in line with the amended section of the Labour Code. Through the Apparel Lesotho Alliance to Fight AIDS (ALAFA), a comprehensive HIV programme for textile workers covering 26 factories representing 87% of the sector's workforce has been in operation since 2007.⁴⁷ Larger companies like Lesotho Flour Mills, Standard Lesotho Bank, and Lesotho Electricity Corporation have put in place HIV&AIDS programmes. However, the small and medium size businesses and the informal business sector are still challenged to acquire the technical capacity to design workplace interventions relative to the size and type of their enterprises. Recently, a business and labour coalition was formed to strengthen private sector responses to HIV & AIDS. Through the Global Fund Round 8 grant, a significant increase in resources will be

⁴⁵ GOL. 2008. Know Your Status Campaign Review Report. Maseru, LS: MOHSW.

⁴⁶ See Moleli-Habi. 2009. HIV & AIDS-related Conditions within the Private Sector in Lesotho: Formative Assessment. Maseru, LS: UNAIDS; PBMS. 2008. Rapid Assessment in Select Public and Private Organisations Report (DRAFT). Maseru, LS: NAC. Senkhome Consultants. 2008. HIV and HIV Management Survey (DRAFT). Maseru, LS: NAC.

⁴⁷ See section 4.4.8 below and www.alafa.info for the programme description. See also ALAFA. 2009. Follow-up Sero-Prevalence Study Report. Maseru, LS: ALAFA/DFID.

available for both public and private sector workplaces to finally close these gaps in the development and implementation of effective HIV & AIDS interventions.

4.3.7 Blood Safety

The Lesotho Blood Transfusion Services screens 100% of all units of collected blood for HIV and other blood-borne pathogens. In addition, blood collection methods have changed in order to reduce further the risk of collecting HIV-infected units. The strategies include targeting the younger population and encouraging repeat donations by offering different types of non-monetary incentives. During 2008 and 2009, however, the number of units collected represented less than 50% of the overall national need for blood.

4.3.8 Post-exposure Prophylaxis

Post-exposure prophylaxis (PEP) guidelines and protocols have been rolled-out by the MOHSW across the country. This has included health facilities as well as workplaces for professions where the risk of occupational exposure to HIV is high (uniformed services and health care workers, for example). Since medications used for PEP are Schedule 1 pharmaceuticals in Lesotho, they can only be dispensed by a licensed health professional. This can create challenges for some workplaces where health professionals able to dispense PEP are not always available. Outside of health facilities, there are low levels of awareness about the importance of PEP and the 72-hour window after exposure for PEP to be initiated. More communication about the importance of PEP, and more advocacy to ensure that trained health professionals are readily accessible for situations requiring it, are needed to improve PEP availability.

4.3.9 Diagnosis and treatment of sexually transmitted infections

The incidence and prevalence of STIs amongst the sexually active population in Lesotho is a strong indicator of trends for HIV transmission. Lesotho's 2007 sentinel survey showed that HIV prevalence amongst individuals diagnosed with an STI was 56.2% (CI: 52.6, 59.8%).⁴⁸ In 2009, HIV

Voices: Soldiers (staff at Mabolomi Hospital)

'We have no support at all. The senior officers are the ones who receive funds for everything and it never gets down to the junior staff. Even where treatment is offered, the senior staff get preference.'

'There is service for the patients but there is nothing for the staff unless we are patients.'

prevalence within this same group was 54.4% (CI: 51.6, 59.7%).⁴⁹ 63.3% (59.6% in 2007) of STI clients who knew their status were HIV-positive compared to 44.7% (53.8% in 2007) of those who did not know their status. Both these indicators show that there is still a high incidence of at-risk sexual activity within the population that contracts STIs. In order to address this, STI treatment guidelines were revised in 2008 and additional training sessions conducted to ensure that syndromic management of STIs is available in all health

facilities. A revised STI module has also been incorporated within the training curriculum for registered nurses and midwives.

⁴⁸ GOL. 2008. Lesotho Sentinel Survey Results 2007. Maseru, LS: MOHSW.

⁴⁹ GOL 2010, op. cit. note 40. STI surveillance results are from Motebang and QE II (n=1143 for both sites).

Voices: Police officers

‘There is no real support. It all depends on who is in charge and whether that person feels it’s important.’

‘Pregnant women are being tested without their consent, without giving them a choice. Some are not ready or have not been prepared for living with HIV. So they try to have abortions in a country where this is illegal. Other women do not want to be abandoned by their husbands so they abandon HIV-positive children. That too is a crime. Nobody who is not ready should be forced to test.’

‘Sometimes there are condoms but since there is no one directly responsible for that they are sometimes not there. At times some senior female officers feel that the male officers are being given too many so the purchase is cut short.’

‘We have counsellors in the police force but they are few while demand is getting bigger. Although we have counselling and testing there is no safe space to provide it.’

‘There is a disconnect between management and junior officers on issues of HIV & AIDS with the former showing less interest’

‘There are a number of good initiatives towards dealing with HIV & AIDS in the police which get started, but not sustained. There was an hour per week dedicated towards Health-Talk which has since died. HIV & AIDS Counsellors have been trained in good numbers, but are not given an opportunity to counsel people due to pressures of work and lack of space.’

4.4 ADDRESSING KEY POPULATIONS⁵⁰

Within the general population of Lesotho, there are specific sub-groups which are at greater risk of HIV transmission. The massive effort the GOL has made to address the general population, the group within which most HIV transmission occurs, has not yet fully included the needs of these key populations. This situation is changing as the following sections indicate:

4.4.1 Uniformed services

Situational assessments have recently been conducted within the Lesotho Mounted Police Services (LMPS) and the Lesotho Correctional Services (LCS). HIV surveillance studies within these services are currently underway.

Voices: Correctional officers

‘No one on the staff has disclosed their HIV status but we suspect some are positive. Some of the prisoners in support groups have told other their status.’

‘We stopped going to the New Start testing clinic. We had to stand in the street and did not get any counselling before or after. Even results were not revealed to the person who tested. The only people knew whether they were positive or negative was if they were told to go to Queen II or Senkatana.’

‘Management does not provide us with condoms. Lesotho Planned Parenthood Association used to supply condoms but it ran out of funds and the supply has stopped.’

‘We are convicted with the inmates because each time a man is convicted and is admitted to prison, we are equally trapped with him following him around and knowing each and every movement—their lives become our lives.’

‘We have no protection. Prisoners become violent and blood is freely flowing and we have to touch and separate the prisoners and overpower them and this involves pinning them down using our own hands and physical strength. It is a war and we are in combat.’

‘The prisoners don’t own any personal space. Only the critically ill are taken to hospital; otherwise all—sick or not, wounded or not, bleeding or not—sleep together.’

‘In the morning when one goes to open the cells, one can feel the stench and the heat gushing out at one’s face like fire from a furnace and there are no face masks.’

The challenges that have been identified include the persistence of HIV-related stigma, inconsistent levels of training on HIV and infection control, inconsistent availability of gloves, masks and other protective equipment, and less than full coverage of HIV prevention strategies in both the professional and personal lives of the members of these services. LCS and LMPS are addressing these gaps through strengthening workplace programmes and through more involvement of line

⁵⁰ Included in this section are excerpts from focus group discussions convened during the development of the report. In general, groups had 10-20 participants; accidental sampling was used as the participant recruitment method. The statements contained in the excerpts may not fully represent the views of the overall key population. The interpretation of the statements should be kept within this context.

staff in the development and implementation of HIV prevention interventions. The Lesotho Defence Force (LDF) has implemented its workplace programme since 1998. In partnership with the US Department of Defence and PEPFAR, the LDF provides HIV & AIDS programmes for its members, as well as their dependents, civilian employees, and surrounding civilian communities. The programmes include PTMCT, support for infant feeding, implementation of prevention activities at all military bases, and provision of equipment and supplies for HIV/TB care and for palliative care services. The partnership also provides supplies and technical support for a mobile health care clinic, support for health management information systems, provision of ART management training, training for laboratory personnel, and support for strategic information collection and management and staffing.

4.4.2 Male and female inmates

The prevalence of HIV infection amongst the 2,700 male and female inmates will only be known once the prevalence study is completed in 2010. The self-reported HIV prevalence was 17% in 2009 of which 30% were receiving ART.⁵¹ However, inmates said that most individuals who are HIV-positive do not yet know their status or have not disclosed it. Health services are available in correctional facilities or accessible from hospitals and clinics in the surrounding community. This includes HTC and provision of ART. Acknowledging that sexual activity is occurring between inmates within correctional facilities

Voices: Female inmates

‘A few of us are HIV-positive and on ARVs. We get the services we need.’

‘There are no condoms here because we don’t participate in sex while in prison.’

‘We are looked after and there are no fights.’

‘We take care of each other. We are a family. Our babies are looked after with necessary food and medication if they are HIV-positive.’

Voices: Male inmates

‘We are given lots of knowledge about HIV & AIDS while we are prisoners. We can also be tested when we enter prison. We learn a lot from our support groups.’

‘The guards don’t know much about HIV. They will freely punish us, even HIV-positive inmates and not even care whether they shed blood or not. You wonder what violence they are afraid of from such a weak person who is barely struggling to live.’

‘We have never heard anywhere that ARVs are interchangeable except in our prison. We have been given other people’s ARVs as it is. The guards change our medication at will as though ARVs are vitamins for small children to cure a common cold.’

Condoms used to be distributed in prison through a project sponsored by LPPA, but that has since stopped. Apparently they have run out of funding. When the guards found them on us, they took them away and forbade them. But of course they know there is sex that goes on in male prisons. It seems they would rather allow unprotected sex. It is ironic that you are given something and yet when it is found on your person you are punished.’

‘The life of a person living with AIDS [in prison] is in jeopardy.’

has been challenging for LCS. Condoms are made available to inmates but not always in ways that are anonymous or confidential. Many correctional facilities are overcrowded creating ideal conditions for the spread of infections, including HIV and TB. Not all facilities have adequate space to offer health care services and to isolate inmates who are very sick and require constant care. Inmates who participated in the focus group discussions were generally very knowledgeable about HIV prevention and treatment. In most facilities, support groups have been formed by HIV-positive inmates. In a few facilities, support groups have been given plots for gardens and are given some additional foods. Inmates do

⁵¹LCS 2009, op. cit. note 13. 463/2673 disclosed their HIV-positive status. 145/463 indicated they were on ART.

Voices: Sexual minorities (women-loving-women, men-loving-men)

‘There is total silence. We can find no information about ourselves. We have to discover things on our own.’

‘The gay guys here at university are always changing partners. They are afraid to test. They don’t want to know their status. If they are HIV-POSITIVE, very few are taking treatment.’

‘You have to be strong in life. I have to know why I am who I am.’

‘My family did terrible things to me but now they are accepting who I am. I want to talk to them about what they did to me. One day I will forgive them but I am not ready yet.’

‘If we have problems like rape or black mail, the police don’t help us.’

‘I think we need more interpersonal understanding. We need more public articles so that it is easier for us to be open in our families.’

‘I know how to prevent HIV and my girl friend and I, we are safe.’

not feel, though, that they are receiving an adequate standard of care and that their entitlement to protect and improve their own health while in prison is fully recognized. When inmates are transferred between facilities or released back to their communities, no proper referrals are done to ensure continuity of care for those on ART.

4.4.3 People with disabilities

Living with a disability in Lesotho is a life of tremendous challenge. The terrain is mountainous and difficult in rural areas. Few facilities outside of urban settings have been adapted for people with disabilities. Particularly in rural areas, disabilities are stigmatized and some families hide their

Voices: People with disabilities

‘HIV & AIDS information is not accessible to most people with disabilities. We are not even able to get to pitsos since the grounds are far and not accessible to people in wheel chairs.’

‘Information is unintelligible to the mentally disabled, flyers are not available in braille and there are no sign language interpreters for the deaf.’

‘There is no care and support for the disabled. People on ARVs cannot read the expiry dates on their supplies, not even on condoms.’

‘People are rude to us and as women we receive double discrimination at clinics since we are not expected to be pregnant because it is assumed we don’t participate in sex.’

‘Unless we are being cared for within our families by care providers, we don’t have a chance, even in support groups which work in communities.’

children or send them to one of the few residential facilities in the country to avoid social stigma. People with disabilities are considered not to be sexually active. Some programmes have been implemented by the MOET and other partners to help people with disabilities address HIV in their lives. These include adapting HIV prevention and life-skills materials for the blind and the hearing impaired, both for use in schools and in communities. The Lesotho Network of Organizations for the Disabled (LNFOD) has also been supported to undertake community mobilization and advocacy activities through its partner organizations. A comprehensive base of information upon which to develop and implement effective HIV interventions for people with disabilities does not yet exist. This gap will be addressed in 2010.

4.4.4 Sexual minorities

In Lesotho, the term ‘sexual minorities’ is used to refer to men and women who desire emotional and sexual relationships with people of the same sex – Men who have sex with other men (MSM) and women who have sex with other women (WSW). It was identified during the mid-term review

of the NSP that sexual minorities were not explicitly included in the strategy and no interventions were underway for this group. In 2009, a sexual minorities network was launched in Lesotho called the Matrix Support Group. One of the first activities of Matrix was undertaking a rapid assessment to gather information on HIV-related risk factors within the sexual minorities community.⁵² Over 500 men and women participated in the assessment. The results showed that there was general silence around the existence of sexual minorities in Lesotho and, consequently, no targeted programmes on HIV prevention or sexual health were being implemented. Although all respondents had received some information about HIV, only 6% of women and 3% of men could identify the sexual behaviours relevant to them that bear the highest risk for HIV transmission. 48% of women and 40% of men used condoms consistently with either male or female partners. Matrix has already begun to act on the results with assistance from UNDP and the Open Society Institute for Southern Africa(OSISA). They are creating informational materials on sexual health and HIV prevention for sexual minorities to be printed and released in 2010.

⁵² UNDP/NAC 2010, op. cit. note 9. All other data in this section comes from this report.

4.4.5 Herd boys

Herding is still a traditional occupation for many adolescent boys and young men in the rural areas of Lesotho. Because herders spend long periods of time isolated in mountainous areas, they are difficult to include in HIV interventions. The Lesotho Herd Boys' Association/*Monna ka Khomo* coordinates interventions nationally. Other non-governmental partners have included herders in their community-level HIV programmes but the coverage of these has been limited. In 2009, a situational assessment was completed.⁵³ The findings of the assessment showed that literacy levels amongst herders were low and that only a few were adequately informed about HIV. Very few employers or families discussed HIV or other sexual health issues with herders. The

Voices: Herd boys

'Some of us don't know how to read or write. We learn a lot from our older brothers, including things about HIV.'

'We who have been initiated can't discuss sexual things around boys.'

'When we look for girl friends and try to persuade them to come with us, sometimes we are accused of harassment or rape.'

'We have never been to clinics because we have never been sick.'

assessment recommended that literacy programmes for herders be expanded and that relevant HIV information be mainstreamed within the MOET's distance learning materials. The assessment also

recommended that herders be included within the target population for OVC-related programmes on HIV and that local health care workers make additional efforts to provide HIV and other health services to them. The situational assessment informed the development of a national policy and strategic plan for herd boys to be completed in 2010.

4.4.6 Commercial sex workers

Poverty continues to push more and more young women (and some young men) into sex work as a means of income to support themselves and their families. The level of involvement of young women in sex work varies between those who engage in it on a full-time basis and those who engage

Voices: Commercial sex workers

'Sometimes when we insist on condoms, clients threaten us and sometimes rape us. It is difficult to identify the culprits since the police don't listen to a rape story from a prostitute who is illegal.'

'We are always armed with condoms in the bodice and if you are strong you can slip it on and feel half secure though angry.'

'The police are our worst enemy. When they arrest us we know it is not just the violation of the law that they are looking at, we know they are going to try to rape us. Otherwise they just whip us and scatter us. We use to hide behind that gate there but the owner found us once and said that if he ever found us there again he would kill us.'

'We take care of each other although we are not formally organized. We have learned to look out for each other. We get free services at Queen II. If there is a need for PMTCT we get that too. Those of us on ART used to receive free food to take with our medication but that has stopped now.'

'I would rather do any other job than this, but it has to be a better paying job, not where I will get money per month that I can make in two nights here.'

'If I sold fruits on the street at least I would have something at the end of the day. Sometimes I am hear all night and get nothing.'

'When business is good at times I get four clients per night and I go home feeling good that I have done a good job with money in my pocket'

'There are pregnant girls here because some clients specifically request to sleep with them'

⁵³ NAC. 2009. Situational Analysis Report for the Development of HIV & AIDS Strategic Plan 2009-2011 for the Herd Boys' Community in Lesotho. Maseru, LS: NAC.

in it only when they are in need of additional income or other practical support (food, clothing or school fees for children, for example). Sex workers are fully aware of the risk of HIV transmission and usually insist on condoms. However, the offer of more money or the threat of violence will sometimes push one of these women not to insist on condoms. Sex workers themselves report that they face constant threats of sexual and physical violence and abuse from clients and police. They also endure high levels of stigma and discrimination when accessing HIV services. Faith-based organizations and other local NGOs have begun to implement outreach programmes either to help these women to transition to other ways of earning income. Other organisations such as Care Lesotho/South Africa will provide peer education and support interventions to strengthen sex worker's self-esteem and to help them avoid HIV infection. A comprehensive situational assessment will be completed in early 2010. This will provide further evidence to guide the development of more interventions for this group.

4.4.7 Adolescents and youth (ages 15-24):

The NSP places a major emphasis on adolescents and youth as a key target population for HIV prevention interventions. It is as this group becomes sexually active that HIV transmission occurs. The new BCC strategy also places this group as one of the top priorities for BCC campaigns. Ongoing prevention interventions to stop HIV infection amongst adolescents and youth include the implementation of a life-skills training curriculum in primary and secondary schools, the creation of youth resource centres to offer peer education and support programmes to youth out-of-school, and community sensitization dialogues to make everyone aware of the sexual and reproductive rights of women and girls.

The life-skills training programme in schools has been institutionalized by the MOET as part of the core national curriculum for primary and secondary level education. 88% of all schools have been trained on the programme. The remaining schools will be trained in 2010.⁵⁴ By the end of 2009, 246,393 learners had participated in life-skills training in schools.⁵⁵

The MOGYSR, in collaboration with NGOs and development partners, implements a wide range of life skills and HIV prevention interventions for out-of-school adolescents and youth. By the end of 2009, over 500,000 young people had been reached with life-skills and peer education interventions

Voices: Adolescents and youth

'We are afraid to test. When nurses see a young HIV-positive person they assume she is a prostitute, or has been involved in trans-generational sex, or has a sugar daddy. They accuse us of being promiscuous. Although these factors are responsible for fuelling the pandemic, we do not expect them to be personalized since each person has their own story to tell.'

'Youth out of school are neglected by government programmes for education, health, social welfare, food for work. All the programmes are for orphans, old people or the chronically ill.'

'Parents should have public education that sensitizes them on how to handle children's sexual problems and open more to their children and their children's partners.'

'Boys and girls should be trained in how to take responsibility for safe sex. Most know that they should be responsible but they don't know how to handle practical situations because there has been no education on how to do so.'

'There should be premarital counselling on such topics as 'dating procedures' in order to change our style to respond to HIV.'

'The church should open up about sex and not about narrow morality and formalism.'

'There should be open dialogue and communication to empower youth.'

⁵⁴ MOET 2009, op. cit. note 8.

⁵⁵ MOFDP/GFCU. Global Fund Round 7 Q6 Progress Report. Available: www.gfcu.org.ls

operated through the MOGYSR's youth resource centres and other youth-oriented venues.⁵⁶ These interventions include information about delaying sexual activity until marriage; using condoms to prevent the transmission of HIV and other STIs; and the importance of confidence and self-esteem in deciding when and how to become sexually active. The interventions have also included important information for adolescent girls and young women about the existence of services and supports for those who are victims of sexual violence or who are coerced into sexual relationships by people in authority around them (family relatives, teachers, older men for example).

A recently completed study found that the availability and the quality of sexual and reproductive health (SRH) services integrating HIV prevention for this target group were not consistent across the country.⁵⁷ The study also found low levels of awareness of the national, regional and international legal and human rights frameworks entitling adolescents and youth to appropriate SRH interventions. The study recommended greater sensitization of service providers, teachers, principals, youth workers and others to the sexual and reproductive health needs of young people. The study also recommended that more efforts be made to involve youth themselves in the development of SRH policies and guidelines, and in the implementation of relevant and appropriate programmes.

4.4.8 Migrant workers

Outside of government, the two other main sources of formal employment in Lesotho are the textile factories and the mines in neighbouring RSA. There is also a significant amount of cross-border informal employment, particularly in the large border towns of Maseru and Mafeteng. Within the textile factories, where approximately 60% of workers are migrants from other parts of Lesotho, the ALAFA intervention has been underway since 2007. The HIV prevalence rate amongst textile workers, where 88% are women, is 40.1%. A recent assessment of changes in knowledge, attitudes and behaviours regarding HIV & AIDS showed significant improvements as a result of ALAFA's work.⁵⁸ There were greater rates of consistent condom use, a lower frequency of sexual relations with non-regular partners, and a lower frequency of multiple and concurrent partnership in comparison to 2007 when the baseline survey was done.

As for cross-border migrant workers, Lesotho is working with its SADC partners to harmonize HIV related protocols and data collection tools. Lesotho will be part of a 14-country HIV Cross-border initiative that will go further in harmonizing and coordinating approaches to HIV & AIDS, other STIs and TB within the SADC region starting in 2010.⁵⁹ One of the aims of the initiative is to ensure that wherever migrant labourers seek out HIV-related services, a basic package of interventions is always available. One of the other aims is to ensure that data collection and analysis related to mobile populations is standardized so that the impact of the cross-border initiative can be monitored and further evidence-based interventions developed and implemented.

⁵⁶Ibid.

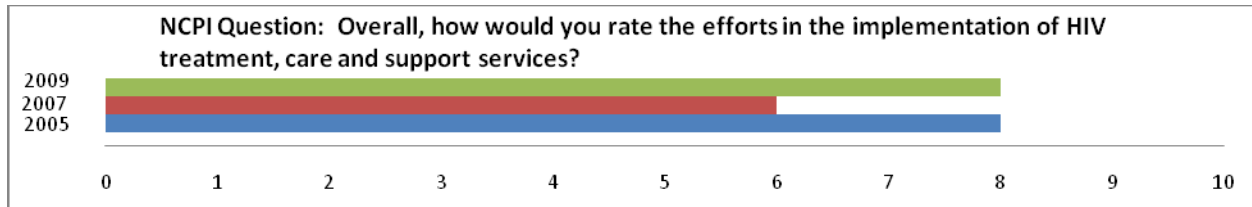
⁵⁷ See Kimane 2009, op cit. note 26. See also GOL/UNICEF 2009, op. cit. note 36.

⁵⁸ ALAFA 2009, op. cit. note 47.

⁵⁹ SADC. 2009. Global Fund Round 9 Multi-Country Proposal: HIV Cross-border Initiative. Available: <http://www.theglobalfund.org/programs/portfolio/?CountryId=MAS&Round=9&lang=en>

4.5 TREATMENT, CARE & SUPPORT

For 2009, it was estimated that of the 280,000 adults and children living with HIV&AIDS, 122,818 or 44% were in immediate need of ART of which 7,433 or 6% where children under the age of 15. These adults and children also require community-based care and support programmes to assist them to stay on ART and to cope with the impacts of HIV & AIDS on their families and in their households.



Since the national scale-up of treatment, care and support programmes began in 2004, there has been steady progress and increasing momentum in meeting these needs. In the eyes of the GOL and its multi-sectoral partners, this has been one of the most significant achievements to date within the national HIV & AIDS response.

4.5.1 Provision of ART to adults and children

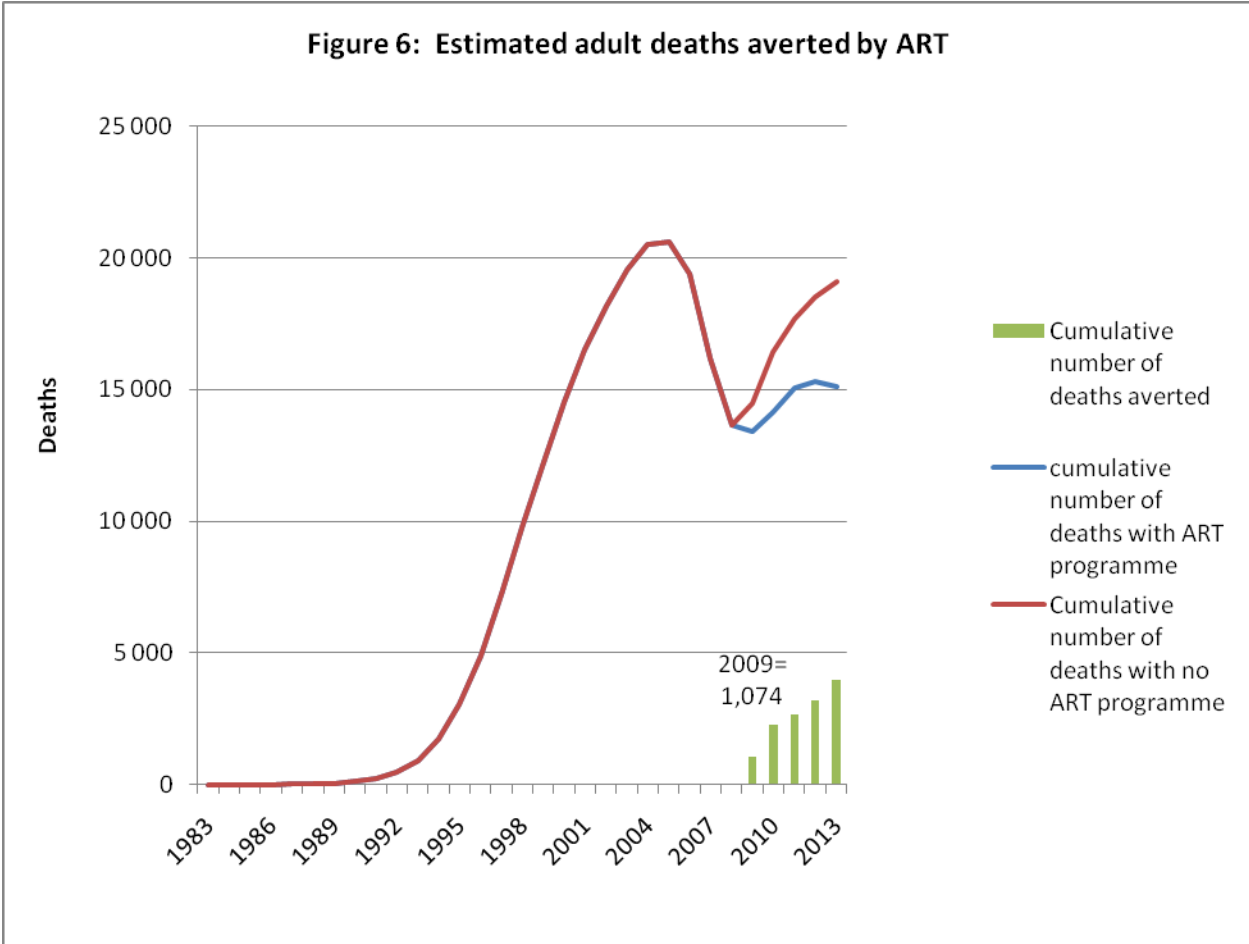
The ongoing decentralization and expansion of the MOHSW's ART programme to the health centre level in each district has resulted in a significant increase in the rate at which HIV-positive men, women and children have been enrolled on ART. At this time, 180 of 216 ART service points have been accredited and accreditation of the remaining 36 sites is underway. While some challenges remain to stabilize the ART programme and to ensure that it remains accessible and dependable for the adults and children who need treatment, there is no doubt now that individuals, families and communities are experiencing the beneficial effects of the programme. The figure below shows the growing number of current and projected deaths averted by the introduction and expansion of ART services in Lesotho since 2004.

*Voices: People living with HIV & AIDS
(LENEPWHA members)*

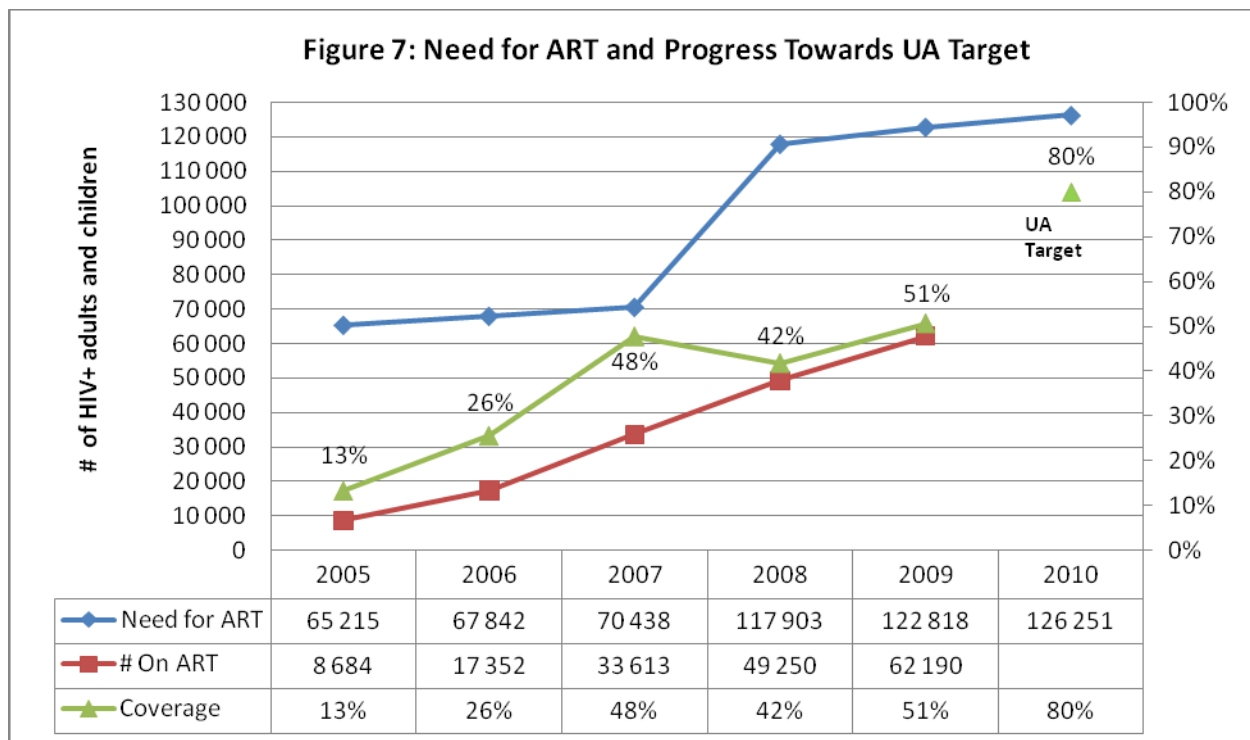
'ARVs have been a window of hope for us but it seems that they are creating different people altogether who do not recognize themselves let alone be recognized by their families. Women are becoming slimmer on the legs, losing their buttocks and gaining large breast. Men are gaining a new face and heavy shoulders.'

'Husbands as heads of families should take the lead in testing and administrators should ask the men to bring the wives. It is well known that *nyatsi* [MCP] fuels HIV infection and re-infection, so it is a right for men and women to know each other's status.'

'In Lesotho, if one claims rights one is regarded as rude.'



The MOHSW introduced revised ART guidelines in 2008 and provided orientation to them in 2008 and 2009. The changes included more detail on using DNA PCR to screen infants for HIV infection, full inclusion of paediatric ART information within the guidelines, use of Tenofovir (TDF) in first line regimens, and more integration of HIV and TB treatment for co-infected individuals.



The major change to the guidelines was the adoption of the revised WHO standard for eligibility for ART from a CD+ lymphocyte count of $\leq 200\mu^2$ to a CD+ lymphocyte count of $\leq 350\mu^2$. This significantly increased the estimate of the number of PLWHAs deemed to be in need of ART between 2007 and 2008. Despite this change, by 2009, over 60,000 adults and children had been enrolled on ART. With this increased momentum, Lesotho is well positioned to achieve its Universal Access target of 80% coverage by the end of 2010.

In 2009, the MOHSW carried out the first national HIV drug resistance monitoring study.⁶⁰ The study has two components. The clinical component measures the presence of ART drug resistance through blood samples obtained from a random sample of individuals on treatment. The second component involves using a WHO-developed framework of six indicators to measure access to ART and the quality and completeness of patient tracking mechanisms and pharmacy stock management procedures. This second component was recently completed. The sample for the study involved 27 ART sites, with representation from hospitals and health centres in each district. All of the sites started offering ART before 2007, meaning that they had well-developed programme management systems. The results on each indicator are indicated in Table 3 below.

⁶⁰ GOL. 2010. Report on HIV Drug Resistance Early Warning Indicators (HIVDR EWIs) Monitoring in Lesotho (DRAFT). Maseru, LS: MOHSW.

Table 4:
Results from the 2009 HIV Drug Resistance Early Warning Indicators (EWI)
Monitoring Study

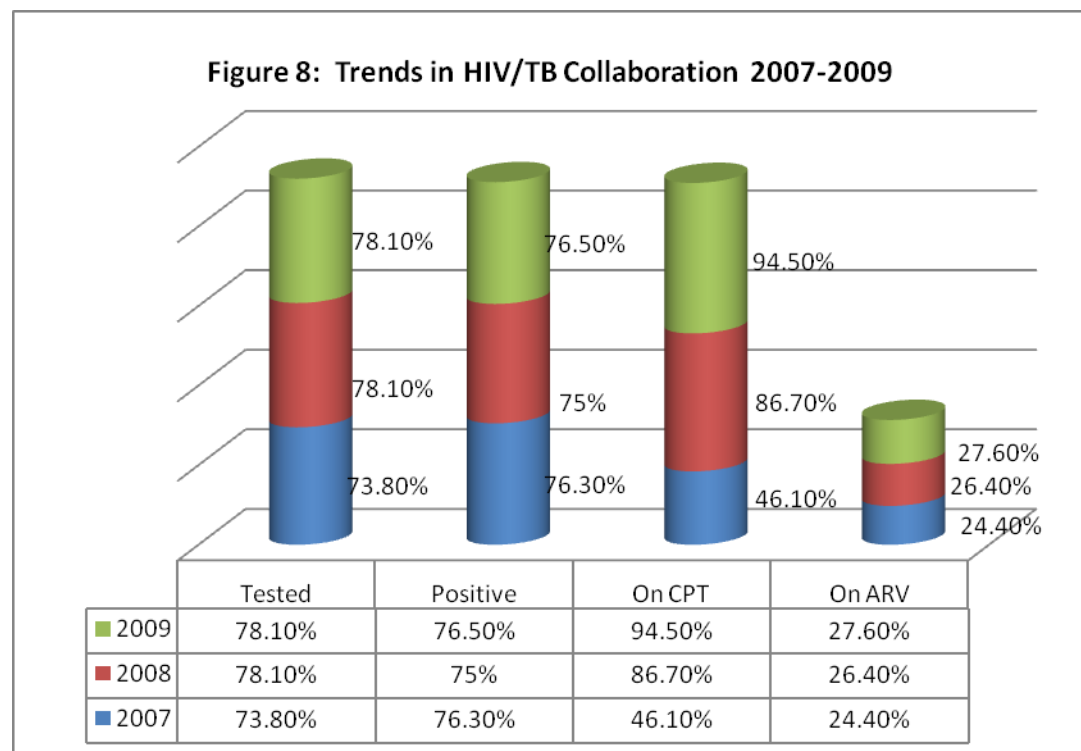
Indicator	WHO target	# and % of sites achieving (n=27)
EWI 1: Prescribing practices. % of patients initiating ART who are prescribed an appropriate first-line regimen over a specified time period (Jan-March 2007)	100%	100% (20/20)
EWI 2. Proportion lost to follow-up during the first 12 months of ART. % lost to follow-up 12 months after initiating ART during a specified period (Jan.-Mar. 2007)	< 20%	65% (11/17)
EWI 3. Patient retention on first-line ART. % of patients initiating ART during a specified time period who are on an appropriate first-line ART regimen 12 months later (Jan.-Mar.2007)	≥ 70%	67% (12/18)
EWI 4. On-time ARV drug pick up. % of ART patients picking up prescribed ARV drugs on time (before previous drugs run out) (Jan.2007)	≥90%	84% (16/19)
EWI 5. ART appointment-keeping. % of ART patients attending all clinic appointments on time (within 7 days of scheduled appointment) (Jan.2007)	> 80%	71% (12/17)
EWI 6. Drug supply continuity. % of months during a year with no antiretroviral drug stock outages (Jan.-Dec.2007)	100%	Insufficient data

The results of study showed that the ART was performing well on two of the six indicators (1,4) and moderately well on one other (5). The results also showed that there was a very low percentage (<20%) of individuals enrolled in HIV care, eligible to receive ART but not yet initiated on treatment. Areas for improvement were patient follow-up procedures, when individuals did not return to the clinic for their scheduled appointment, and patient retention on first-line therapy. Inconsistencies in pharmacy stock management records prevented an analysis of the sixth indicator; however, no instances of ART stock outs were found in the study sites. The study confirmed that transport costs were major barriers for patients to access their ART site. The recommendations for improvement generated through the study included more training and support for record keeping, data abstraction and cohort analysis (all sites but one used paper-based data collection systems), improvements in patient tracking methods, operational research to understand patient lost-to-follow-up trends, and improving stock management practices at all ART service points. Starting in 2010, the MOHSW will engage data clerks to support ART at hospitals and clinics across the country to address many of these recommendations.

4.5.2 Management of TB/HIV co-infection

The GOL through the MOHSW has made significant progress in strengthening collaboration and coordination between the national TB and HIV treatment programmes. A national TB/HIV Coordinating Committee has been established along with a Technical Working Group. These bodies have supported the development of a revised TB/HIV policy manual and strategic plan. They have also supported the development of revised TB/HIV monitoring and evaluation tools.

Health care workers in all facilities have been trained on TB/HIV coordination. Figure 9 below shows the current trend in HIV/TB collaboration.



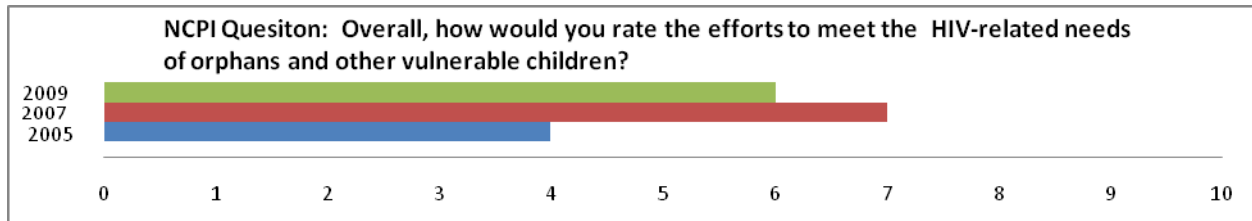
In 2009, 78% of individuals diagnosed with TB were also tested for HIV. Of those, 76.5% were found to be HIV positive. 94.5% of that group was put on cotrimoxazole prophylaxis (CPT) and 27.6% were enrolled on ART. Some of the ongoing challenges include universalizing TB/HIV collaboration across all of the health sector, improving the number of health care workers able to provide combined TB/HIV care, improving infection control standards, and addressing cross-border migration and its impacts on TB/HIV prevention, diagnosis and treatment. In order to address these challenges, the MOHSW will continue to train health care workers on collaborative TB/HIV care, to improve the availability and quality of these services at the community level, to support the functioning of district level TB/HIV technical working groups, and to work towards harmonization with neighbouring countries of TB/HIV treatment protocols and monitoring and evaluation (M&E) tools. The MOHSW will also engage more private practitioners as partners in the implementation of the TB/HIV strategy.

4.5.3 Community and home-based care

The provision of a continuum of care and support services has always been an important component of the MOHSW's HIV chronic care strategy. Each year, community health workers (CHWs) and village health workers (VHWs) receive training and support to provide effective home-based care services to chronically ill individuals at community level, including PLWHAs and people on TB treatment. Since 2006, increasing numbers of community health workers have received incentives to motivate them to provide consistent, high quality services. Home-based care services have been expanded to include adherence monitoring for HIV and TB treatment, PMTCT support, and identification of children who may be suffering from the consequences of HIV infection but not yet diagnosed. Global Fund grants have provided support to this important cadre within the health care system. The GOL is considering ways to institutionalize these services in partnership with non-governmental organizations and development partners. With support from the Global Fund Round 8 grant, home-based care guidelines will be reviewed and updated. Refresher trainings will be done in all districts to ensure that these community-level health workers have the knowledge, skills and tools to effectively perform their functions.

4.6 IMPACT MITIGATION

The number of children orphaned or made vulnerable (OVC) by the impacts of HIV & AIDS on families has been growing in Lesotho for over a decade. In Lesotho, the large number of OVC are now the most visible negative social impact of the HIV epidemic.⁶¹ Data from the 2006 population census indicated that there were an estimated 221,403 OVC (from all causes) in Lesotho during that year.⁶²



It is estimated that for 68% of all OVC, HIV & AIDS is the major factor causing orphanhood and vulnerability.⁶³ The magnitude of this challenge has caused many of the traditional systems of care and support for orphaned children to disintegrate. In many families, the ‘middle generation’ has succumbed to the HIV epidemic and children are left in the care of grandparents or on their own in child-headed households. The GOL and its stakeholders viewed their efforts to respond to this situation more favourably in the previous UNGASS reporting period. At this time, however, they expressed concern that the increase in the number of OVC was rapidly outpacing the ability of all partners to scale-up interventions to keep up with this growth.

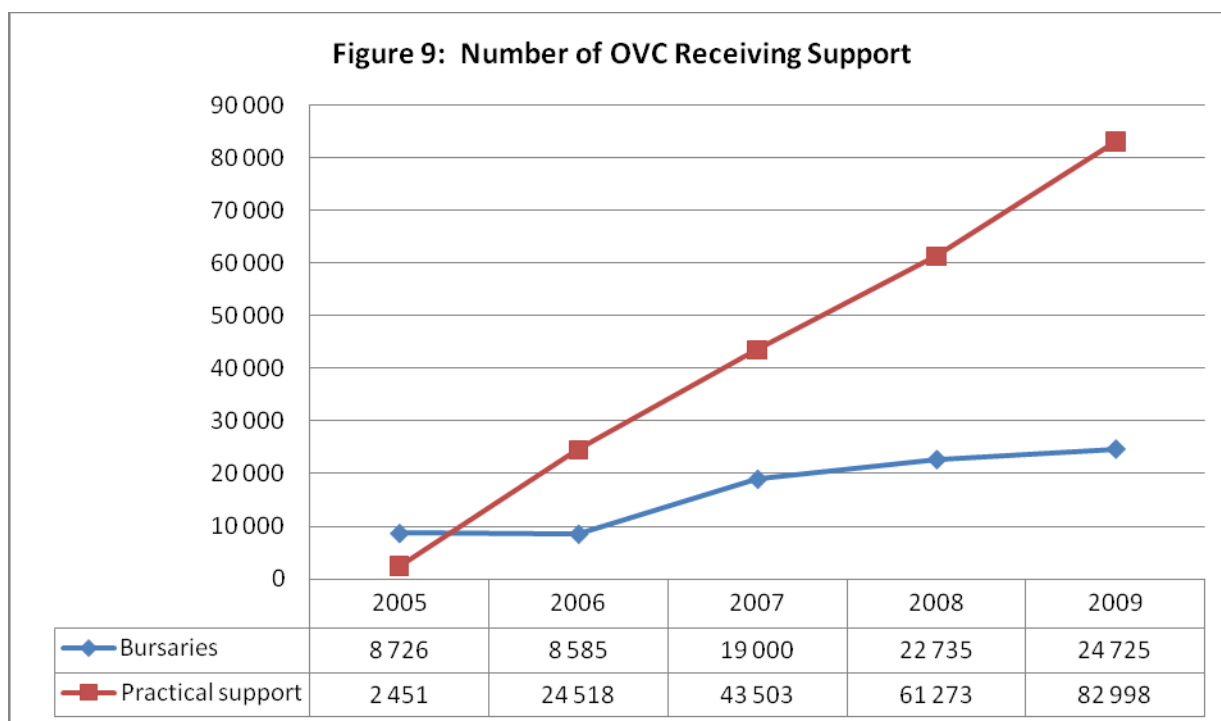
4.6.1 Support for Orphans & Vulnerable Children

To respond to the challenge of the large and growing number of OVC, the GOL, under the leadership of the Department of Social Welfare (DSW) has developed strategic frameworks and policy to guide the national response for OVC. An essential package of support was designed by the DSW through consultative forums with different stakeholders. The package is provided through the DSW in collaboration with non-governmental organizations, international organizations and bilateral and multi-lateral partners. These interventions include health services, shelter, emergency food assistance through a school feeding programme, distribution of food packages to OVC households, school bursaries (including funds for uniforms, stationery and toiletries), and psycho-social support through trained caregivers. Out-of-school programmes include technical and vocational skills development, home gardening projects, and income generation activities. Child protection systems have been strengthened and expanded. The DSW has piloted a cash grants programme (see section 4.4.2). The Child-Help Line is expanding. Child and Gender Protection Units (CGPUs), run by LMPS in each district, have been strengthened. The Office of the Master of the High Court, the statutory body protecting children’s inheritance, has been decentralized to all districts. Orphan registration has been piloted and birth registration expanded through the Ministry of Local Government and Chieftainship (MOLGC).

⁶¹ GOL. 2009. National HIV&AIDS Strategic Plan 2006-2011 (Revised). Maseru, LS: NAC. p50.

⁶² GOL 2009, op cit. note 18.

⁶³ MOHSW. 2009. Spectrum database output for the 2008 sentinel survey.



Despite these interventions, many children still remain out-of-reach for the support and assistance that they need. As a step towards improving the scope and the reach of OVC support programmes, the DSW, with support from UNICEF and PEPFAR, has undertaken new situational analysis and the review and revision of the strategic framework for the national OVC response. The process will take into account the results of recent operational research at the international level that calls for a fundamental shift from vertical, targeted programmes to those which rebuild and strengthen families in communities as the core unit of care and support for OVC.⁶⁴ In addition, the high school bursary programme will be strengthened and expanded. Technical assistance is being provided to the National OVC Coordinating Committee and the office of the National OVC Coordinator to strengthen their contribution to the DSWs leadership role for the national OVC response. Finally, a Child Protection and Welfare Bill has been making its way through the legislative process. It is anticipated that the bill will be enacted before the end of 2010. Collectively, these interventions will form the basis for a comprehensive, child-centred social protection system to offer permanent, long term support to vulnerable children.

4.6.2 Support to vulnerable households

Data on school enrolment rates between OVC and other children have shown that orphanhood in itself is not a strong predictor of school enrolment, the predictor is poverty.⁶⁵ A destitute child with parents is no more likely to be in school than a destitute orphan. In Lesotho, 16% of all primary-

⁶⁴See Joint Learning Initiative on Children & HIV & AIDS. 2009. Home Truths: Facing the Facts on Children, AIDS and Poverty. Available: <http://www.jlica.org/protected/pdf-feb09/Final%20JLICA%20Report-final.pdf>

⁶⁵ World Bank. 2005. Primary and Secondary Education in Lesotho: A Country Status Report. African Human Development Working Papers Series 101. Available: http://siteresources.worldbank.org/INTAFRICA/Resources/no_101.pdf

school-aged children are not in school.⁶⁶ The primary cause of this is poverty and household vulnerability. In some regions of Lesotho, faith-based organizations and other non-governmental partners have identified such households and worked with government partners in communities to address and reduce the causes of vulnerability. Through these partnerships, communities and families were strengthened and therefore were able to reduce the impact that HIV and TB were having on their livelihoods.⁶⁷ Lesotho's social welfare system has been overwhelmed with the number of households becoming vulnerable as a result of HIV. In 2007, the European Union committed €11 million to support a range of interventions aimed at assisting vulnerable households, especially those caring for OVC. The main component of the project is the development of the Lesotho Child Grants Programme.⁶⁸ In 2009, the programme completed the pilot phase and began to roll-out to selected districts across Lesotho. Community level structures identify eligible households which receive quarterly cash payments to assist them to meet basic needs. These structures also provide a measure of accountability to ensure that the programme has its intended impact. The programme will attempt to reach 8,000 destitute households and 24,000 children in five districts by the end of the current phase in 2011.⁶⁹ The EU has already pledged support for a second phase of the programme to expand it to all districts.

4.6.3 Addressing the needs of women and girls

In 2007, the MOGYSR issued a *National Action Plan on Women and Girls and HIV&AIDS: Facing the Future Together 2007-2011*.⁷⁰ The impetus to develop the plan was the evidence of the reality in Lesotho that women and girls are disproportionately affected by the HIV epidemic. A higher proportion of adolescent girls and young women are HIV-positive than their male counterparts and, overall, more women are HIV-positive than men. There is a serious risk of HIV infection as adolescents and young women become sexually active and move into adulthood.⁷¹ A study was carried out in 2009 through a partnership between the MOHSW and PHELA Communications to collect evidence about violence against women.⁷² The study, when completed, will inform the development of stronger legal protections for women who are victimized by violence in their homes. Community-level activities are ongoing to sensitize women and girls and their communities to their legal and human rights in Lesotho. Both FIDA and WILSA work at the central, district and local level to educate women and girls about rights and entitlements and also to make communities aware of laws and protection available for this group. In addition to this, the MOGYSR, along with other NGOs, has distributed simplified versions in Sesotho of laws governing marriage, inheritance and sexual assault. As noted above, CGPUs have been established in each district to help protect and

⁶⁶ *Ibid.* The ongoing implementation of free primary education since the study was completed is likely to have reduced this proportion in a meaningful way.

⁶⁷ See Section 9 for a description of the MOVE programme which is an example of the integrated approach.

⁶⁸ For a description of the programme see L. Blank. 2008. Lesotho Children Grant Pilot Operations Manual. Maseru, LS: UNICEF.

⁶⁹ GOL/UNICEF/EU. 2009. Support to Lesotho HIV & AIDS Response: Empowerment of Orphans and Vulnerable Children. Revised Description of Action. Maseru, LS: UNICEF.

⁷⁰ GOL. 2007. National Action Plan on Women and Girls and HIV&AIDS: Facing the Future Together 2007-2011. Maseru, LS: MGYSR.

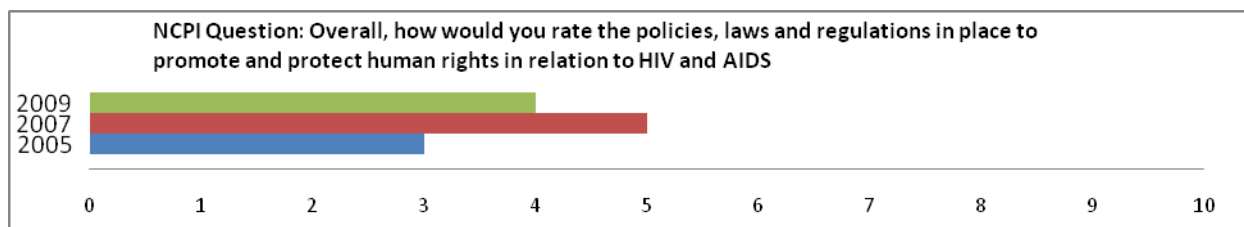
⁷¹ For young women starting families, by the time they are 25 there is a 40% to 50% chance of being infected with HIV. See GOL 2010, op. cit., note 40.

⁷² This will complement the findings of Anderssen et al. 2007. Risk factors for domestic violence: national cross-sectional household surveys in eight southern African countries. *BMC Women's Health* 7(11): 1-13. This study found that, in Lesotho, 47% of male and 40% of female respondents believe that women may not refuse to have sex with their husbands and boyfriends.

support women and girls, particularly with respect to gender-based violence and sexual abuse. Life-skills education in schools is equipping adolescents and young women with knowledge and skills to have more control over how and when they become sexually active. Further investigations will be conducted in 2010 in order to identify all of the social and cultural practices in Basotho society that directly or indirectly place women and girls at greater risk of HIV infection. The findings will inform intensified community level interventions to empower women and girls to claim their rights and entitlements to be free from HIV infection and to protect themselves from all forms of exploitation, violence and abuse.

4.6.4 Preventing stigma & discrimination against PLWHAs, OVC and other vulnerable groups.

All partners involved in the national HIV&AIDS response in Lesotho have noticed a significant decline in instances of stigma and discrimination against PLWHAs and the individuals, families and communities that provide them with care and support. This has largely come about as a result of the significant increase in the number of individuals who know their status and the growing number of adults and children on ART. Despite this progress, HIV-related stigma is still a barrier for individuals causing them not to seek out health services and, consequently, not to undergo HTC or enrol in the ART programme. Culturally stigmatizing attitudes towards males who are ill limit male involvement in all aspects of the national HIV programme and inhibit those men who are HIV-positive from knowing their status and addressing it within their social and sexual relationships. Within the uniformed services, very few members are open about their HIV status and more fear the consequences to themselves if their colleagues were aware. Commercial sex workers and sexual minorities are sometimes treated within health services as though they deserved HIV infection. Within sexual minorities, 76% of men and 73% of women report having experienced stigma and discrimination within health services and elsewhere.⁷³



NAC continues to support non-governmental partners to work at the community level to provide education and awareness about the damaging effects of stigma and discrimination and the protections that are in place for those who are victimized by it. It has recently provided support for non-governmental organizations to begin to work with commercial sex workers in a supportive and enabling manner. Development partners are also working with NAC to begin to recognize and understand the presence of sexual minorities in the country, a which first step towards creating a more constructive environment in which to develop appropriate interventions for protection and support for this group.

In collaboration with the MOHSW and NAC, NGOs continue to develop national public relations campaigns to decrease the level of stigma and discrimination. Related to HIV. PLWHIVs have been

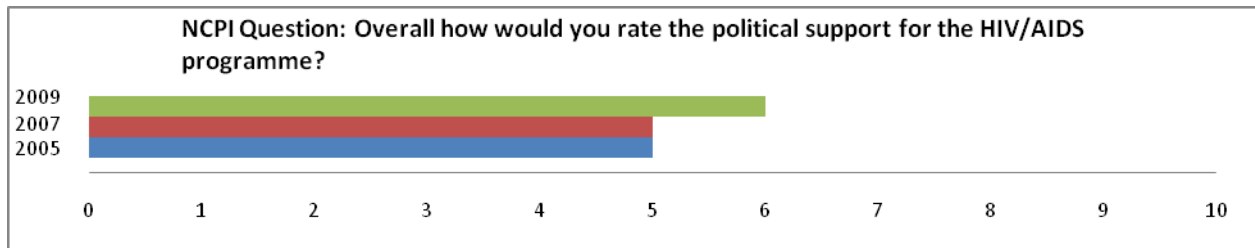
⁷³ UNDP/NAC 2009, op. cit. note 9.

trained in human rights, advocacy and conflict resolution. Paralegals in each district conduct community sensitization sessions and provide support to PLWHIVs who are victims of discrimination and abuse. In 2010, the GOL will undertake an assessment of stigma and discrimination within the health sector in order to inform an action plan to ensure that there is always a supportive and enabling environment for service provision throughout all health and social services.

4.7 LEADERSHIP, MANAGEMENT & COORDINATION

4.7.1 Leadership

Political support for the national HIV & AIDS response remains strong. His Majesty King Letsie III regularly speaks publicly about HIV and the importance for everyone to become involved and to make a personal commitment to ending HIV transmission. The Prime Minister is equally outspoken both internally and publicly about the critical importance of addressing HIV in the country. He has undergone HIV testing repeatedly to show by example his personal commitment to the national response.

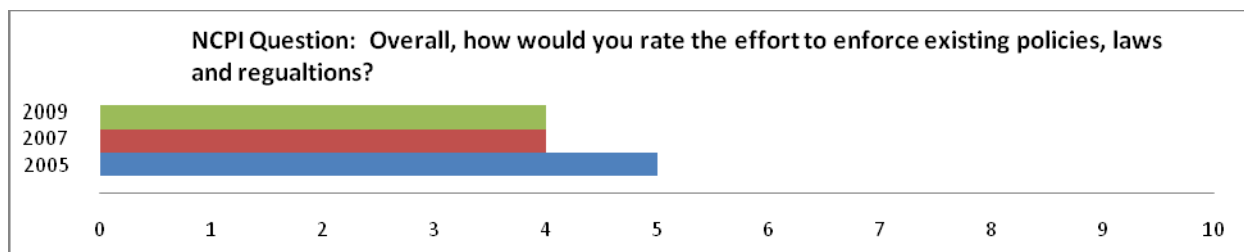


During the World AIDS Day ceremony in 2009, cabinet members and other dignitaries joined the Prime Minister to undergo HIV counselling and testing as hundreds of adults and children watched the proceedings. Portfolio committees on HIV & AIDS within the Parliament, for both the Senate and the National Assembly, are very active. The Cabinet Sub-Committee on HIV and AIDS chaired by the Deputy Prime Minister works closely with NAC and other stakeholders within the national response. HIV & AIDS has been mainstreamed throughout the legislative and executive processes within government. The GOL's commitment to addressing HIV & AIDS through the recurrent budget has increased significantly over the 2007 to 2009 period (see Section 6.0).

While NAC provides overall coordination and leadership for the national HIV & AIDS response, there are other partners that provide leadership at the sectoral level. For instance, the MOHSW coordinates and leads the health sector on a range of health-related issues in addition to HIV & AIDS. LCN plays the same role within the non-governmental sector. Lesotho Sports and Recreation Commission (LSRC), as the supreme sporting body, has mainstreamed HIV & AIDS within its member organizations. Faith-based organisations under the leadership of the Lesotho Inter-Religious AIDS Consortium (LIRAC) are fully engaged in the response. In 2009, members of the parliamentary portfolio committees toured the country to examine HIV and AIDS services by engaging members of the public and both public and private service providers. A detailed report on the findings will be issued in 2010

4.7.2 Advocacy, policy & legislation

The law and policy environment continues to improve in Lesotho. The National HIV & AIDS Policy remains in force to guide all sectors in the provision of an effective and accessible HIV & AIDS response. This includes provisions that address such things as non-discrimination against key groups as well as the obligation to adapt core components of the HIV response so that they reflect the specific needs of these groups, in particular people with disabilities.



NAC has made a commitment to strengthen the HIV policy framework by developing more specific policies for key populations. The HIV&AIDS policies and strategic plans for Lesotho Correctional Services and for herd boys were recently completed and approved. Policies for other uniformed services and for key populations will be completed in 2010. An education sector policy has been drafted and is still in development. The Health Sector Policy on Comprehensive HIV Prevention will be finalized in 2010. The Ministry of Labour and Employment released national workplace guidelines in 2008 to facilitate the implementation of the Labour Code Amendment Act which contains specific provisions regarding worker entitlements to HIV-related programmes.⁷⁴ An AIDS bill has undergone extensive consultation. At the moment, the multi-sectoral partners are working together to examine SADC model laws with a view to incorporating some of their provisions within the draft AIDS Bill.

4.7.3 Coordination & management of the multi-sectoral response

The national HIV response in Lesotho continues to be guided by the NSP, the National Monitoring and Evaluation Plan and the Coordination Framework for the National HIV & AIDS Response. All of these documents are guided by the ‘three ones’ principle. Since 2008, there has been a notable increase in the willingness of all stakeholders to plan and implement HIV interventions within the national strategic framework. HIV & AIDS is considered a development challenge of great magnitude for Lesotho and, for that reason, responding to the epidemic has been mainstreamed within all of Lesotho’s development frameworks, including the 6th National Development Plan, the Millennium Development Goals, the National Vision 2020, the Poverty Reduction and Growth Strategy and the African Peer Review Mechanism. HIV & AIDS are also mainstreamed within all of the major development assistance partnerships, including the UN Country Assistance Framework and the World Bank Country Assistance Strategy. While discussion of a sector-wide approach incorporating donor contributions to the national HIV&AIDS response continues, no major developments have occurred to-date. However, a development partners forum meets regularly and helps to foster collaborative approaches to improve the efficiency and effectiveness of donor support. The UN family in Lesotho began implementing its first Joint UN Programme of Support on AIDS in 2009 (see Section 8.0).

Since its creation, NAC has had the mandate on behalf of the GOL to coordinate and provide management support to the national multi-sectoral response. Starting in 2007, NAC has convened national partnership forums for all stakeholders on a quarterly and annual basis. The forums are a platform for all those involved in the national response from all districts to meet and review progress against the annual operational plans for NSP implementation. Using district level technical officers, NAC has expanded and strengthened its ability to collect and share information on district and local level interventions. The partnership forum reports have become important tools for all

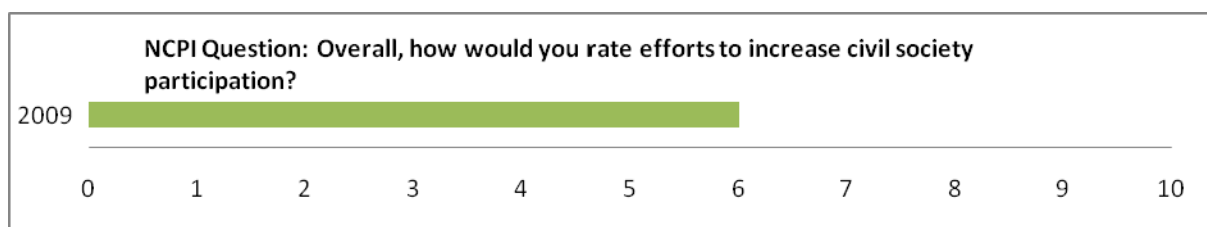
⁷⁴ MOLE. 2008. Guidelines for Implementation of the Labour Code Amendment Act No. 5 of 2006.

stakeholders to be aware of the role of their efforts within the national multi-sectoral framework, to be more aware of relationships and synergies between stakeholders.

NAC has also been providing financial and technical support to umbrella bodies (LENEPWHA, LIRAC, LCN, LNFOD, LENASO, LSRC, LYFE and NGOC, among others) to ensure that these organizations are able to provide coordination and support to their affiliates at district and local level. As the number of local, regional and international partners addressing HIV in Lesotho has grown, there is still a need to intensify coordination activities and to strengthen coordination mechanisms. While Lesotho is fortunate to have such a broad range of stakeholders and partners focused on mitigating the impact of the HIV epidemic on the country, without a strong and effective coordination framework the efforts of these entities become fragmented and, at times, duplicate similar national programmes or those of other stakeholders. Lesotho has requested technical support from the World Bank to address these challenges and to strengthen the effectiveness of all coordination mechanisms starting in 2010.

4.7.4 Civil society engagement & community systems strengthening

Civil society partners perceive that their role within the national response and the engagement of this sector in all aspects of developing, implementing and monitoring of the national response is improving. Civil society organizations participate in the NAC governance structure through the HIV&AIDS Forum and through the representative from the Lesotho Network of People Living with HIV & AIDS (LENEPWHA) that sits on the five-member Board of Commissioners. There have been ongoing efforts to strengthen the organizational and technical capacity of non-governmental organizations. NAC has provided opportunities for training and capacity development and, through the Global Fund programme in Lesotho, community organizations have benefited from training and support in M&E, programme management and financial management. PACT Lesotho, with support from PEPFAR and USAID, CARE Lesotho and Sentebale also provided capacity building interventions for their partner organizations. More recently, through a global partnership between Standard Bank and the Global Fund, Standard Lesotho Bank has been providing financial management training to non-governmental organizations



The participation of civil society organizations on the Lesotho Country Coordinating Mechanism, which oversees the country’s Global Fund programmes, has strengthened considerably since 2008. This re-engagement began in 2008 when non-governmental and private sector partners motivated themselves to participate fully in the Global Fund Round 8 proposal development process. As a result, the Lesotho Council of Non-governmental Organizations (LCN) was made a Principal Recipient under the approved grant. LCN will provide leadership in the implementation of the non-governmental and private sector activities which comprise approximately 30% of the total value of the HIV component. The Round 8 grant will substantially augment support for civil society engagement in the national HIV response. The sector as a whole, however, does not yet perceive

that there is significant national support, either political or financial, for the importance of its work, especially at the local community level. Because of this, the sector is of the opinion that it has not yet been able to contribute to its full scope within the national response.

4.7.5 Health system strengthening

During the reporting period, the MOHSW continued to work with its partners to increase the number of health care providers in the country as well as to retain those already employed either by the MOHSW or CHAL. The Rural Health Initiative, a partnership between the GOL, CHAI, Irish Aid and DIFD, supported recruitment of both national and expatriate nurses to fill gaps in coverage at the health centre level. Starting in 2010, the GOL will begin to implement a new establishment structure for health care workers, which will include changes in salary grades and the provision of allowances and other incentives aimed at providers who work in rural and remote areas.

4.7.6 Decentralization

Under the leadership of the MOLGC, the GOL continues to implement its local governance and decentralization strategies. District AIDS Committees (DAC) monitor the provision of decentralized HIV & AIDS programmes. DACs are multi-stakeholder bodies including representatives from all sectors at the district and local level. Between 2008 and 2009, NAC continued to provide technical support and capacity building to these structures.

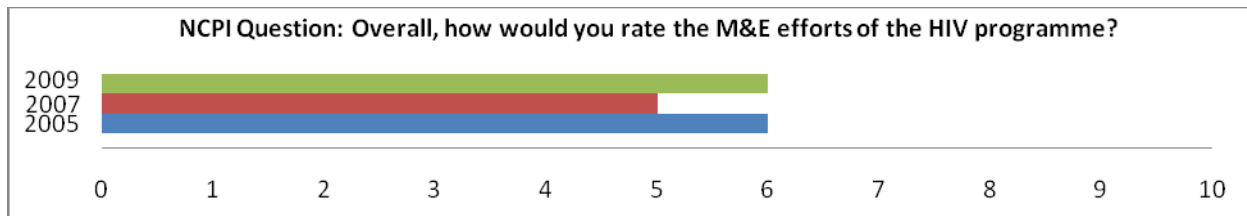
Starting in 2005, the MOLGC has been implementing a strategy for using local government structures as the gateway to expanded responses to HIV & AIDS at community level. The Gateway Approach works within the functions and legal mandates of local authorities to plan, implement and monitor development activities. In 2007, through a strategic partnership between the MOLGC, NAC, GTZ and UNAIDS, the Essential HIV & AIDS Services Package (ESP) project was launched.⁷⁵ Each of the 128 Community Councils decided on relevant interventions in collaboration with local stakeholders. The councils then received funds through NAC to implement the chosen interventions. The NAC M&E section facilitated development of M&E indicators for the ESP that were linked to the national M&E framework. Phase 1 implementation of the ESP took place between 2007 and 2009. At the end of 2009, the partners commissioned an external review.⁷⁶ The findings of the review will inform the implementation of a second phase supported by the World Bank and expected to begin in 2010.

⁷⁵ The project description is available at <http://www2.gtz.de/Dokumente/social-development/HIV-AIDS/en-local-response-longversion-2006.pdf>

⁷⁶ MOLGC/GTZ. 2009. An External Review of the Essential HIV & AIDS Services Package. Maseru, LS: NAC.

5.0 NATIONAL M&E SYSTEMS

While Lesotho has achieved a great deal of progress in many other aspects of its response to HIV and AIDS throughout 2008 and 2009, improving the extent and the quality of strategic information that is required to plan and implement effective and relevant interventions has not always kept pace. More recently, through the modes of transmission study and the related sub-studies, the new situational analyses of the HIV-related needs of key populations, and through the ongoing strengthening of the national M&E system, the gap in strategic information is beginning to close. In addition, UNAIDS has facilitated the institutionalization of more sophisticated uses of the Spectrum and the Country Response Information System (CRIS) databases. This has resulted in higher quality interpretation and estimation techniques used to model the impact of the epidemic.



In 2008, an assessment of the national M&E systems and structures took place.⁷⁷ The assessment found a number of challenges, including insufficient organizational structures to support M&E at all levels and insufficient human resources dedicated to M&E activities. It also found gaps in commitment to a national M&E system and a national M&E plan. Finally, it found inadequacies in more sophisticated M&E processes, including behavioural monitoring, operational research and other outcome and impact research activities. The review acknowledged that data collection was improving, particularly with respect to the range of indicators and the quality of data collected. However, it noted that this information was not always fed back to implementers in user-friendly formats that could guide HIV and AIDS programme development.

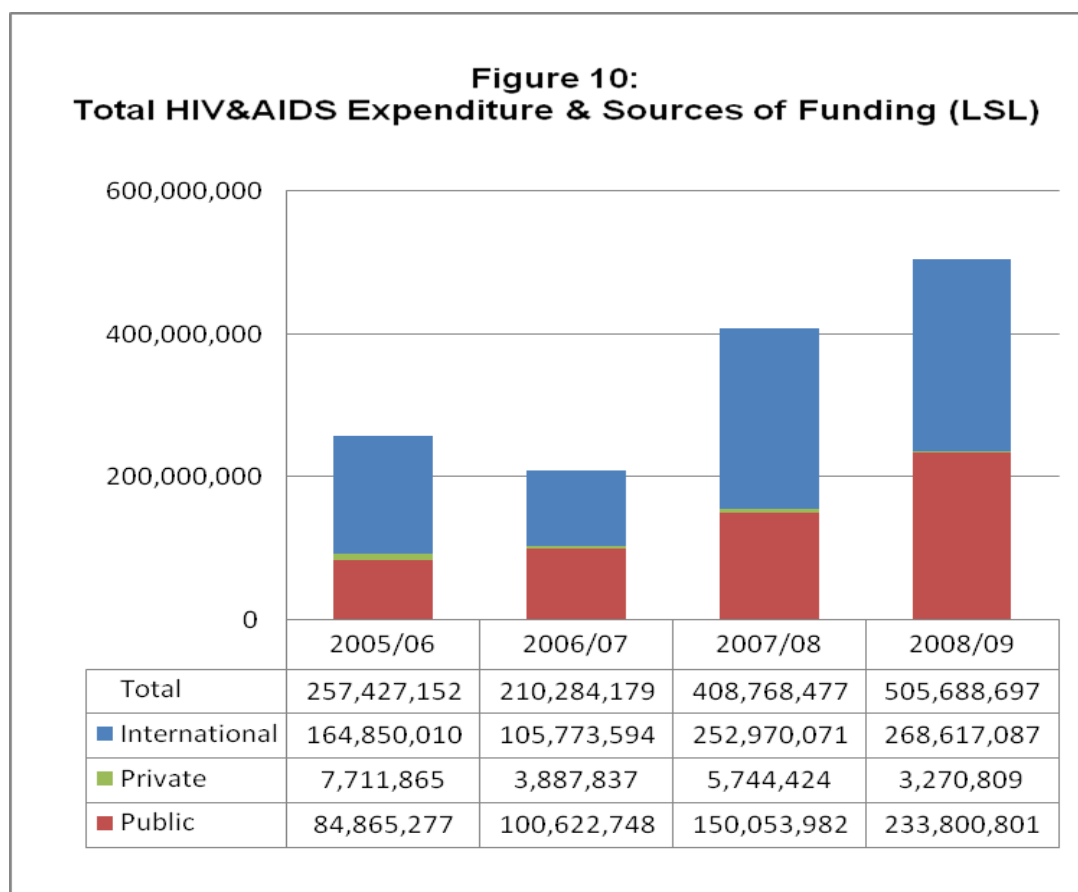
The review has informed a national plan of action to strengthen M&E capacities and systems. The Japanese International Cooperation Agency (JICA) and John Snow International, among others, have provided ongoing support for M&E strengthening. With this support, M&E officers within governmental and non-governmental civil society organizations, for example, have participated in advanced training. A new data collection and analysis framework called the Lesotho Output Monitoring System for HIV & AIDS (LOMSHA) has been developed.⁷⁸ Training is ongoing for users of the new system. M&E systems have also been decentralized to district and local levels. However, while partners have provided opportunities for operational research and epidemiological surveys, these have not always been effectively utilized. This is partly because NAC, in collaboration with the MOHSW, has not yet created effective research management and support mechanisms. This need will be addressed through World Bank support in the next phase of its technical support programme for Lesotho. This will provide for much more effective management of activities aimed at generating high quality evidence for all partners in the national response.

⁷⁷NAC. 2008. Assessment of National and Sectoral HIV M&E Systems in Lesotho. Maseru, LS: NAC.

⁷⁸ GOL.2009. Lesotho Output Monitoring System for HIV & AIDS (LOMSHA) Operations Manual. Maseru, LS: NAC.

6.0 FINANCIAL MANAGEMENT AND RESOURCE MOBILIZATION

Throughout 2008 and 2009, there were significant changes in the availability and allocation of resources supporting the national HIV&AIDS response. Figure 10 below shows these year-over-year changes.

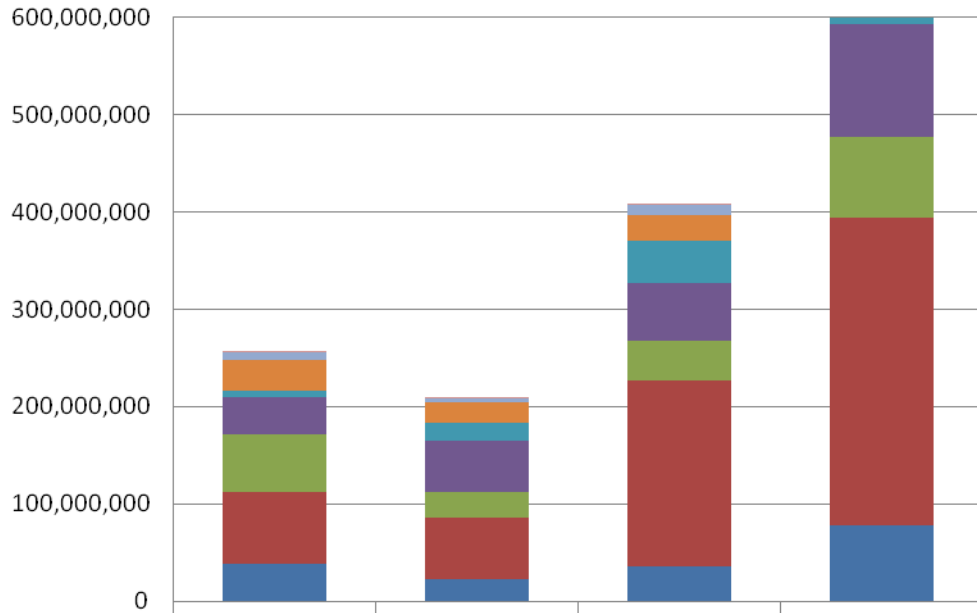


The resource envelope for the national HIV & AIDS response has increased by 140% since 2007, while the increase that has been registered between 2008 and 2009 is 24%.⁷⁹ Growth has occurred largely in the GOL budget contribution. Between 2008 and 2009, the GOL contribution to HIV & AIDS grew by 56%, which is an increase of 132% since 2007. For development partners, their contribution has increased by 6% since 2008 and 154% since 2007. The private sector contribution has declined by 16% and 43% respectively.

The distribution of HIV & AIDS spending by major thematic area is shown in Figure 11 below.

⁷⁹ NAC 2010, op. cit. note 2. For the 2008/2009 assessment, hospital costs for HIV&AIDS treatment were included. These totalled LSL 121,265,468. When these are added to the 2008/2009 public contribution to HIV&AIDS expenditure, the national recurrent budget share rises to LSL 355,066,269 and total spending on HIV&AIDS to LSL 626,954,165. The hospital costs are removed in this table for purposes of trend analysis with other assessment results in years when these costs were not included.

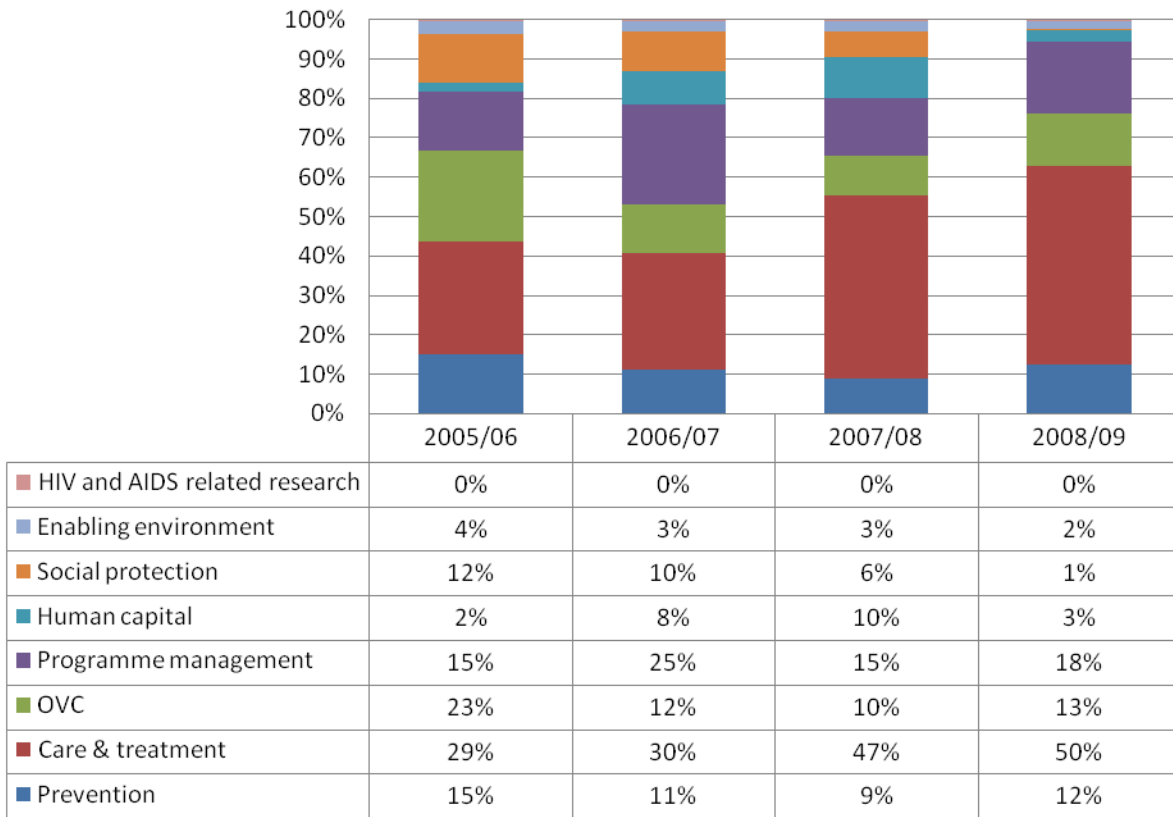
Figure 11: Total HIV expenditure by thematic area (LSL)



	2005/06	2006/07	2007/08	2008/09
Total	257,427,152	210,284,179	408,768,477	626,954,165
■ HIV and AIDS related research	28,510	412,850	499,946	2,587,170
■ Enabling environment	9,633,850	6,075,870	12,059,381	11,318,697
■ Social protection	31,490,057	20,902,252	26,536,321	3,495,471
■ Human capital	6,213,599	17,800,137	42,839,344	16,581,065
■ Programme management	38,316,316	53,402,224	59,383,629	115,944,646
■ OVC	59,266,049	25,875,234	40,868,517	83,131,734
■ Care & treatment	73,948,177	62,532,444	190,562,835	316,151,687
■ Prevention	38,530,594	23,283,168	36,018,504	77,743,695

Significant changes have occurred between the 2007 and 2009 NASA. Expenditure on prevention has increased by 234% largely due to increases in programme costs for PMTCT and workplace interventions. Expenditure on ART has increased by 219% and on OVC by 221% reflecting the substantial growth in these programmes over the 2008 and 2009 period.

Figure 12:Proportional HIV & AIDS Expenditure (all sources) by Thematic Area



The proportional distribution of expenditure by thematic area and by source of funds has also changed significantly since 2007. Major changes for proportional spending between 2007 and 2009 have occurred in prevention, care & treatment, support for OVC and programme management.

7.0 ACHIEVEMENTS & CHALLENGES: 2007/2009 COMPARISON

NSP Component	2007		2009		
	Challenge	Proposed Remedial Action	Achievements	Ongoing Challenges	Proposed Remedial Actions
Prevention	Slow progress in achieving behaviour change.	Undertake prevention review to gain understanding of prevention efforts in place.	<p>Completion of MOT study and studies on MCP, and youth and SRH.</p> <p>Completion, launch and distribution of national BCC strategy.</p> <p>Partnerships strengthened with PEPFAR, Global Fund to support implementation of BCC strategy.</p>	Still slow progress in achieving sustained behaviour change in the general population and in key target populations.	<p>Develop and implement operational plan for national BCC strategy.</p> <p>Develop and implement a National HIV Prevention Strategy</p> <p>Strengthen and expand continuous M&E processes attached to prevention interventions.</p> <p>Undertake more targeted operational research to determine effectiveness of prevention interventions.</p>
	Low coverage of prevention programmes for main target populations.	Enhance capacity in all sectors to deliver prevention interventions	<p>Significant additional resources for prevention interventions mobilized through PEPFAR, Global Fund.</p> <p>Completion of implementation strategy for scale-up of male circumcision.</p>	<p>Ongoing need to improve technical and programmatic capacity of multi-sectoral partners to develop and implement country-wide prevention interventions.</p> <p>Ongoing social reticence to openly acknowledge and discuss HIV sexual risk issues.</p> <p>Slow change in cultural and social expectations of women and girls, particularly within sexual relationships.</p> <p>Insufficient commitment on the part of men and boys to address HIV prevention within sexual relationships.</p>	<p>Provide training and technical support to multi-sectoral partners on BCC and other prevention interventions.</p> <p>Scale-up prevention interventions focusing on interpersonal communication skills.</p> <p>Improve availability of female condoms.</p> <p>Develop and implement interventions aimed at empowering women and girls to claim rights and entitlements in all aspects of their lives.</p> <p>Scale-up interventions that engage men and boys in HIV prevention and support.</p>
	Low number of interventions for key populations.	Undertake situational assessments, prevalence studies and consultative activities to provide evidence for relevant	Situational assessments/behavioural studies completed for youth out-of-school, inmates, uniformed services (LCS,	<p>Ongoing gaps in knowledge regarding HIV-related risks for key populations.</p> <p>Ongoing stigma and discrimination</p>	Work with non-governmental sector to scale-up development and implementation of evidence-based prevention interventions.

NSP Component	2007		2009		
	Challenge	Proposed Remedial Action	Achievements	Ongoing Challenges	Proposed Remedial Actions
		interventions.	<p>LMPS), herd boys, sexual minorities.</p> <p>Prevalence studies pending for LCS & LMPS. Situational assessments pending for commercial sex workers & people with disabilities.</p> <p>HIV policies and workplace programmes in place for LCS, LDF, LMPS.</p> <p>Additional resources mobilized through development partners to support implementation of workplace programmes and other prevention interventions involving key populations.</p> <p>Clear commitment in revised NSP to address needs of key populations.</p>	<p>against key populations (sexual minorities, commercial sex workers, inmates).</p> <p>Need for additional technical capacity to design effective interventions.</p>	<p>Strengthen and expand activities at national, district and local level sensitizing individuals and communities regarding rights and dignity of all members of Basotho society.</p> <p>Ensure that key policies, laws and strategies in prevention programmes ensure access to prevention interventions for key populations.</p>
Treatment, care and support	Limited human resources to support attainment of Universal Access targets for ART.	<p>Train health care providers in ART.</p> <p>Support nurses in health centres to provide ART at community level.</p>	<p>All cadres of health care providers trained on HIV chronic care.</p> <p>Rural health initiative has increased nursing coverage in rural and remote regions.</p> <p>Necessary drugs and commodities provided to health centres to support ART on a routine basis.</p> <p>Training and incentives for CHWs and VHWs.</p>	<p>Addressing gaps and weaknesses in logistics systems that support health centres.</p> <p>Recruitment and retention of adequate human resources on a long-term basis.</p> <p>Integrating HIV chronic care within the essential services package offered through primary care programmes at community level.</p> <p>Maintaining reliable supply of home-based care commodities.</p>	<p>Mobilize additional resources to address gaps in PSM systems (reliable transport, accurate inventory management and forecasting at hospital and health centre level).</p> <p>Develop and pilot integrated service delivery models.</p> <p>Implement health human resource retention strategy.</p> <p>Engage development partners in dialogue on long-term support for ART programme.</p>

NSP Component	2007		2009		
	Challenge	Proposed Remedial Action	Achievements	Ongoing Challenges	Proposed Remedial Actions
				Securing long-term resource commitments to support ART.	
	Lack of food security impacts effectiveness of ART.	<p>Improve coverage of community-based IGAs and food security programmes.</p> <p>Support WFP and other partners to increase coverage of emergency food assistance programmes.</p>	<p>Expansion of IGAs and food-security programmes at community level with assistance from development partners.</p> <p>Evaluation of interventions in order to determine best-practice.</p>	<p>Ongoing vulnerability and food insecurity of rural & remote populations engaging in subsistence farming.</p> <p>Ongoing impact of poverty on HIV-positive individuals and families.</p>	<p>Continue to work multi-sectoral partners to develop interventions to address and resolve food insecurity.</p> <p>Improve nutritional support for adults and children on ART.</p>
	Need for community level strategies to support long-term adherence to ART.	Increase capacity of communities and families to support individuals on ART.	Expert patients, community health workers, village health workers, traditional healers, police officers, correctional officers and others all sensitized and given training on assisting individuals on ART to maintain adherence.	<p>Maintaining long-term adherence to ART.</p> <p>Managing need for 2nd line ART.</p> <p>Identifying, treating and supporting HIV-positive children.</p>	<p>Continue to collaborate with multi-sectoral partners to provide ongoing support to individuals on ART at community level.</p> <p>Undertake more participatory research to identify enabling factors for treatment adherence.</p>
HIV&TB Collaborative Activities	Insufficient coverage of HIV/TB collaborative activities.	Implement strategies to attain collaboration and integration of HIV & TB programmes at health facility level.	<p>Training provide for health care providers on HIV/TB co-management.</p> <p>HTC and ART provision for TB patients improved.</p> <p>Data gathering and analysis strengthened.</p>	<p>Developing integrated patient management strategies of HIV/TB co-infected individuals.</p> <p>Identifying and managing MDR and XDR TB patients.</p> <p>Improving capacity for isolation of MDR and XDR patients.</p> <p>Strengthening community support for adherence of HIV/TB regimens.</p>	<p>Ongoing training of health care providers on HIV/TB co-management strategies.</p> <p>Improvement of district level facilities to identify MDR and XDR TB patients and to refer for appropriate care.</p> <p>Expansion of clinical facilities in northern and southern districts for treatment and management of MDR and XDR TB patients.</p> <p>Implementation of community mobilization and support interventions.</p>
Impact Mitigation	Insufficient capacity to address basic needs for OVC in all districts.	Strengthen the multi-sectoral response and engage new partners.	<p>New commitments of resources mobilized through EU and Global Fund.</p> <p>Launch of Lesotho Child</p>	Mobilizing sufficient resources to provide for basic needs, including food security, safety, access to education and shelter.	<p>Engage development partners in resource mobilization activities.</p> <p>Scale-up implementation of community-oriented interventions</p>

NSP Component	2007		2009		
	Challenge	Proposed Remedial Action	Achievements	Ongoing Challenges	Proposed Remedial Actions
			<p>Grants Programme.</p> <p>Capacity-building programmes provided through multi-sectoral partners.</p> <p>Strengthening of social protection systems (CGPUs, Auxiliary Social Welfare Officers).</p> <p>Expansion of Child Help Line.</p> <p>Para-legal training for community based people who have since assisted many OVC and widows who had been disposed by relatives.</p>	<p>Encouraging and strengthening community-ownership of OVC challenges.</p> <p>Limited coverage of social protection services.</p> <p>Limited numbers of paralegals to cover the whole country effectively.</p>	<p>addressing OVC.</p> <p>Roll-out LCGP to all districts.</p> <p>Maintain and increase support for school bursaries.</p> <p>Improve opportunities for TVET and provide start-up funds for IGA projects engaging OVC.</p> <p>Improve social protection systems at all levels (enact the Child Protection & Welfare Bill).</p> <p>FIDA should be supported to increase paralegal services.</p>
	Fragmentation of OVC response across all stakeholders.	Strengthen commitment to national coordination mechanisms.	<p>Establishment of Letsema network as forum for multi-sectoral partners in OVC response.</p> <p>Capacity-building for NOCC.</p> <p>Engagement of National OVC Coordinator.</p> <p>Strengthening of technical and programmatic capacity at DSW to lead national OVC response.</p>	<p>National coordination mechanisms not functioning at full capacity.</p> <p>Inconsistent coordination and collaboration of multi-sectoral partners addressing OVC.</p> <p>Need for review and revision of national policy and coordination frameworks.</p>	<p>Build technical and programmatic capacity of NOCC and NOCC secretariat.</p> <p>Review, revise and strengthen national coordination frameworks.</p> <p>Continue support for NGO networking and collaboration activities.</p>
	Insufficient capacity to identify OVC and to monitor impact of interventions.	Address gaps in birth registration and orphan registration at district level.	Additional support provided through development partners to sensitize stakeholders on importance of birth registration, and to improve capacity of	<p>Incomplete coverage of OVC registration systems.</p> <p>Gaps in M&E framework, particularly at community level.</p>	<p>Ensure availability of birth registration in all districts.</p> <p>Strengthen M&E tools and coordination systems.</p>

NSP Component	2007		2009		
	Challenge	Proposed Remedial Action	Achievements	Ongoing Challenges	Proposed Remedial Actions
			<p>MOLGC to provide service at district level.</p> <p>Orphan registration piloted. Evaluation pending to determine next steps.</p>	<p>Incomplete commitment from all stakeholders to improve M&E activities and to strengthen evidence-based interventions.</p>	<p>Continue training and support to stakeholders on M&E systems.</p>
	<p>Ongoing stigma & discrimination against PLWHIVs and other key populations at community level.</p>	<p>Promote awareness of human rights and legal protections at community level.</p> <p>Encourage more PLWHIVs to live openly with their status.</p> <p>Strengthen mechanisms to identify and resolve conflicts at community level.</p>	<p>Expansion of community-based programmes addressing stigma & discrimination.</p> <p>LENEPWHA support group members trained on advocacy & conflict resolution.</p>	<p>Insufficient capacity to collect data on acts of stigma & discrimination at community level.</p> <p>Social environment remains hostile to the needs of key populations.</p> <p>Tension between social and cultural traditions and human rights perspective protecting fundamental rights and entitlements.</p>	<p>Improve media monitoring and other activities to measure intensity of stigma & discrimination.</p> <p>Increase support to key populations to develop public education materials.</p> <p>Scale-up community dialogue interventions to resolve apparent conflicts between cultural beliefs and the fundamental dignity of all Basotho</p>
Leadership, management & coordination.	<p>Gaps in coordination frameworks between national and district & local level.</p>	<p>Strengthen coordination mechanisms at district & local level.</p>	<p>Increased frequency and improved quality of NAC-facilitated partnership forms.</p> <p>Reflection on strengths and challenges through NSP mid-term review.</p> <p>Increased support to District AIDS Committees and District AIDS Officers with assistance from development partners.</p> <p>Facilitation of partnerships between community councils and local organizations through ESP programme.</p>	<p>Some among the multi-sectoral partners still resist to be coordinated by the relevant structures.</p> <p>Duplication of coordination mechanisms.</p> <p>Insufficient technical capacity amongst stakeholders to develop effective & sustainable coordination mechanisms.</p>	<p>Review and revised coordination frameworks.</p> <p>Seek technical assistance to improve management and coordination mechanisms.</p>
Monitoring and Evaluation	<p>Insufficient capacity and commitment to data collection and M&E processes</p>	<p>Provide training and technical assistance to all stakeholders on M&E process and their</p>	<p>Stakeholders trained in M&E processes through NAC and Global Fund.</p>	<p>Need for ongoing training and support for all stakeholders to improve data quality and to improve commitment to national M&E</p>	<p>Continue to provide training and support on M&E for all stakeholders.</p>

NSP Component	2007		2009		
	Challenge	Proposed Remedial Action	Achievements	Ongoing Challenges	Proposed Remedial Actions
	amongst stakeholders.	importance.	Improvement of district level M&E systems through deployment of NAC technical support officers in each district.	<p>systems.</p> <p>Volume of ART patients and HTC clients that goes beyond current paper-based data collection systems.</p> <p>Ongoing differences amongst stakeholders regarding common indicators and common data collection and analysis processes (still too many partners who collect their own data for their own purposes).</p>	<p>Invest in newer technologies to capture and analyze data from the community to the national level.</p> <p>Review and revised national M&E framework.</p> <p>Build consensus on national core indicator framework.</p> <p>Strengthen commitment to national goals and targets, including Universal Access and MDG goals.</p>
	Limited range of strategic information available on a routine basis.	Expand range of strategic information available through targeted operational assessments, situational analysis, behavioural surveys, etc.	<p>Second DHS (2009) is being conducted.</p> <p>Situational assessments, prevalence studies, behavioural studies have been undertaken and completed</p>	Capacity to develop and manage research programmes still needs improvement.	<p>Mobilize additional support for training and technical assistance for development and management of research programmes.</p> <p>Engage all stakeholders in the establishment of a national research council together with strong sectoral research coordination structures.</p> <p>Strengthen national coordination mechanisms for research initiatives.</p> <p>Identify and engage knowledge-brokers to translate research results into operational improvements for HIV&AIDS interventions.</p>

8.0 CONTRIBUTIONS FROM DEVELOPMENT PARTNERS

Lesotho's national response to HIV&AIDS receives significant support from its development partners.

8.1 JOINT UN COUNTRY TEAM

Between 2008 and 2009, the UN agencies operating in Lesotho contributed USD 17,949,082 to support the implementation of the NSP. Approximately 60% of these funds were for emergency food assistance provided by WFP. WFP augmented the GOL's school feeding programme and FAO provided technical support to GOL on food security and agricultural policies. Other interventions supported through UN agencies included adolescent and youth-oriented prevention interventions (UNICEF), the strengthening of social protection systems for OVC (UNICEF), review and way-forward recommendations for the Know Your Status Campaign (UNDP, WHO) and support to NAC for the mid-term review of the NSP and for preparations for the 2009 NASA (UNDP). ILO supported the development of workplace programmes in the public and private sectors. UNAIDS provided ongoing technical support to multi-sectoral partners and, most importantly, coordinated the implementation of the modes of transmission analysis. The WHO provided ongoing technical support to the MOHSW for its programmes in HIV and TB, as well as HIV/TB collaborative activities. UNESCO provided technical support to the MOET for the development of HIV-related education sector policies and interventions. UNFPA assisted the MOHSW with the procurement and distribution of condoms and the integration of HIV prevention within the national SRH programmes.

Starting in 2009, the JUNCT began the implementation of the Joint UN Programme of Support on AIDS.⁸⁰ While the development of the programme was challenging, it fulfilled the commitment of the UN family to "deliver as one" in its assistance to Lesotho through a well coordinated and harmonized approach. The main goal of the programme is to assist the GOL to meet and exceed its universal access targets in prevention, care and treatment, and impact mitigation within a resilient programme environment. Throughout the entire framework, the programme will pay special attention to enabling government and civil society to promote and protect the rights of women, girls and PLWHIVs. The JUNCT estimates that implementing the five-year programme will require USD 80 million of which USD 38 million, or 47.5%, has already been pledged. Between 2006 and 2009, the JUNCT agencies have collectively provided USD 35 million to the national response to HIV & AIDS or 18% of Lesotho's total resource needs during that period. The new programme effectively doubles the UN contribution provided that the resource gap is filled. The JUNCT has committed itself to actively mobilizing the remaining balance from development partners, potential new bilateral and multi-lateral partners, and from within the global UN family itself.

8.2 GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA

Between 2007 and 2009, two new grant agreements were signed between the and the Global Fund. In this same period negotiations took place regarding a third grant and one new grant was awarded to Lesotho. The agreement for the Round 6 grant was signed in 2007. The value of the grant is

⁸⁰ The full programme document is available at <http://www.undp.org.ls/hivaids/default.php>

USD 5.5 million over five years.⁸¹ The focus of the grant is improving community mobilization and community involvement in TB prevention and treatment, strengthening laboratory services (an enhancement of similar activities funded under Round 2), improving the technical capacity of the management and leadership levels of the NTP, and ensuring that HTC and ART are integrated within TB diagnosis and treatment.

In 2008, the GOL signed the agreement for the Round 7 grant. The value of the grant is USD 33.2 million over five years. The focus of the grant is strengthening HIV diagnosis and treatment for children, scaling up life-skills programmes and peer education interventions for adolescents and youth in and out of school (started under the Round 2 grant), providing practical support and school bursaries for OVCs (in addition to the Round 2 grant contribution), and improving child protection systems. The grant will also support operational research activities, including the 2009 DHS and the revision of the OVC situational assessment.

In 2009, negotiations began for the completion of funding agreements for the Round 8 grant. Implementation of the grant is expected to start in early 2010. The grant has three main components: HIV, health systems strengthening, and scaling-up the management of MDR-TB. The value of the grant is USD 129 million. The HIV component addresses a comprehensive range of interventions in prevention, treatment, care & support, impact mitigation, HIV&TB collaboration, community systems strengthening, national policy development, reduction of stigma and discrimination, and, finally, renewing and expanding the evidence base through situational assessments, operational research projects, and expanded support for M&E systems at central, district and community level. As noted previously, for the HIV component, there are two PRs: the MOFDP and LCN. The HSS component of the Round 8 grant will enable the GOL to implement its health human resource retention strategy through a complete overhaul of job classifications and compensation levels for all categories of health care providers. The component will also strengthen central, district and local level capabilities in data capture and analysis. Finally, under this component, the grant will support improvements to all aspects of the logistics systems supporting the national HIV and TB programmes. The third component of the grant will support rapid scale-up of Lesotho's capacity to identify and treat cases of MDR and XDR TB. It is expected that over the life of the grant, in excess of 2,500 cases of MDR TB and XDR TB will be identified, managed and successfully treated.

In November 2009, the Lesotho CCM received news of the approval of its Round 9 submission. The value of the grant is USD 33 million and is expected to commence implementation by mid-2010. It focuses almost entirely on improving access for OVC to education, primarily secondary school, but also to literacy training and distance learning for children and youth not in school. The grant will provide school bursaries and practical support for between 5,000 and 7,000 OVC per year for five years. This will complement the ongoing provision of bursaries through the MOET. Round 9 will cover approximately 36% of the overall need while the MOET will cover the remaining 64%. In addition, the grant will support capacity development and expansion of the MOET bursaries unit. Finally, the grant will enable civil society organizations to work collaboratively with government to encourage swift enactment of a proposed new Child Protection and Welfare Bill. Following enactment, the grant will provide support for timely and efficient implementation of the new Act.

⁸¹ Full details regarding Lesotho's portfolio of Global Fund grants are available at www.gfcu.org.ls or <http://www.theglobalfund.org/programmes/country/?countryID=LSO&lang=en>.

In addition to these new commitments, the implementation of two other ongoing grants continued through 2008 and 2009. The Round 2 grant came to a close in June 2009. It was the first Global Fund grant to Lesotho and assisted the country to launch its intensified national response to HIV starting in 2004, in particular the national HTC, PMTCT and ART programmes. Phase II of the Round 5 grant began in 2007 and will come to a close in 2010. Expanding and stabilizing the national ART programme and increasing the skills of health care providers in HIV chronic care are the main priorities for this grant.

With these new commitments, in total, since the approval of the Round 2 grant in 2003, the Global Fund has pledged approximately USD 248 million to Lesotho for its HIV and TB programmes and for the improvement of its national health care system.

8.3 PEPFAR AND OTHER UNITED STATES GOVERNMENT (USG) PARTNERS

Between 2006 and 2009, PEPFAR the USG partners contributed 25% of the total resource requirement for HIV&AIDS and TB programmes for that period. It was the largest share of all contributors, including the GOL and the other development partners. Between 2008 and 2009, PEPFAR and the USG partners supported a broad range of interventions. This included efforts to improve rational pharmaceutical management of ARVs and other HIV-related drugs, supporting integration HIV and TB programmes, strengthening and expanding access to HTC, improving TB detection and diagnosis, and improving treatment and monitoring of HIV/TB co-infected individuals. The USG partners also supported community-based OVC interventions, small grants for community-based HIV&AIDS activities, and technical assistance to the MOHSW to train and retrain all health care providers. Through the US Peace Corps, the partners supported HIV & AIDS programmes in schools, peer education and support for adolescents and young people, capacity-building for HIV support groups, and locally-based interventions for OVC. In 2009, the USG partners renewed their support for Lesotho's NSP. From approximately USD 13 million in 2008, the USG commitment reached USD 27 million in 2009 and is pledged to remain at that level until 2014. This new commitment, covering the 2009-2014 period, is detailed in a five-year Partnership Framework that establishes clear priorities and expected outcomes.⁸² The plan is comprehensive and pledges to assist Lesotho to dramatically expand and improve the effectiveness of its prevention interventions, including BCC (with emphasis on reduction of multiple concurrent partnerships), HTC, male circumcision, condom promotion and distribution, PMTCT and targeted interventions addressing key populations. The plan will provide support to reach Lesotho's universal access targets for ART coverage while at the same time strengthening and stabilizing the national ART programme for the long-term. This includes providing ongoing, relevant training for health care workers involved in HIV care at the hospital, health centre and community level. The plan commits the USG partners to work collaboratively with other stakeholders to close the gaps in support for OVC. Finally, the plan makes a major pledge to support the GOL to address and ultimately resolve its health human resource training, recruitment and retention challenges.

8.4 MILLENNIUM CHALLENGE ACCOUNT

⁸² The full text of the framework is available at <http://www.pepfar.gov/frameworks/lesotho/index.htm>

The GOL's Millennium Challenge Account (MCA) programme, a component of which addresses the entire health sector, was approved by the US Millennium Challenge Corporation (MCC) in July.⁸³ Lesotho was one of the first countries in the African region to qualify for MCC support. The value of the agreement is \$362.6 million over five years with an overall goal of reducing poverty and increasing economic growth. The different projects covered by the agreement will focus on improving the provision of water supplies for industrial and domestic use, improving health outcomes, and removing barriers to foreign and local private sector investment. Approximately USD 140 million will be invested in the renewal of the country-wide health care infrastructure, across the central, district and local levels. Renovation and equipping of local health centres is a key component of the programme and will substantially improve Lesotho's ability to offer an essential health care package accessible to all Basotho at community level, including HIV and TB treatment. In addition, ART centres at hospital level will either be refurbished or rebuilt, or, where practical, existing outpatient facilities will be expanded to include capacity to support HIV care. The programme became effective in September 2008. It will close upon completion in 2013.

8.5 CLINTON HIV&AIDS INITIATIVE

Through the Clinton HIV&AIDS Initiative (CHAI), the Clinton Foundation provides technical support to the GOL for its HIV & AIDS programmes. The shared priorities include improving access to paediatric HIV treatment by ensuring that the national ART programme is accessible to children across the country. Through its global network, CHAI also works to provide access to lower cost paediatric ARV combinations and other HIV-related commodities. CHAI is a partner in the Rural Health Initiative launched by the MOHSW in 2006. The initiative provides ART in the most remote areas of Lesotho. CHAI has facilitated partnerships with PIH, Irish Aid, Mission Aviation Fellowship, BIPAI and others to support Lesotho's Rural Health Initiative. CHAI also works to bring innovative, community-level approaches for strengthening local ART programmes to Lesotho. For example, it has formed a partnership with World Bicycle Relief to supply bicycles to health providers and community health workers to assist them in their support for ART at community level. Other priorities that CHAI addresses in partnership with the GOL include health human resource recruitment and retention and procurement and supply management for ARVs and other HIV-related commodities.

8.6 WORLD BANK

Between 2004 and 2008, the World Bank supported an HIV&AIDS Capacity-Building and Technical Assistance Project. The value of the project was USD 5 million. It focused on building multi-sectoral capacity to manage and implement Global Fund programmes as well as addressing and resolving key weakness in the procurement and supply management process for health care products, including ARVs and other HIV-related supplies.⁸⁴ The project also funded the development of the BCC strategy, the improvement of community-level M&E capacity, and created a grants management unit within NAC. As the project closed, negotiations were underway for a second phase. The second phase was approved at the end of 2009 and will begin implementation in

⁸³ Details about the MCC commitment to Lesotho are available at <http://www.mcc.gov/mcc/countries/lesotho/index.shtml>

⁸⁴ The project completion report is available at <http://web.worldbank.org/external/projects/main?pagePK=64283627&piPK=73230&theSitePK=40941&menuPK=28424&Projectid=P087843>

2010. This next phase continues to provide technical assistance with respect to Global Fund programmes with the emphasis this time on the civil society sector, including LCN and its new responsibilities as a PR for Round 8. The project will provide technical assistance and support to NAC in its coordination and management role. Similar support will be provided to the MOHSW to address ongoing challenges within its national HIV&AIDS and TB programmes. Finally, the project will support the development of a health research management process and will provide capacity-building to local government structures and local community-based organizations. The value of the project is USD 5 million over a five- year implementation period ending in 2014.⁸⁵

In 2007, the World Bank signed a public-private-partnership agreement with Lesotho for the construction of a new, national, tertiary referral hospital.⁸⁶ The private partner is a regional consortium led by Netcare, South Africa.⁸⁷ The value of the partnership is M 850 million (USD 113 million).⁸⁸ Construction of the facility began in 2009. The new hospital is expected to open in 2011.

8.7 EUROPEAN UNION

In 2007, the EU committed € 11 million to support the NSP with a particular focus on OVC. The funding for this partnership project with the GOL is managed through UNICEF. The main contribution of the project to OVC in Lesotho is the development of the Lesotho Child Grants Programme (see above section 4.6.2). This initiative provides quarterly cash payments to destitute household caring for OVC. It follows an emerging global best-practice of providing unconditional cash transfers directly to destitute families.⁸⁹ The programme completed the pilot phase in 2009 and will roll-out shortly to selected other districts in Lesotho. Discussions have begun for additional support to the programme to commence in 2011. During this second phase, complete national coverage will be implemented and appropriate arrangements for long-term sustainability will be made.

In 2009, the EU-funded Local Governance and Non-State Actors Project began implementation targeting three of the northern districts in Lesotho.⁹⁰ The goal of the programme is to capacitate both local government structures and local community organizations to collaborate to address local development challenges. It is expected that many of the priorities identified by these entities will involve HIV-related issues, including support for PLWHIVs on treatment, improved community mobilization around HTC and BCC, income generation and food security, and support for OVC households.

⁸⁵ More details on the second phase of the project are available at <http://web.worldbank.org/external/projects/main?pagePK=64283627&piPK=73230&theSitePK=40941&menuPK=228424&Projectid=P087843>

⁸⁶ The text of the agreement and more details about the project are available at <http://web.worldbank.org/external/projects/main?pagePK=64312881&piPK=64302848&theSitePK=40941&Projectid=P104403>

⁸⁷ See http://www.netcare.co.za/live/netcare_content.php?Item_ID=5406&Revision=en/6

⁸⁸ See http://www.lesotho.gov.ls/articles/2008/GOVERNMENT_NETCARE_SIGN_M850.php

⁸⁹ See Save the Children (UK). 2009. Lasting Benefits. The role of cash transfers in tackling child mortality. Available: http://www.savethechildren.org.uk/en/docs/Lasting_Benefits.pdf. See also Blank 2008, op. cit. note 68.

⁹⁰ See http://www.lesotho.gov.ls/articles/2009/EDF_EARMARKS_M75MILLION.php

8.8 IRISH AID

Lesotho is the longest standing beneficiary of the Government of Ireland's foreign development aid programme (Irish Aid). Irish Aid has always worked closely with the GOL to provide assistance for health related priorities among others. Along this line, Irish Aid has consistently supported the national response to HIV & AIDS from its inception at the end of the 1980s until the present time. More recently, since 2006, Irish Aid has provided support for the extension of HIV and TB services to rural and remote communities living in mountainous areas in collaboration with Partners in Health, the Clinton Foundation and Catholic Relief Services. To address the need for human resources in the context of scaling up the roll out of ART in all areas of Lesotho, Irish Aid has partnered with the Clinton Foundation for the recruitment of 150 additional nurses from Kenya and Zimbabwe in addition to those engaged from Lesotho.⁹¹

In 2009, Irish Aid supported NAC to undertake a mid-term review of the NSP and to develop a revised, results-based approach for the remaining period of the strategy. Between 2006 and 2008, Irish Aid supported nine civil society organisations and two international non-governmental organisations (PSI and ALAFA) in HIV treatment, prevention and impact mitigation.

Through Irish Aid support to the education sector, 3,600 OVC have benefited from school bursaries and a book loaning scheme to ensure that all children, especially those most vulnerable, can access education, including access to text books and other learning materials. Irish Aid has also committed to strengthening the Joint UN Team on AIDS in Lesotho by funding a capacity assessment study and undertaking strategic information assessment on male circumcision. Technical support was also provided to the GOL during the development of the Round 7 and Round 9 proposals which together raised over USD 60 million to support OVC and youth-orient HIV interventions.

8.9GTZ

Between 2008 and 2009, GTZ, through its continued support to the MOLGC on decentralisation processes, financially, technically and logistically supported the strategic partnership of the MOLGC and NAC in the area of ESP implementation at local community council level (See section 4.5.6 above). At the end of 2009, GTZ supported the internal and external review of the ESP to inform the continuation of this programme through a Phase II implementation period. HIV&AIDS has been mainstreamed within all of GTZ's assistance programmes in Lesotho.

8.10 DFID

Through its southern region programme based in Pretoria, the Department for Foreign International Development (DFID), the Government of the United Kingdom's foreign development assistance agency, contributed £12 million to Lesotho between 2007 and 2009. The main priorities during this period were addressing HIV&AIDS, improving food security, and improving the economic and regulatory environment for trade and investment.⁹² DFID also supported Lesotho's participation in the Children and HIV&AIDS Regional Initiative. Through DFID, the UK contributes to grants provided to Lesotho by the Global Fund, World Bank,

⁹¹ More detailed information is available at <http://www.irishaid.gov.ie/lesotho.asp>

⁹² A detailed list of DFID-funded projects in Lesotho is available at <http://projects.dfid.gov.uk/SearchResults.asp?countrySelect=LS-Lesotho>

European Union, UNAIDS, UNICEF and other UN agencies. In addition, DFID supports ALAFA. In 2009, DFID funded the knowledge, attitudes and practices survey to demonstrate the effectiveness of the ALAFA intervention against all of the main indicators in the programme.⁹³

8.11 JAPANESE INTERNATIONAL COOPERATION AGENCY (JICA)

As described in section 5.0 above, JICA has been assisting the GOL, NAC and the multi-sectoral partners to improve national M&E capacity. This support continued throughout 2008 and 2009 and is set to remain in place for future years.

8.12 OTHER EXTERNAL PARTNER CONTRIBUTIONS

There are a number of smaller external contributions to individual projects and agencies in Lesotho. These funders include the Canada Fund for Local Initiatives, the Canadian International Development Agency, the Mennonite Central Committee, the Swiss Development Corporation, , the Government of China, the UK-based Prince's Fund, and Standard Bank, among others.

⁹³ See ALAFA 2009, op. cit. note 47.

9.0 DOCUMENTATION OF BEST PRACTICES IN HIV & AIDS RESPONSE IN LESOTHO

9.1 INTRODUCTION

In order for the HIV & AIDS response to be effective, organizations and countries need to develop and document their best practices for sharing knowledge, experiences, and lessons learned, both internally and externally. If interventions are documented and shared, they can contribute to a world of knowledge of what works and what does not, therefore resulting in successful interventions. This section presents highlights of some best practices in Lesotho documented for the 2009 UNGASS report. Two best practices have been identified. These are the Sentebale ‘Mamohato Network and Camps, and the CRS Mountain Orphans and Vulnerable Children Empowerment (MOVE) Project. The criteria used to select these projects were effectiveness, ethical soundness, cost effectiveness, relevance, replicability, innovativeness and sustainability.

9.2 SENTEBALE ‘MAMOHATO NETWORKS AND CAMPS

9.2.1 Background

In 2007, the Tšepong Counselling Centre conducted a study amongst 45 HIV-positive children ages 6 to 18. The findings of the study highlighted a serious lack of knowledge and communication about HIV & AIDS issues among infected children, their caretakers, families and friends in Lesotho. These findings indicated a pressing need for open communication about HIV & AIDS among the Basotho people, and more especially with children living with HIV & AIDS.

As a response to the findings of the study, in January 2008, Sentebale launched a pilot camp for HIV-positive children from Maseru in collaboration with the Association of Hole-in-the-Wall Camps, the Baylor College of Medicine Children’s Foundation–Lesotho, and the Bophelong Paediatric Clinic at Queen Elizabeth II Hospital. Thirty-two children between the ages of 12 and 18 from the Baylor and Bophelong clinics attended Camp ‘Mamohato where they participated in activities regarding living with HIV in a safe, supportive environment.

The pilot Camp ‘Mamohato programme aimed at improving communication about HIV & AIDS, beginning with the children who were already infected with the disease. The camp introduced child-to-child communication whereby children educated, supported and encouraged each other to remain healthy and to reduce the spread of HIV.

After the success of the pilot camp, the remainder of the year was spent establishing the ‘Mamohato Network model and planning for the future of the programme. The ‘Mamohato Network combines the powerful impact of camps with the continuous support and communication of follow-up programmes such as Teen Clubs, Caregiver Days and Camp Reunions to ensure a maximum, sustained impact on the children involved in the network.

The programme has three components namely Camp ‘Mamohato, Teen-clubs and Caregiver days. A camp is usually one week long and is held once or twice a year depending on the need, and each and every activity during camp has an underlying purpose to help the children grow and develop. Carefully selected camp staff balance educational, HIV-focused sessions with games, sports, arts and

crafts, and drama. Since the camp serves HIV-positive children, special sessions are designed to address healthy living with the virus. There is a nutrition session in which the children are taught about food groups and how to choose a balanced diet. There is also emphasis placed on the children's antiretroviral drugs and adherence to these medications. The doctors distribute medications to campers before breakfast and dinner every day during camp. All of the other camp activities focus on building positive characteristics and behaviours such as team work, leadership, healthy risk taking, self-expression and creativity. Staff members create a safe, encouraging environment meant to increase the children's self-esteem, confidence and assertiveness.

Teen-clubs are held on a monthly basis in the various health centres that Sentebale is working with including Baylor, Bophelong, Karabong and Scott hospital. Teen clubs are a continuation of what was taught during camp. All members of the teen clubs have been to the camps to ensure continuity and sustainability of the information they gathered during camp. During teen clubs the children have an opportunity to further interact with the medical team on issues such as adherence to ART and general understanding of HIV & AIDS. Social activities including sports and a variety of games. Caregiver days on the other hand assist parents and guardians of the children to understand HIV & AIDS and the importance of offering proper care and support to the children. The caregivers have commended the sessions saying they bring hope to them as parents which they in turn give back to the children. They say it is uplifting for them to know they are not alone in soldering on and encouraging the kids to adhere to treatment.

Building on the success of the first 'Mamohato Network in Lesotho, Sentebale and its partners organized a second season of Camp 'Mamohato in January 2009. Two sessions of the camp were held for children from the Baylor and Bophelong paediatric HIV clinics as well as the Karabong clinic at Mafeteng Hospital which is 'Mamohato's newest partner. Once again, the focus of the camp was on living healthy lives with HIV including adhering to antiretroviral medications, dealing with stigma and discrimination and preparing for the future.

9.2.2 Purpose

The mission of 'Mamohato Network and Camps is to offer the HIV-positive children of Lesotho recreation and key health education in a unique residential environment. Through activities that offer children self-awareness and growth, and through greater sensitivity to their environment, Camp 'Mamohato strives to empower children to become ambassadors for themselves and their communities.

The first goal of the Camp 'Mamohato Network is to increase life expectancy among HIV-positive children and adolescents in Lesotho. In order to obtain this goal, Sentebale and partners concentrate on teaching HIV-positive children how to live healthy lives, increasing clinic attendance and increasing adherence to antiretroviral drugs.

The second goal of the Network is to reduce the spread of HIV in Lesotho. To reach this goal, Sentebale and partners establish adolescent and youth networks which foster child-to-child communication resulting in children teaching other children about the disease. This goal also focuses on opening the lines of communication between children and their caregivers, families, friends and medical staff.

9.2.3 Effectiveness

The 'Mamohato Camps and Networks has created an environment in which over 500 HIV-positive children have been able to communicate openly among each other and with adults thereby breaking the silence that surrounds HIV & AIDS. The programme transformed the participants from being shy, withdrawn and timid into being confident, outgoing and happy despite their HIV status. The effect seen on the 500 children could be extended to other HIV positive children throughout Lesotho as the 2009 estimates reveal that in 2008 about 21,000 children were living with HIV.

9.2.4 Ethical soundness

Children who participate in this programme complete consent forms in collaboration with their caregivers to indicate their willingness to be part of the programme. As a result, no child is forced to participate. The staff working with the children have been thoroughly trained. The programme has also developed a policy on the use of photos whereby any child who feels uncomfortable with his or her photo being used in any document is respected and never featured. There is also a policy regarding the media to protect the privacy of children both at the camp and in the Teen Clubs.

9.2.5 Cost-effectiveness

The quality of the programme and its concomitant impact on the children justifies the funds used at the camp which are minimal compared to the benefits. The staff employs world-class techniques in educating the children on HIV & AIDS for they have received comprehensive training themselves. During Teen-Clubs locally available staff members from the clinics in partnership with Sentebale are utilized and the same goes for Caregiver Days. During the sessions one social worker and one medical officer work with Sentebale to undertake the club activities, and this ensures that clinic services remain available to other clinic users.

9.2.6 Relevance

The 'Mamohato Networks and Camps has proved to be a very relevant intervention targeting children up to 18 years. The emphasis is on support for children and adolescents to comprehend that a person can live a long and positive life even when infected with HIV. The programme is also relevant in preventing the further spread of HIV through awareness and education. It has proved to give hope to the participants and also provides them with an opportunity to be among a likeminded group. Therefore the children come to realize that there is life even when one is infected with HIV.

9.2.7 Replicability

The programme can easily be replicated through camps and teen clubs of children living with HIV & AIDS. In Lesotho, the programme started in Maseru, and it has since been introduced in the district of Mafeteng. Plans are underway for it to be rolled-out to Leribe as well. When replicated throughout the country, it will give hope to HIV-positive.

9.2.8 Innovativeness

The 'Mamohato programme has a unique programme focus on improving the lives of HIV-positive children and on strengthening the ability of parents and caregivers to provide appropriate support.

The caregivers have commended the project for providing them with coping mechanisms and relieving them of stress involved in taking care of their HIV-positive children. According to them, the children seem happier and more content with their lives more like children due to the programme.

9.2.9 Sustainability

The programme promises to be sustainable due to the commitment of the partners to enhance the quality of life of HIV-positive children in Lesotho.

9.3 CRS MOUNTAIN ORPHANS AND VULNERABLE CHILDREN EMPOWERMENT (MOVE) PROJECT

9.3.1 Background

In the mountain regions of Lesotho, communities are experiencing multiple negative effects related to the high HIV prevalence rate. As increasing numbers of adults are becoming sick and dying, the number of OVC continues to rise and outpace the communities' capacities for care and support. With this imbalance in need and capacity, social cohesion is slowly being eroded and OVC rights are threatened.

CRS Lesotho, with support from the NAC and Irish Aid, is implementing the Mountain Orphans and Vulnerable Children Empowerment (MOVE) project in the mountainous, rural and hard-to-reach communities of Lesotho in order to provide support and protection to vulnerable children. The programme operates in the communities of Bobete, Nkau and Nohana, in the districts of Thaba-Tseka and Mohale's Hoek. These areas can only be reached by air or on horseback. In these places, children wait eagerly for the sound of the plane that brings supplies and personnel to the only clinic in the area. The look on in awe as it lands and takes off as if it is the first time they have in seen it. It is the only thing that links them to the outside world. Formal employment is non-existent in these areas except for schools and the health clinic. The community survives mainly through subsistence farming.

The project was initiated in 2006 in conjunction with Partners in Health, Mission Aviation Fellowship, and Peace Corps who together provide assistance to improve access to health care in general and more specifically for HIV prevention, care and support services within the target communities.

9.3.2 Purpose

The project's focus is on supporting 6,000 OVC and 3,000 care givers in the three project areas. It was designed to meet the immediate needs of the children through interventions such as assistance with school enrolment. It also sought to enact long-term structural change by engaging and reviving community spirit and cohesion. The goal of the MOVE project is enable OVCs in the catchment areas of the Lesotho Flying Doctors Service to grow up in communities where their basic needs are met.

9.3.3 Effectiveness

MOVE's broad objectives were to strengthen the capacity of families to protect and care for OVC by prolonging the lives of parents, promoting food and nutrition security, and providing psychosocial and other support. It functions by mobilizing and supporting community-based responses. It ensures OVC's access to essential services, including education, basic health care, and psychosocial support. It raises awareness through social mobilization to create a supportive environment for children and families affected by HIV & AIDS. Its specific objectives are stated as improving education and training opportunities for OVC, especially girls, and to capacitate targeted communities to mitigate the socio-economic impact of HIV & AIDS. MOVE has reached over 5000 OVC, providing them with school uniforms, school fees in the form of resource exchanges with schools, and through sensitising the community on the importance of children attending school. The community has been trained on psychosocial support services for OVC, mobilised on production of food through provision of starter packs and gardening tools for growing vegetables. Most households, even those that are not vulnerable, have keyhole gardens in their yards. Having been trained on micro finance, the community is running a savings fund to cater for the needs of OVC and the members at-large.

9.3.4 Ethical soundness

Support groups take on a large share of the responsibility for the implementation of this project. They were one of the first groups of people, together with school teachers and community leaders, that were consulted to identify OVC in each area using the national OVC criteria and vulnerability scale. The community was trained on these guidelines to avoid community politics around selection of OVC. A conscious effort was made to identify children with disability for assistance, since such children are usually marginalised and kept away from the rest of the community and therefore denied essential services. The community has been involved all the way; and male involvement is beginning to pick-up momentum as they were sensitised on their own by male facilitators to understand the needs of children and women and provide the necessary support.

9.3.5 Cost-effectiveness

The MOVE project has personnel staying within the community, hiring accommodation at very low cost. The mode of transport in the rural areas is horses and they use these to reach all villages in the catchment areas at low cost. The community has been trained on keyhole and trench gardening and community fundraising mechanisms. They are provided with starter packs and, thereafter, they produce and sell surplus and use it to fund their community society. Some of the funds of the club are used to provide for other basic needs of OVC in the community. CRS also works in partnership with Mission Aviation Fellowship, who provide project staff with air transportation whenever needed.

9.3.6 Relevance

According to the community, MOVE responded to a need to address problems of mitigating the impact of HIV & AIDS on OVC as well as food security, which were major hindrances to children attending school. Children did not attend school because they did not have a uniform, or their parent or guardian did not see the importance of them going to school. Adequate care and support

is now enjoyed by OVC. Children who used to have one meal per day are now able to have three meals per day due to thriving vegetable gardens run by the community.

9.3.7 Replicability

MOVE has the potential of becoming a national OVC response model as it is holistic in nature, covering issues of basic needs for OVC, HIV & AIDS education, community training on income generating activities and psychosocial support. The project can be replicated in other remote areas where services are not readily accessible.

9.3.8 Innovativeness

The holistic nature of the project to reach both OVC and the rest of the community with the vision to continue provide care and support to OVC as opposed to the usual provision of food packages to OVC has allowed for full participation and ownership of the intervention by the community.

9.3.9 Sustainability

The MOVE project has adapted a 'phase out approach' to exit the community. This is being achieved by minimizing the need for external inputs, strengthening the community's capacity and transferring responsibilities. In order to ensure maximum time necessary to achieve sustainability in the target area, in the final twelve months of the three-year project, the project gradually hands over to the local structures to spear-head the project. The community, including OVCs, has been trained on the importance of good nutrition and food production, given starter-packs and gardening tools, and are now able to produce for both consumption and sale. Having been trained in micro finance, each village has a savings fund, run by community members, to cater for other basic needs of members and as well as for OVC.

10.0 LIST OF ORGANISATIONS THAT PARTICIPATED IN THE 2009 UNGASS PROCESS

LINE MINISTRIES & GOVERNMENT AGENCIES

Ministry of Agriculture & Food Security
Ministry of Education & Training
Ministry of Finance & Development Planning
Ministry of Gender, Youth, Sports & Recreation
Ministry of Health & Social Welfare
Ministry of Justice, Human Rights & Correctional Service
Ministry of Local Government & Chieftainship
National AIDS Commission
National Assembly
Lesotho Correctional Services
Lesotho Defence Force
Lesotho Mounted Police Services

DEVELOPMENT PARTNERS

European Union
GTZ
Irish Aid
PEPFAR (for all of the USG Partners in Lesotho)

UN AGENCIES

UNAIDS
UNDP
UNESCO
UNFPA
UNICEF
WHO
WFP

NON-GOVERNMENTAL ORGANIZATIONS

Action Aid International Lesotho
Apparel Alliance Lesotho to Fight AIDS
Baylor Children's Clinical Center of Excellence on HIV&AIDS
CARE Lesotho/South Africa
Catholic Relief Services

Communication for Change Project
Elizabeth Glazer Paediatric AIDS Foundation
Habitat for Humanity
ICAP
Lesotho Council of NGOs
Lesotho Inter-religious AIDS Consortium
Lesotho National Federation of Organizations for the Disabled
Lesotho Network of AIDS Service Organizations
Lesotho Network of People Living with HIV&AIDS
Lesotho Planned Parenthood Association
Lesotho Red Cross Services
Lesotho Youth Federation
Matrix Discussion Group
Monna ka Khomo/Lesotho Herd Boys Association
Mothers-2-Mothers
Non-governmental Coalition on the Rights of the Child
PACT Lesotho
Partners in Health
Phela Communications
Population Services International
Solidarmed
Touch Roots Africa
National University of Lesotho
Sentebale

11.0 REFERENCES

- ALAFA. 2009. Follow-up HIV Sero-Prevalence Study Report. Maseru, LS: ALAFA.
- Andersson N et al. 2007. Risk factors for domestic violence: national cross-sectional household surveys in eight southern African countries. *BMC Women's Health* 7(11): 1-13.
- Blank L. 2008. Lesotho Children Grant Pilot Operations Manual. Maseru, LS: UNICEF.
- CIET .2008. Survey of HIV and AIDS related knowledge, attitudes & practice. PowerPoint Presentation. May 2008.
- CRS/WVI/USAID/PEPFAR. 2009. Lesotho Faith-Based HIV Prevention Campaign: Baseline Survey Report April 2009. Maseru, LS: CRS.
- GOL/UNAIDS/NAC. 2005. UNGASS country report: Status of the national response to the 2001 declaration of commitment on HIV/AIDS.
- GOL. 2007(a). National Action Plan on Women and Girls and HIV&AIDS: Facing the Future Together 2007-2011. Maseru, LS: MoGYSR.
- GOL. 2007(b). National antiretroviral treatment guidelines. Maseru, LS: MOHSW.
- GOL. 2007(c). PMTCT Scale-up Plan. Maseru, LS: MOHSW.
- GOL. 2008. Behaviour change communication in Lesotho: National behavior change communication strategy 2008-2013. Maseru, LS: NAC/MOHSW.
- GOL/WHO/UNAIDS. 2008. Male Circumcision in Lesotho: Situational Analysis Report. Maseru, LS: MOHSW.
- GOL. 2008(a). Know Your Status Campaign Review Report. Maseru, LS: MOHSW.
- GOL. 2008(b). Lesotho Food Security and Vulnerability Monitoring Report May 2008. Maseru, LS: Office of the Prime Minister.
- GOL. 2008(c). Lesotho Sentinel Survey Results 2007. Maseru, LS: MOHSW.
- GOL. 2008(d). Lesotho UNGASS country report. Status of the national response to the 2001 declaration of commitment on HIV/AIDS. January 2006-December 2007. Available: http://data.unaids.org/pub/Report/2008/lesotho_2008_country_progress_report_en.pdf
- MOJHRCS /LCS. 2008(e). Situation assessment of the LCS HIV & AIDS situation. Maseru, LS: LCS.
- GOL. 2008(f). Statistical Yearbook. Maseru, LS: MOFDP/BOS.
- GOL. 2009(a). Annual Joint Review Report 2008/2009. Maseru, LS: MOHSW.

GOL. 2009(b). Lesotho HIV Prevention Response and Modes of Transmission Analysis. Maseru, LS: UNAIDS/NAC/MOHSW.

GOL.2009(c). Lesotho Output Monitoring System for HIV & AIDS (LOMSHA) Operations Manual. Maseru, LS: NAC.

GOL. 2009(d). Lesotho 2006 Population and Housing Census. Maseru, LS: MOFDP/BOS.

GOL. 2009(e). National Guidelines for the prevention of Mother to child transmission of HIV. Maseru, LS: MOWSW.

GOL. 2009(f). Revised national guidelines for HIV testing and counseling [HTC]. Maseru, LS: MOHSW

GOL. 2009(g). Revised National HIV & AIDS Strategic Plan 2006-2011. Maseru, LS: NAC.

GOL/UNAIDS. 2009. Lesotho Sentinel Survey Results 2008. Maseru, LS: MOHSW

GOL/NAC. 2009. Report of the mid-term review of the national HIV & AIDS strategic plan 2006-2011. Maseru, LS: NAC.

GOL/UNAIDS. 2009. Lesotho Sentinel Survey Results 2008. Maseru, LS: MOHSW.

GOL/UNAIDS. 2009. National HIV and AIDS Estimates for Lesotho. PowerPoint Presentation. Maseru, LS: MOHSW/UNAIDS.

GOL/UNICEF. 2009. Communication for social and behavior change: Operational framework for young people. Maseru, LS: MOHSW.

GOL/UNICEF/EU. 2009. Support to Lesotho HIV & AIDS Response: Empowerment of Orphans and Vulnerable Children. Revised Description of Action. Maseru, LS: UNICEF.

GOL/USG.2009. Partnership framework to support implementation of the Lesotho national HIV and AIDS response. Available: <http://www.pepfar.gov/frameworks/lesotho/index.htm>

GOL. 2010(a). Health sector policy on comprehensive HIV prevention (DRAFT). Maseru, LS: MOHSW

GOL. 2010(b). Lesotho 2009 Sentinel Survey Report. Maseru, LS: MOHSW.

GOL. 2010(c). Report on HIV Drug Resistance Early Warning Indicators (HIVDR EWIs) Monitoring in Lesotho (DRAFT). Maseru, LS: MOHSW.

Hercules A. et al. 2009. Technical assistance to conduct the identification and formulation of €27M human development programme. Maseru, LS: EU/UNICEF.

- Joint Learning Initiative on Children & HIV & AIDS. 2009. Home Truths: Facing the Facts on Children, AIDS and Poverty. Available: <http://www.jlica.org/protected/pdf-feb09/Final%20JLICA%20Report-final.pdf>
- Khantsi M. 2009. Life skills education data from primary and secondary schools around Maseru. Maseru, LS: MOET.
- Kimane I, Ntimo-Makara M, Lebuso M. 2009. Study on Sexual and Reproductive Health Issues and HIV in the Context of Youth People in Lesotho. Roma, LS: NUL-CONSULS
- MOET/UNICEF 2010. An assessment of the bursary scheme for orphans and vulnerable children (OVC). Maseru, LS: MOET.
- MOHSW/UNICEF. 2008. Capacity assessment of adolescent friendly health services in Lesotho. Maseru, LS: MOHSW.
- MOLE. 2008. Guidelines for Implementation of the Labour Code Amendment Act No. 5 of 2006. Maseru, LS: MOET.
- Moleli-Habi. 2009. HIV & AIDS-related Conditions within the Private Sector in Lesotho: Formative Assessment. Maseru, LS: UNAIDS.
- MOLGC/GTZ. 2009. An External Review of the Essential HIV & AIDS Services Package. Maseru, LS: NAC.
- NAC. 2008. Assessment of National and Sectoral HIV M&E Systems in Lesotho. Maseru, LS: NAC.
- NAC. 2009(a). Gender and Multiple Concurrent Partnerships in Lesotho. Maseru, LS: NAC.
- NAC. 2009(b). Situational Analysis Report for the Development of HIV & AIDS Strategic Plan 2009-2011 for the Herd Boys' Community in Lesotho. Maseru, LS: NAC.
- PBMS. 2008. Rapid Assessment in Select Public and Private Organisations Report. Maseru, LS: NAC
- SADC. 2006. Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa Report. Gabarone, BT: SADC Secretariat.
- SADC. 2009. Global Fund Round 9 Multi-Country Proposal: HIV Cross-border Initiative. Available: <http://www.theglobalfund.org/programs/portfolio/?CountryId=MAS&Round=9&lang=en>
- Save the Children (UK). 2009. Lasting Benefits. The role of cash transfers in tackling child mortality. Available: http://www.savethechildren.org.uk/en/docs/Lasting_Benefits.pdf
- Senkhome Consultants. 2008. HIV and HIV Management Survey (DRAFT). Maseru, LS: NAC.

- UNAIDS. 2008. Lesotho: Progress towards universal access and the declaration of commitment on HIV/AIDS. Available: http://www.unaids.org/en/KnowledgeCentre/HIVData/mapping_progress.asp
- UNAIDS. 2009. AIDS Epidemic Update: Geneva, CH: UNAIDS. Available: http://data.unaids.org/pub/Report/2009/JC1700_Epi_Update_2009_en.pdf
- UNAIDS. 2009. United Nations General Assembly Special Session on HIV/AIDS; monitoring the declaration of commitment on HIV/AIDS: guidelines on construction of core indicators 2010 reporting. Available: http://data.unaids.org/pub/Manual/2009/jc1676_core_indicators_2009_en.pdf
- UNDP/NAC 2010. A cross-sectional assessment of population demographics, sexual practices, HIV risk status, and human rights contexts of sexual minorities in Lesotho. Maseru, LS: UNDP/NAC.
- UNDP. 2009. Human Development Report. Geneva, CH: UNDP. Available: http://hdrstats.undp.org/en/countries/data_sheets/cty_ds_LSO.html
- UNDP. 2009. The joint UN Programme of Support on AIDS in Lesotho 2009-2012. Available:
- USAID 2010. Regional assessment on HIV-prevention needs of migrants and mobile populations in Southern Africa. Available: <http://www.undp.org/ls/hivaids/default.php>
- WFP. 2007. Lesotho Food and Nutrition Fact Sheet. Geneva, CH: WFP
- World Bank. 2005. Primary and Secondary Education in Lesotho: A Country Status Report. African Human Development Working Papers Series 101. Available: http://siteresources.worldbank.org/INTAFRICA/Resources/no_101.pdf