The Government of Lesotho

Report of the Mid-Term Review of the National HIV and AIDS Strategic Plan 2006 - 2011

National AIDS Commission
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Table of contents

List of Tables

Acknowledgments

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National AIDS Commission, Lesotho

Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ANC	Ante-Natal Clinics
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behaviour Change Communication
CCM	Country Coordination Mechanism- Global Fund
CRIS	Country Response and information System
DCPT	District Child Protection Team
DFID	Department for International Development (United kingdom)
DNA	Dioxyribose Nucleic Acid
EU	European Union
FAO	Food and Agriculture Organisation
GBEM	Girls & Boys Education Movement
GIPA	Greater Involvement of People living with HIV-AIDS
GOL	Government of Lesotho
GTZ	German Technical Assistance
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
IEC	Information Education & Communication
ILO	International Labour Organisation
KYS	Know Your Status (Campaign)
LBTS	Lesotho Blood Transfusion Service
LDHS	Lesotho Demographic Health Survey
LENEPWA	Lesotho Network of People Living with HIV-AIDS
LIPAM	Lesotho Institute of Public Administration & Management
LIRAC	Lesotho Inter- religious AIDS Council
LPPA	Lesotho Planned Parenthood Association
M&E	Monitoring & Evaluation
MGYSR	Ministry of Gender, Youth, Sport and Recreation
MOET	Ministry of Education and Training
MOHSW	Ministry of Health and Social Welfare
NAC	National AIDS Commission
NGO	Non-Governmental Organisation
NOCC	National OVC coordination committee
OPD	Out Patient Department
OVC	Orphan and Vulnerable Children
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	Prevention of Mother To Child Transmission
PSI	Population Services International
SAFAIDS	Southern African HIV/AIDS Information Dissemination Services
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USG	United States Government
WFP	World Food Programme
WHO	World Health Organisation

1. Executive Summary

The multi-sectoral National Strategic Plan (NSP) for HIV and AIDS was developed and launched in 2006. It covers a five-year period from 2006-2011. The NSP was developed through an extensively participatory process following the joint review of the national multi-sectoral response to HIV and AIDS in 2005. From October 2008 to April 2009, the National AIDS Commission in collaboration with its stakeholders and partners who are involved in the national response to the HIV and AIDS commissioned the Mid-Term Review (MTR) of the NSP. The purpose of the review was to take stock of the national response through determining progress made, identifying challenges and programme gaps together with emerging issues. The joint review process adopted a participatory approach which involved consultations with key stakeholders at national and district levels. The MTR report will inform the revision of the current NSP (2006-2011) and the development of the two-year National Operational Plan (2009-2011).

The HIV prevalence in Lesotho is the third highest in the world currently standing at 23.2%[1].
It is evident that the prevalence pattern has not changed much since 2004 when the first Demographic and Health Survey was conducted. In particular the drivers of the epidemic have not changed as confirmed by recent studies that include the Modes of Transmission Study (MOT) and the study on Multiple and Concurrent Partnerships among others. The identified epidemic drivers include the following:

- Multiple and concurrent sexual relationships;
- Inter-generational sex;
- Early sexual debut;
- Mother to Child Transmission;
- Income inequality compounded by poverty and food insecurity;
- Migration and mobility;
- Alcohol and drug abuse;
- Gender based violence; and
- Some cultural practices that expose vulnerable groups to HIV infection.

It is also evident that in-spite of the high levels of HIV and AIDS awareness, the level of comprehensive knowledge remains low. The awareness and existing levels of knowledge has not translated into desired behaviour change.

The objective of the NSP review was to establish the extent to which the plan had been implemented and achieved its set objectives and targets in the four thematic areas of (a) management, coordination and support, (b) prevention, (c) Treatment, care and support, and (d) impact mitigation. The review further considered emerging issues, lessons learnt, gaps and challenges encountered during the implementation of the NSP. The review process was informed and guided by the Terms of Reference (TOR) as outlined in Annex 3.

In terms of institutional arrangements for the review a multi-sectoral Review Core Team (Committee) and the NSP Review Advisory Forum were established and then the review guidelines, and data collection tools were then developed. Stakeholders were sensitised and mobilised to participate in the review process.

[1] Lesotho analysis of prevention Response and Modes of Transmission Study, ver.3.0 Jan 31st 2009 and Ministry of Health and Social Welfare Strategic Plan 2008-2011'

A comprehensive desk review was conducted to establish performance of the country on implementing the plan with regard to meeting the set objectives and targets. Documents reviewed included progress reports, technical and research studies, concept papers, policies and programme guidelines which were obtained from a variety of sources including NAC, development partners, civil society organisations including organisations of people living with HIV and AIDS (PLHIV), private sector, Government Ministries and in particular Ministry of Health and Social Welfare (MOHSW).

The stakeholders participated in the joint review of the NSP in different ways ranging from the consultative meetings, individual interviews, to providing the necessary documents.

The Findings of the Review of the National HIV and AIDS Strategic Plan

The review of the NSP focused on four strategic focus areas i.e. Management, Coordination and Support Mechanisms; Prevention; Treatment, Care and Support and Impact Mitigation. Under each of the strategic areas, the review focused on the implementation of the identified programmes and in particular the performance towards realising the strategic objectives.
The findings of the review that cover assessment of Capacity and Programme Gaps, background information, achievements, challenges, recommendations and emerging issues for each of the strategic focus areas are well articulated in the document.The review has also considered the effectiveness of strategies, stakeholder participation, service coverage and uptake.

2. Background Information

2.1 Introduction

This document is a report of the Mid-Term Review (MTR) of the National HIV and AIDS Strategic Plan (NSP) - 2006-2011. The joint review was undertaken by the National AIDS Commission (NAC) in consultation with other stakeholders involved in the national response to HIV and AIDS. The Process of the review started in October 2008 and was completed in April 2009.

2.2 The Objectives and Scope of the NSP Joint Review

The objective of the NSP review was to establish the extent to which it had been implemented and achieved its set objectives and targets in the four thematic areas i.e. (a) management, coordination and support, (b) prevention, (c) Treatment, care and support, and (d) impact mitigation. The review further considered emerging issues, lessons learnt, gaps and challenges encountered during the implementation of the NSP. The review process was informed and guided by the following Terms of Reference (TOR)

i. To collect any new evidence on the drivers of the epidemic in Lesotho that have emerged in the past 3 years (to assess whether HIV services provided and target groups reached are relevant to the drivers of the epidemic) ;
ii. To assess which HIV services (those defined in the NSP and those not originally defined in the plan) have been delivered by stakeholders from various sectors in the past 3 years;
iii. To assess the coverage of HIV services in Lesotho (to determine whether the HIV response is of an appropriate scale);
iv. To assess the extent to which HIV services have been provided to most at risk populations;
v. To assess the extent to which an enabling environment is in existence for implementing the NSP;
vi. To assess the effectiveness of managing the HIV response in all sectors at all levels;
vii. To assess the resources mobilised and utilised by all sectors since the start of the NSP and the resources committed for the remainder of the NSP implementation period;
viii. To assess the challenges and gaps in terms of HIV service delivery, the enabling environment, and M&E of the national response; and
ix. To assess whether HIV stakeholders are collecting, capturing, storing, processing, disseminating and using appropriate information about HIV response, the drivers of the epidemic, and the outcomes of the HIV response;
x. To identify and indicate any emerging issues relevant to HIV and AIDS and need consideration in revised National Strategic Plan.

2.3 The NSP Review Process, Methodology and stakeholders Participation

The Process

The review process started with the development of a concept note that articulated the objectives, scope and the methodologies. This was followed by articulating the review coordination mechanisms. A multi-sectoral Review Core Team (Committee) and the NSP Review Forum were established. The review guidelines, and data collection tools were then developed. Stakeholders were sensitised and mobilised to participate in the review process.

The Methodology

In the process of collecting data and relevant information the review process used a combination of participatory methodologies ranging from stakeholder consultation meetings at national and district levels, interviews with key stakeholders' representatives, and an in-depth literature review. Stakeholder consultations were used to establish the perceptions of the stakeholders on the extent to which the NSP was implemented, what achievements were made, as well as identifying and documenting emerging issues, the challenges they encountered in the process of implementing NSP activities. The consultations were also used to identify existing or emerging programme and coordination gaps in the context of the multi-sectoral national response. Interviews with key informants were used to generate technical data and validate information obtained through the consultative meetings or literature review. Consultative meetings were held both at national and district level. At national level consultations involved key stakeholders including government ministries, UN agencies, bilateral development partners, and umbrella civil society organisations and selected private sector companies. At district level, consultations were mainly with district level institutions including District Councils, District AIDS Committees, Representatives of Civil Society operating at district level, and from the Community Councils AIDS Committees. Stakeholders were also involved.

A comprehensive desk review was conducted to establish implementation and performance evidence that was supportive of the achievement of NSP objectives and targets. Documents reviewed were obtained from a variety of sources including NAC, development partners, civil society organisations including organisations of people living with HIV and AIDS (PLHIV), private sector, government ministries and in particular Ministry of Health and Social Welfare (MOHSW). The documents reviewed included progress reports, technical and research studies, concept papers, policies and programme guidelines.

Stakeholders' participation

The stakeholders participated in the joint review of the NSP in different ways ranging from the consultative meetings, individual interviews, providing documents for reviews. Stakeholders also participated in the various forums organised and the having representation in the NSP Review Forum.

3. The status of HIV and AIDS in Lesotho

3.1 HIV prevalence Levels and Trends

HIV prevalence among people aged 15-49 years is estimated at 23.2% (women -26.4% and men – 19.3%)[2]. By 2007 the daily HIV infection rate was estimated at 58 new infections[3] years. According to the Lesotho Demographic and Health Survey (LDHS 2004), infection among people aged 15-19 was 5.3% and among 20-24 year-olds was 19.2%. The LDHS noted that infection increased significantly among people aged 25 – 39 years with a low rate of 33.2% increasing to a high rate of 41.6%. The LDHS found that HIV prevalence was higher (39.2%) in women than men less than 30 years. This finding reversed among people aged 40-49 years where men had higher prevalence rates of 31% compared to women with 23%. Prevalence among divorced or separated men and women was highest (women =51%, men=37%) compared to the never married persons (women=15%, men =9%). Prevalence in married or co-habiting persons was 27% for women and 33% for men. Available data shows lower prevalence rates in rural (29.1%) compared urban areas with 21.9%.

[2] Lesotho Demographic and Health Survey 2004)
[3] Lesotho Analysis of Prevention Response and Modes of Transmission Study, (ver. 3 January 2009)

The 2007 Sentinel surveillance show a decline of prevalence among ANC clients from 27% in 2005 to 25.7% in 2007. The survey indicates that prevalence varied between age groups. Prevalence among people aged 30-40 years was 40.2%, and for people in the age bracket 25-29 years was 36.1%. The 2007 Sentinel surveillance showed a slight downward trend in prevalence among young women aged 15-24 years with prevalence dropping from 11% in 2005 to 8.9% in 2007.

The recent Lesotho Analysis of Prevention Response and Modes of Transmission (2009) indicate that the annual incidence rates has stabilised at approximately 1.7%. This is significant progress compared to 2.9% in 1995 and 2.35% in 2007[4]. Annual incidence rates among children has halved in the last 8 years to 0.17%.

The sentinel HIV/Syphilis survey showed that the prevalence of HIV among STI patients was high at 56.2%. Among young people aged 15-19 and 20-24 years, HIV prevalence among STI clients was around 20% and 40% respectively compared to the prevalence among young people surveyed in 2004 (LDHS) which was at 7.72%. The Sentinel HIV Surveillance (2007) showed that 1.4% of ANC clients and 2.3% of STI clients were infected with syphilis. STIs were among the top ten causes of frequent Out Patient Department (OPD) consultations at health facilities in 2006.

By the end of 2007, approximately 270,273 people were living with HIV and AIDS. Of these 11,801 were children[5] . The epidemic has had a gender bias. The review noted that 153,581 (56%) of PLHIV were females compared to 116,692 (44%) males[6]. Of the 46,116 young people aged 15-24 living with HIV 33,174 (71.9%) are women. Eighty percent (80%) of people with TB are said to be infected with HIV[7].

The number of people who died of HIV in 2007 was estimated at 18,244[8]. As more people die so do the increase in the number of OVC. The total number of children orphaned due to AIDS has increased from 88,500 in 2005 to 108,700 in 2008.

By the end of 2007, approximately 81,270 were in need of compared to 88,500 people who were in need of ART in 2005[9]. By 2008, ART coverage increased to 45% (38,586)[10]. In 2007, the number of pregnant HIV positive women who received anti-retroviral treatment to prevent mother to child transmission (PMTCT) was estimated to be 3966. Available data indicate that PMTCT coverage increased from an estimated 5% in 2005 to 31% in 2007. Antenatal care, postnatal care (PNC) and PMTCT were being offered in 19 hospitals and 116 health centres out of 167 public health facilities. PMTCT coverage has increased from 5.9% in 2005 to 31% in 2007[11].

Although life expectancy has improved slightly from 36.81 (2006) to 42.6 years in 2009[12], overall population growth has drastically slowed down to about 0.1% in 2009[13]

By the end of 2007, the cumulative number of people who had tested and received results was 229,092. Although there has been significant progress, HIV testing still remains low at only 12% of

[4] NAC, 2008 "Overview of the National with specific focus on Prevention",- Power point present
[5] Ibid (2)
[6] Ibid (3)
[7]Ibid (2)
[8] Ibid (2)
[9] Ibid (3)
[10] Lesotho Analysis of Prevention Response and Modes of Transmission (MOT) Study,2009
[11] Ibid (8)
[12] Reviewing "Emergencies" in HIV and AIDS affected Countries in Southern Africa: Shifting the Paradigm in Lesotho, Kwame Owuso-Ampomah et al, 2009
[13] Ibid (8)

the total population. The population is currently estimated at 1.88 million. Lesotho offers both provider and client initiated HTC from 161 health facilities.

The Mid-term review of the NSP noted that approximately 376,318 out of school youth were trained in life skills based HIV and AIDS education in 2006. This number increased to 408,529 by September 2008[14]. According to the LDHS 2004, the school attendance among orphans and non-orphans aged 10-14 in Lesotho was 1:1. This has been achieved by making primary education free, providing bursaries and supporting offers with education needs such as books and uniforms. By 2008, 32% of OVC were receiving free basic support.

Lesotho has identified vulnerable groups through a number of studies. These groups include people with disability, men who have sex with other men (MSM), sex workers, herd boys and migrant populations. It was the intention of the NSP to address challenges posed by HIV and AIDS on vulnerable populations. These intentions are mainly articulated under the NSP impact mitigation component. However, the mid-term review noted that empirical data on the extent of HIV and AIDS among these groups was largely lacking with the exception of PLHWA, women and the girls where some limited data was available. With regard to sex workers, the LDHS (2004) reported that approximately 1.7% of men had paid for sex in the last twelve months. Fifty eight percent (58%) of them reported having used a condom in their most recent sexual intercourse. The recent Mode of Transmission study confirmed the presence of men who have sex with men (MSM) in Lesotho. Similarly there is no HIV prevalence among MSM.

3.2 The Drivers of the Epidemic

The NSP has not categorically identified the key drivers of the epidemic in Lesotho. The drivers have been articulated in the National HIV and AIDS Policy. However, the following drivers have been mentioned intermittently across the strategic plan document.

- Multiple and concurrent sexual partners – this is common in Lesotho;
- Unemployment;
- Poverty and food insecurity;
- Alcohol and drug abuse ;
- Migrant labour –mainly to South African mines that have provided employment for most people;
- Gender inequality and gender based violence: promoted by low social economic status and legal positions for women. – women not empowered to make decisions on their lives;
- Inter-generational sex.

[14] NAC, 2008 “Overview of the National with specific focus on Prevention”,- Power present

3.3 The National Response

Political & Leadership commitment

i. Lesotho established the National AIDS Commission in 2005 and the commission became fully operational in 2006. The commission is responsible for coordinating the national response to HIV and AIDS. However, Ministry of Health and Social Welfare is responsible for coordinating the health sector response;
ii. Having developed the national universal targets, Lesotho has embarked on implementing the National Strategic Plan with the hope of achieving universal access by 2010;
iii. Political commitment by politicians, religious leaders, people living with HIV and AIDS, traditional leadership has been consistent since 2000. Politicians continue to speak about HIV public meetings and events. To promote the campaign "know your status" the Right Honourable, the Prime Minister with other leaders took a HIV test in public. The campaign is also intended to support stigma and discrimination reduction;
iv. In 2007, 15 senior Christian church leaders from various denominations issued a signed statement of commitment on HIV and AIDS in the presence of His Majesty King Letsie III and the Rt. Honourable, the Prime Minister Pakalitha Mosisili. Since then church leaders have spoken openly on issues of HIV and AIDS;
v. The Lesotho Inter-Religious AIDS Consortium was established to facilitate coordination of faith based response to HIV and AIDS;
vi. LENEPLWHA is increasingly becoming a strong force in coordination of the PLHIV response and support and in particular promoting the GIPA principles. LENEPWA has actively participated in the development of the National AIDS policy, strategic plan and M&E plan, in the consultations land drafting of the draft National AIDS Bill. PLHIV are represented in national decision–making bodies like CCM, National HIV and AIDS Forum and the Multi-sectoral Partnership Forum;
vii. The NAC Board of Commissioners, the senior management and staff took a HIV test in public to demonstrate commitment and leadership in the response to HIV and AIDS.

4. The Findings of the Review of the National HIV and AIDS Strategic Plan

The review of the NSP focused on four strategic focus areas i.e. Management, Coordination and Support Mechanisms; Prevention; Treatment, Care and Support and Impact Mitigation. Under each of the strategic areas the review focused on the implementation of the identified programmes and in particular the performance towards realising the strategic objectives. The review has also considered the effectiveness of strategies, stakeholder participation, services coverage and uptake.

The following section articulates the review findings

4.1 Assessment of Capacity and Programme Gaps

The following tables attempt to provide capacity assessment for the implementation of the NSP and programme gaps.

4.1.1 Capacity and programming Gaps and Challenges

The following are identified capacity and programming gaps identified during the MTR process.

Table 1: *Capacity Gaps and Challenges*

Area of Assessment	Description of Capacity Gap	Suggested Strategies for mitigation
ART	• Uptake of ART is slow in both children and adults. • To focused on providing ART rather than preventing people progress on ART	• Build capacity to increase provision of ART including paediatric ART • Introduce PRE-ART interventions
BCC	• Interventions are fragmented, generic in nature • No targeted interventions for MARP groups	Develop a national Prevention Operational Strategy focusing on NSP priorities and key epidemic drivers
Condoms	• Low levels of condom use	• Increase distribution points
Coordination	• The mandate of NAC is not universally a accepted by all stakeholders. • Inadequate support and leadership on the part of key stakeholders i.e. politicians including the office the Prime Minister • Mainstream of 3-Ones principles not done across all sectors	• Lobby the Prime Minister for greater involvement and commitment by his office, the Senate and the Parliament • Organise briefings for all stakeholders on coordination modalities and the statutory requirements • Implement the National Coordination Framework
Data	• Data management is extremely weak. Data is missing or not documented.	• Strengthen data management systems in all sectors • Strengthen the national M&E framework • Undertake critical research studies to generate data needed for evidence based decision making
Indicators	• In most cases not measurable, not clearly defined • Indicators are not harmonised i.e. NSP / GFATM/ MOHSW	• Revisit the indicators and re-formulate them and with measurable baselines and targets • Develop a national indicator reference including UA and MDG indicators
Human Resource	• Inadequate skilled and experienced human resources • High levels of attrition especially in the health sector and among civil society organisations	• Develop a capacity building programmes • Recruit additional skilled and experienced staff. • Develop a staff retention strategy
Impact mitigation	• The impact mitigation is inadequately developed and not comprehensive enough. • No data on the extent of the problem and vulnerable groups affected. • Interventions are not sustainable	• Collect data and conduct an Quality of Impact Mitigations services to set the stage for the next NSP planning based on evidence and focused on results

M&E	• Lack capacity to manage HIV and AIDS data.	• Institutionalise CRIS • Operationalise the GIS • Improve data collection tools. • Strengthening reporting capacity
OVC	• Support for OVC is not clearly defined and seem fragmented	• Develop an National OVC Action Plan to operationalise the OVC policy
Partnerships development	• Collaboration between MoHSW and NAC is very weak •	• Convene a high level meeting to articulate the partnership based the respective mandates
Planning	• The current planning is more of service delivery rather than results (impact / outcome) focused.	• Build capacity for RBM and Evidence based planning
Prevention	• Low coverage of prevention programmes • Inadequate funding for Prevention	• Increase funding • Develop a national prevention operational plan
Programme Development	• Inadequate use of evidence in programme design and planning • Programmes are not adequately targeting the key epidemic drivers	• Review programme interventions and apply available evidence in planning
Sustainability	• The NSP sustainability strategy is not defined. Current NSP is heavily dependent on external	• Develop a sustainability strategy and donor exist strategy
Workplace	• Slow pace of developing workplace HIV and AIDS programmes	•

4.1.2 Programme Gaps

The table below identifies the programme gaps against national need or NSP targets. It is evident as mentioned above that data is largely lacking in nearly all the areas.

Table 2: Programme Performance Gaps

Indicator	Baseline	NSP Target 2011	MTR results (March 2009)	Gap Analysis (against NSP target)
Comprehensive knowledge of HIV and AIDS	23% (2004)	80%	(15-24 yrs) M=18.4%/ W=25.8%	
Multiple and concurrent partners	M=29% F= 11% *(DHS)*	Men= 20% Women = 15%	24% (2007 – MOT)	MOT noted a decline of 28% in women and 26% in men
Early Sexual debut (15-24 years) olds	8% M=12% / W= 6%	M = 15% W= 10%		M=3% W= 4%
Increase in use of condoms in high risk sex	58% (2004 – DHS)	80%	W=42% / M= 46% (2008- MOT)	
Use of condoms in last sexual intercourse	M=40.5% W= 18.7%			
People who have tested and know their HIV status	5.9% (2005)	80%	71%[15] (Dec 2008)	
Treatment of STIs		80% (2010)		
# of PMTCT clients who received ARV prophylaxis and HAART	85.8% [2224]		4318	
Pregnant women receiving complete course of ART prophylaxis to reduce MTCT	2005	80%	3134	
Babies who received ARV prophylaxis	82% [1839]		4111	
Pregnant women who accept taking HIV test	51% (2005)		95.6% (Sept 2008)	
Health facilities providing PMTCT	37		179	
Blood safety		100%	100%	0
People accessing and using PEP		80% (2007)		
Treatment of opportunistic infections		80% (2007)		
People receiving ART	10.2% (2005)	80% (2010)	45% (Sept 2008)	35%
Children on ART				
People with TB tested for HIV			47%	
Decrease burden of TB in PLWHA		100%		
OVC households receiving free basic external support		80%		
OVC access to psychosocial support		80% (2010)		
PLWHA access to care and psychosocial support		80% (2010)		
Alleviate deterioration of PLWHA living conditions		80%		
Legislation to improve quality of life on women and girls				
Vulnerable populations[16] access to HIV and AIDS services				

[15] Presentation by Dr. Limpho Maile, Ministry of Health and social Welfare – during the NSP MTR consultations
[16] These are categorized as inmates, sex workers, people with disability, herd boys, migrant workers ,

4.2 Strategic Focus 1: Management, Coordination and Support Mechanisms

4.2.1 Background Information

This section focuses on the management, coordination and support mechanisms for the implementation of the NSP. The section has three sub areas i.e. supportive environment, management and coordination, and evidence based decision making.

Under the supportive environment, the NSP focused on advocacy, public policy and legal environment, leadership involvement and commitment. In the management and coordination, the focus was on resource mobilisation, decentralised financial and procurement systems; partnership building and improved coordination at district and community levels. With regard to evidence based decision making, NSP aimed at strengthening the national capacity for HIV and AIDS research, facilitating biomedical and social research and strengthening of monitoring and evaluation systems

The strategic plan is aligned to Vision 2020, the National Multi-sectoral HIV and AIDS Policy and the Poverty Reduction Strategy Paper. The implementation of the NSP activities will contribute to the achievement of Lesotho's long term goals of poverty alleviation, improvement in the quality of life of all people, and vice versa. The national strategy documents address core issues of concern to NSP, including poverty and income inequality, gender equality, and access to health care services among others. The implementation of the NSP will also help Lesotho address its international and regional commitments such as the Millennium Development Goals (MDG) and the Maseru Declaration among others.

4.2.2 Supportive Environment

4.2.2.1 Advocacy, Public Policy and Legal Environment

Contextual analysis

The implementation of any strategic action plan to a large extent depends on the policy and legal environment in which interventions take place. The implementation of the NSP was intended to strengthen and expand the existing enabling environment, by facilitating the development and operationalisation of a minimum package of policies and legislation necessary. Such legislation was intended to guarantee

- Services equity and gender equality;
- Protection of PLWHA against stigmatisation and discrimination, and women against gender based violence;
- Provide for property and inheritance rights for OVC and widows, and universal access to treatment, care and support, and policies to address girls education;
- Ensure empowerment of women in making informed choices and decisions in issues that make them vulnerable to HIV infection.

Objective 1: To create a legal and policy environment that reduces vulnerability to HIV infection by 2008

The NSP identified a number of areas that required policy or legal instruments developed in order to achieve the desired outcomes. The review noted the following achievements and challenges, and has made recommendations to address the challenges.

Achievements

The following policies and legal instruments were developed.

Table 3: Policies developed

Year	Policy	Status	Comments
2006	National HIV and AIDS Policy	Adopted	Plans are underway to translate the policy into Sesotho
2006	Blood Transfusion Policy	Adopted	
2006	HIV Testing and Counselling Policy	Adopted	The policy is aligned to WHO guidelines for Provider Initiated testing.
2006	National Reproductive Health Policy	Adopted	
	National Health Research Policy		The policy defines the parameters for research and what systems need to be followed.
2007	Education Sector HIV and AIDS Policy	Draft	Has been presented to MOET authorities for consideration
2005	School Health Policy	Draft	As above
2006	National OVC Policy		Provides for comprehensive social, health and legal care of OVC. A multi-sectoral National OVC Coordinating Committee has been established to oversee the implementation of the policy and related OVC programmes.
	Public Sector HIV and AIDS Workplace Policy	Draft	The policy is intended to guide development of work place programmes as part of the sector's internal response to HIV and AIDS
2006	Guidelines for implementation of Labour Code Amendment Act No.5 of 2006	Draft	The Guidelines are facilitate the implementation of the Labour Code Amendment Act No. 5 of 2006

The department of Correctional Services has initiated the process of developing an "Inmate Policy on HIV and AIDS" and a strategic plan to guide the implementation of the policy. NAC is facilitating the development of policy instruments and strategic plans to support services delivery to vulnerable populations such as the herd boys, sex worker and migrant workers.

Table 4: Legislation developed

Year	Legislation	Status	Comments
2006	Labour Code (Amendment) Act, No. 5 of 2006	Adopted	Has been amended to mainstream HIV and AIDS. Prohibits stigmatisation and discrimination or PLHIV and pre-and post testing for HIV for purposes of employment. It is aligned to ILO code of practice
2006	Legal Capacity of Married Persons Act	Adopted	Empowers women to make decisions on issues that affect their lives. Has changed the legal status of women as minors and thus are recognised as equal partners with their male counterparts.
2007	Public Health Act	Adopted	Provides guidelines for procurement of drugs and other equipment including those for ARV, HTC and PMTCT among others.
2006	HIV and AIDS Bill	At concept stage	Still under discussions. Consultations have been held and communities sensitised about the bill

The review also noted the existence of other instruments / mechanisms that support strengthening and expanding the policy enabling environment.

i. The NAC established in 2005 became fully functional in 2006. A multi-sectoral National Coordinating Framework has been established, in addition to the National AIDS Forum;
ii. 3-Ones Principle has been fully operationalised (one National Coordinating Body, one Strategic Framework and one M&E framework);
iii. Vision 2020 developed as a long term framework;
iv. The Cabinet, Senate and the Parliamentary HIV and AIDS Portfolio Committees have been established to facilitate advocacy and political support;
v. The Poverty Reduction Strategy 2004/05 – 2006/07;
vi. National Action Plan on Women and Girls and HIV/AIDS;
vii. The multi-sectoral National Strategic Plan 2006-2011. The NSP is facilitating the progress towards universal access to prevention, treatment, care and support and impact mitigation services by 2010.

Challenges

The following challenges were identified

i. Delays in initiating and finalising strategic policy documents. Analysis of target time frame indicates that most of the policies were to be developed and finalised between 2006 and 2008. Some are yet to be initiated;
ii. Dissemination and monitoring of existing policies and legal documents was found to be weak. There are no strategies articulated on how monitoring will be done;
iii. In-spite of having the HIV and AIDS workplace programme guidelines, only a few sectors have functional programmes. The guidelines also focus mainly on the internal response. Sector's external response to HIV and AIDS is not addressed at all;
iv. The lack of clarity on roles and responsibilities of some of the key stakeholders makes it difficult to sustain an enabling environment.

Recommendations

i. Accelerate the development of all outstanding policies and legislation especially those that relate to service delivery to vulnerable groups such as the herd boys, sex workers, prisoners, and migrant workers;
ii. Advocate for the adoption of existing draft policies;
iii. Develop a clear strategy for dissemination of policies and legal documents to key stakeholders.

Objective 2: To ensure leadership involvement and commitment in the fight against HIV and AIDS throughout the duration of the NSP

Political, traditional and community leadership is perceived as a key driving force for the implementation of the national and community based HIV and AIDS interventions. In particular the role of community leaders in addressing issues such as multiple concurrent partners, inter-generational sex and alcohol abuse have not yielded significant results. The NSP planned to support leaders play their role in a meaningful way through leadership training and advocacy work. In particular it was anticipated that advocacy would result in increased national recurrent budget allocation for HIV and AIDS.

The literature review indicates that in Lesotho, the involvement of leaders is gaining some momentum from His Majesty the King, the Right Honourable the Prime Ministers all the way to community and religious leaders. The review identified the following achievements and challenges

Achievements

i. Approximately 20% political, community and religious leaders have been sensitised on HIV and AIDS issues. Leaders are increasingly getting involvement in HIV response at different levels. His Majesty the King has been involved in a number of initiatives including the launching of the NAC in 2006. Parliamentarians have been engaged in policy and legal review that has seen the adoption of policies and legislation that impact on HIV;
ii. Religious leaders have signed and released a statement supporting the struggle against HIV and AIDS in Lesotho. Since the release of document religious leaders have spoken openly on key issues including HIV testing, PMTCT, ARV and even condom use;
iii. Advocacy with politicians has resulted in increased government funding for HIV and AIDS. The government has also sustained the policy of ministries allocating 2% of their budgets to HIV and AIDS.

Challenges

i. There is no clear strategy for engaging leaders in HIV and AIDS national response. Their current involvement is sporadic and only when convenient to the stakeholder initiating the engagement;
ii. Although there are HIV and AIDS sub committees for Cabinet, Senate and Parliament, none of them have developed a strategic action plan that can assist in measuring their performance.

Recommendations

i. Support leaders at various levels to develop strategic action plans to guide and inform their interventions around HIV and AIDS. Apart from the action plans serving as tools to measure performance they will facilitate identification of areas for technical assistance and resource requirements;
ii. Develop a national advocacy strategy focusing on strategic HIV and AIDS policy and legal issues.

4.2.2.2 Management and Coordination

This Section focuses on the review of the Management and Coordination of the NSP and the national response in general. The review looks at the NSP performance around resource mobilisation, financial management, strengthening capacity for coordination, building and sustaining partnerships and strategic alliances.

Objective 1: To have in place a mechanism for mobilising and strengthening financial resources across all sectors by 2008

The review noted an increase in financial resources earmarked for HIV and AIDS response in Lesotho from domestic and international sources. A total of US$547 million was required for the implementation of NSP activities from 2006 to 2011. NAC continues to receive funding from Government of Lesotho for HIV and AIDS. The NAC has identified strategic umbrella organisations that in turn receive funding from it to support sector activities. The government has further issued a policy statement requiring government ministries to allocate 2% of their sector budgets to HIV and AIDS.

From an international perspective the donor base has increased significantly. The National AIDS Spending Assessment (NASA) indicates that 57% of the resources for the period 2005/06 to 2007/08 came from international sources[17]. Forty three percent (43%) came from the Government of Lesotho with 2% from other sources. The table below illustrates the source of funding for the period 2005/06 to 07/08

Table 5: HIV and AIDS Expenditure (Maloti) for 2005/06 to 2007/08 by year and source

Source category	2005/06	2006/07	2007/08	Total	% of total
International	164,850,010	105,773,594	252,970,071	523,593,675	60%
Private	7,711,865	3,887,837	5,744,424	17,344,126	38%
Public	84,865,277	100,622,748	150,053,982	335,542,007	2%
	257,427,152	**210,284,179**	**408,768,477**	**876,479,808**	**100%**

The HIV and AIDS Expenditure for fiscal year 2006/07 had experienced a decline from the 2005/06 level (M257.43 million) with actual expenditure of M210.28 million. In 2007/08 the expenditure increased to M408.77 million. The increase is associated with the increase in international and public sources contribution. Overall NASA noted that M876, 479,808.00 was spent in HIV and AIDS between 2005/2006 and 2007/08 fiscal years.

According to NASA 2006/07 only 10% of funding was spent on HIV prevention. Prevention was ranked 5th in expenditure. BCC received only 2% of the prevention budget in the same fiscal year. However, VCT received increased funding.

The following table illustrates the key spending priorities as identified by NASA survey

[17] National AIDS Spending Assessment Report

Table 6: HIV spending priorities

NSP programme area	% of the total budget
Treatment, care and support	37%
Programme Management	17%
OVCs (impact mitigation)	14%
Prevention	11%

Source: NASA report

The following table illustrates the NSP resource needs by programme areas

Table 7: NSP – Financial resource needs

Focus area	2006/07	2007/08	2008/09	2009/10	2010/11	Total	% of total
Management Coordination and support	265,214	259,218	280,016	290,554	297,961	1,392,964	46%
Prevention	98,131	100,084	99,486	69,341	65,289	432,311	14%
Treatment, Care and Support	51,164	59,684	106,936	138,817	180,543	537,135	18%
Impact Mitigation	62,189	92,641	125,633	157,767	199,686	637,916	21%
Total	476,698	511,627	612,071	656,479	743,479	3,000,326	

Achievements

The following achievements were made in resource mobilisation

i. Lesotho received US$121,669,572 (US$114, 473, 978) from Global Fund for HIV and TB programmes respectively for Round 8. Of this amount US$102,922,867 was earmarked for HIV. The funding was earmarked to support interventions prevention, treatment care and support, and impact mitigation. Additional areas for support under the funding include health systems strengthening, and development of policy frameworks. The funds from Global Fund are administered through two Principal Recipients (PR), i.e. the Ministry of Finance and Development Planning and the Lesotho Council of NGOs.

   The following table shows a summary of funding received from GFATM for HIV in Lesotho

   Table 8: Global Fund Grants to Lesotho

Round	Period of funding	Amount	Funding coverage
2	July 2007 – June 2009	US$ 39 million	HIV and TB
5	2006 – 2008	US$10,130,000	HIV
6	July 2007 – June 2009	US$2 million	TB
7	July 2008 – June 2010	US$10,626,665	HIV
8		US$ 121,669,572	HIV ($114,473,978)

ii. Additional funding has been received from other sources including the following: European Union (12 million Euros for OVC support); US Government / PEPFAR; Irish AID; Clinton

Foundation; UN agencies UN agencies (ILO / UNAIDS/UNDP/UNFPA/UNICEF/ WHO / WFP and International NGO such as Care, Catholic Relief, Medicines Sans Frontiers, and Partners in Health, Population Services International, and World Vision.

Challenges

The following challenges were noted

i. Resource tracking especially for funds that are provided directly to implementing partners by development partners remains a challenge. The same applies to public sectors (ministries and departments) who receive funding directly from government and their budgets include fund for HIV and AIDS. NAC does not have adequate systems to track such resources. Reporting by fund recipients has been ad hoc;
ii. Civil society and community based organisations are under-resourced. Neither do they have adequate capacity for resource mobilisation;
iii. Distribution of resources across the four strategic focus areas has been an un-equal. Even though prevention is the key strategy for responding to HIV, it is inadequately funded. Prevention received 17% of the total HIV/AIDS budget for the period 2005/06 and 2007/08 compared to Treatment, care and support that received 37%. The NSP budget for prevention stands at 14% compare to 46% for management and coordination, 18% for treatment care and support, and 21% for impact mitigation;
iv. Delays in disbursement of funds to implementing partners. Stakeholders attribute this to weak financial management systems.

Recommendations

i. Strengthen and mainstream resource tracking mechanisms at all sectors. Financial reporting should be incorporated in the M&E framework and made mandatory not only for implementing partners but also development partners to report funds received or disbursed;
ii. Strengthen capacity for resource mobilisation and financial management through training and operational systems development;
iii. Support and encourage joint resource mobilisation based on the experience from the Global Fund Applications. The NAC could play a proactive role in providing leadership and process management in collaboration with the Global Fund Management Unit;
iv. Provide District AIDS Committees (DAC) with financial grants to support community based organisations especially women and girls groups and support groups of PLHIV. Where Districts AIDS Committees don't exist the districts should be supported to establish the committees. All DACs should be capacitated with financial / grant management skills prior to being given any small grants funds.

Objective 2: To establish functioning decentralised financial and procurement systems by 2009

Achievements

The following findings are more related to procurement systems.

i. The Public Health Act provides the guidelines for procurement of quality drugs and diagnostic equipment. The Act was adopted by the end of 2007;
ii. A drug regulatory unit is in place;
iii. Most facilities have some drugs for STIs, ART, PMTCT and HTC and have not experienced stock outs.

Challenges

i. Although the MOHSW has procurement guidelines, quality control remains a challenge. There is need to have explicit guidelines for procurement of quality drugs and diagnostic equipments;
ii. Anecdotal information that procurement procedures between the various stakeholders are not yet harmonised;
iii. While Lesotho developed guidelines for "procurement and supply management", the efficiency of the system has been said not to be very efficient. The district consultations noted that delays in service providers getting supplies on time.

Recommendations

i. Develop guidelines for quality control in procurement not only for drugs and diagnostic equipment but also for other services related to HIV and AIDS service delivery;
ii. Harmonise procurement systems between the various stakeholders involved in the HIV and AIDS response;
iii. Strengthen the procurement and supply management chain to ensure that supplies reach service providers on time. This would require a review of the Procurement and distribution guidelines.

Objective 3: To create mechanisms for partnerships among civil society organisations, public sector, private sector and development partners by 2007

The review noted that efforts were made to strengthen and consolidate existing partnerships while at the same time forging new partnerships. Analysis of the partnership relationships indicates some trends towards sustainable partnerships. NAC for example has identified a number of umbrella organisations and have entered into some form of agreement for them to coordinate some aspects of the national response within their sectors. Although there are no formal public private partnerships (PPP) in place, increased bilateral collaboration with the private sector has seen expansion and wider coverage of services. Partnership with development partners are contributing to resource (financial, information, materials) flows, access to technical assistance, and best practices. Annex 1 lists down the different partners and their areas of collaboration.

Achievements

The review identified the following achievements

i. The National HIV and AIDS Forum was established and strengthened in accordance with the National AIDS Commission Act of 2005;
ii. A capacity assessment and needs of civil society organisations was conducted. There after the capacity was strengthened in key areas such as governance, organisational development, financial management and technical areas of HIV and AIDS;
iii. All districts have established registers of civil society organisation. This has contributed to improved coordination;
iv. Some stakeholders operating at district level have been able to provide their program activity monitoring reports. Copies of the reports are available from existing and functional District AIDS Committees;
v. By 2008, all the districts (10) had PLHIV representatives on the District AIDS Committees;
vi. NAC continues to coordinate its financial support that is provided to the implementing partners who execute HIV and AIDS programmes on the national response as guided by the NSP through the signing of the Memoranda of Understanding with the implementing partners.

Challenges

The following challenges were noted:

i. The composition of the National HIV and AIDS Forum is regulated by the Act. Consequently, it has limitations in facilitating a broad based stakeholders' forum. Equally, it is not clear how other stakeholders get feedback on the deliberations of the forum;
ii. Although the NSP has identified areas of involvement by the various stakeholders, the roles and responsibilities arising from the engagement are not clearly outlined. However, these are evolving as the implementation proceeds;
iii. Mechanisms for information sharing between the partners are not clear and hence information sharing and dissemination is ad hoc.

Recommendations

i. Established a broad based partnership forum, where representation of all the key stakeholders will be assured;
ii. Define and document the roles and responsibilities of all key stakeholders including development partners and umbrella organisations.

Objective 4: To strengthen the capacity for coordination of national HIV and AIDS response at national, district and community levels by 2006

Lesotho has adopted a multi-sectoral approach in the coordination and implementation of the national response. The multi-sectoral coordination of the HIV and AIDS response is often complex, dynamic and transcends institutional boundaries. Lesotho has established a multi-sectoral national coordinating framework that most partners associate with. The framework is premised on the following 3-Ones Principles

- One national coordinating authority,
- One national M&E Framework
- One national strategic plan.

At operational level coordination of the HIV and AIDS response has been decentralised to districts, umbrella organisations, and key government sectors such Ministry of Health and Social Welfare.

The National AIDS Commission has the overall responsibility for coordination the national response, while the Ministry of Health and Social Welfare has the responsibility for coordinating the health sector response. Coordination among civil society organisations is facilitated by umbrella organisations. The private sector is yet to have to form a business network or coalition on HIV and AIDS.

Achievements

A number of institutions have been established to complement existing ones in facilitating coordination of the national response. The review noted that the following institutional arrangements have been developed

i. The NAC was established in 2005 and become fully operational in 2006 (repetition). The Commission has the overall mandate for coordinating the national multi-sectoral response to HIV and AIDS. NAC become a full member of CCM in December 2007;
ii. Ministry of Health and Social Welfare coordinate the health sector response. This involves collaboration with civil society organisations and private sector institutions including Christian Health Association of Lesotho (CHAL);
iii. The National AIDS Forum was also established in 2007, in accordance with the Act;

iv. At District level District AIDS Committees (DAC) have been formed to facilitate the district level coordination. Since the launch of the NSP coordination has been decentralised to sectors and districts. The DACs work in collaboration with other stakeholders including the 128 Community AIDS Committees (CCAC);
v. Where District M&E Technical Working Groups have been established and are functional, they are facilitating monitoring and evaluation, and subsequent reporting;
vi. Umbrella organisations are coordinating sector HIV and HIV responses;
vii. The National OVC Coordinating Committee was established with technical assistance from UNICEF.

In terms of strengthening the capacity for coordination of the response the review found that the following had been done

i. In September /October of 2007 all the 21 line ministries and government departments were trained on HIV and AIDS and development of action plans for mainstreaming HIV within their sectors;
ii. 128 Community Councils were supported to developed their HIV and AIDS actions plans;
iii. Umbrella civil society organisation were strengthened (training and with financial support) to provide effective and efficient sectoral coordination. Among the umbrella organisations supported include the following:
    - Association of Lesotho Employers (ALE),
    - Lesotho Inter-religious AIDS Consortium (LIRAC),
    - Lesotho Youth Federation (LYFE),
    - Action Against Sports and AIDS (AGSA),
    - Lesotho Sports and Recreation Commission (LSRC),
    - National OVC Coordination Committees (NGOC),
    - Lesotho National Federation of Organisations of the Disabled (LNFOD),
    - FIDA, Lesotho Network of People Living with HIV and AIDS (LENEPWHA)
    - Lesotho Network of Service Organisations (LENASO).

iv. Reporting tools were developed and distributed to partners to facilitate regular and consistent reporting programme implementation by all sectors;
v. An 'All-Leaders' Forum' was organized and where leaders from various sectors discussed issues of male circumcision, reviewed the findings of the Multiple Concurrent Sexual Partnerships study, and discussed the rights of PLHIV;
vi. The United Nations Development assistance framework for 2008- 2012 was developed and aligned to National strategic plans and indicators;
vii. Regular meetings of the CCM, National Partnership Forums, the Expanded UN theme group on HIV and AIDS which has since been changed to being a Monthly Partnership Forum co-chaired by NAC and LENEPWHA are being held;
viii. At programme level coordination has also improved. There is more improved collaboration both in planning and joint reviews. The Ministry of Health and Social Welfare, has combined the HIV and TB coordination at district level under the current TB officers. To improve coordination effectiveness the MOHSW is moving BCC functions to health education. With regard to M&E the Ministry intends to combine the various M&E units to one Health Sector M&E Unit.

Challenges

i. While coordination institutions and mechanisms are in place, there are no clear roles and responsibilities among various stakeholders;

ii. The capacity of most coordinating institutions especially Civil Society Organisations, DAC and CCAC are weak. Furthermore, the process of institutionalising these structures is taking too long and this hampers coordination of the district and community response;
iii. The coordination systems between development partners and national systems are not fully harmonised, especially with regard to coordinating financial and technical support extended to implementing partners;
iv. Coordination of Global Fund activities is the responsibility of CCM, and the two Principal Recipients. The role of NAC is not clearly defined, and hence NAC participates in the CCM as any other member in-spite of its legal mandate to coordinate all HIV and AIDS response in the country;
v. Inadequate recognition of the NAC as the statutory mandated institution for HIV and AIDS coordination;
vi. The District Partnership Forums don't hold their meetings regularly.

Recommendations

- Develop a national HIV and AIDS coordination manual that clearly outlines specific roles and responsibilities for each identified coordinating institution;
- Strengthen the capacity of the National Partnership Forum to provide adequate leadership and political support to HIV and AIDS response;
- Develop a capacity building and strengthening training plan for HIV and AIDS. Key areas for consideration include HIV and AIDS Results Based Management (RBM), financial management, strategic planning, M&E, community mobilisation, leadership and governance;
- Strengthen coordination linkages between CCM and NAC in view of the NAC mandate.

4.2.2.3 Evidence Based Decision Making

The increasing complexity of HIV and AIDS, demand the use of strategic information and empirical evidence to make informed choices and decisions on the nature and kind of interventions and strategies to adopt. A pre-requisite to achieve this, is that each country must develop institutional capacities capable of generating the required evidence, and thereafter applying the evidence in decision making in planning of the national HIV and AIDS response. Three critical entry points are necessary, i.e. the adequacy and competency of existing human resource, a strong HIV research agenda and programme and an M&E system capable of collecting, compiling, analyzing and disseminating research findings. The NSP recognized the need to address the challenges and the three entry points. The following are the findings of the mid-term review.

Objective 1: To initiate continuous human resource development programmes for HIV and AIDS research by 2006

It is evident that the impacts of HIV and AIDS are likely to change the overall size of the national labour force, as well as the age and skills composition of the present and future population. In the long term this will affect the accumulation of human capital as well as its productivity. The NSP has identified this as a critical challenge and hence identified the need to continuously develop programmes that improve the quality, competence and adequacy of human resources for the HIV and AIDS response including HIV research.

Achievements

- The Ministry of Health and Social Welfare developed an Emergency Human Resources Plan in 2007. Under the plan a number of skills will be developed in the health sector. Some of the proposed cadres are likely to be involved in HIV research.

Challenges

i. Although the NSP prioritised the development of human resources for HIV research, there is not documentary evidence of any activities being carried out to achieve this objective. The lack of performance in this area has been associated with the fact that none of the NSP collaborating partners is specifically focused on HIV research;

ii. The stakeholders' consultations also identified the inadequacy of competent and skilled human resources for HIV research;

iii. HIV and AIDS research is an area that is under resourced. Lack of adequate funding may be a contributing factor to the lack of recruitment of HIV dedicated research officers.

Recommendations

i. In some cases human resources are available but lack adequate skills, competencies and experience. In such cases, a capacity building programme should be initiated as soon as possible;
ii. Conduct a rapid assessment on the national capacity for HIV research;
iii. Based on the assessment develop a national programme to develop a human resource capacity for HIV research. Collaboration with existing tertiary training institutions such as the University of Lesotho, Institute of Development Management and others should be explored under the public private partnership modality.

Objective 2: To develop programmes for biomedical and social research by 2007 in order to guide national HIV and AIDS policy and interventions

Achievements

The following achievements were identified:

i. A National HIV and AIDS research agenda was finalised in 2007;
ii. The "National Health and Social Welfare Research" policy in 2007 by MOHSW. The policy has been disseminated to various stakeholders;
iii. The Research Ethical Committee, under the MOHSW was reactivated;
iv. The following research studies were completed :
    - The Multiple concurrent sexual partnerships (2009);
    - The Lesotho Analysis of prevention Response and Modes of Transmission Study (2009);
    - Male Circumcision Situational Analysis (2008);
    - Reviewing "Emergencies" in HIV AND AIDS affected Countries in Southern Africa: Shifting the Paradigm in Lesotho, 2009;
    - A Survey of HIV and AIDS related knowledge, attitudes and practices was conducted in 2007;
    - A Survey of HIV and AIDS in the work place was initiated. Data has been collected and analysed. The final report is anticipated in 2009;
    - The National AIDS Spending Assessment (NASA) was completed in 2008. Final report produced in early 2009;
    - Sentinel surveillance was conducted in 2007. The next one is due in 2009. Sentinel surveillance is currently being conducted in 10 sites.

v. Preparations for the second Demographic Health Survey (DHS) in 2009 are underway. A National Steering Committee has been established under the leadership of the Ministry of Health and Social Welfare (MOHSW) to facilitate the planning process. Some of the issues under consideration for inclusion in the standard DHS questionnaire include biomarkers such as blood pressure measurement; Diabetes and hepatitis B.

Challenges

The following challenges were identified:

- The implementation of the research agenda has lagged behind in all the NSP strategic focus areas;
- Although the HIV research agenda has been developed, it has not yet been disseminated;
- There are no clearly defined budgets earmarked for HIV research;
- Access to information on recent research studies was found to be limited and not reaching to all stakeholders;
- Important studies such as the impacts of HIV on specific sectors and demographics have not been conducted. This may compromise planning for the response;
- No studies have been done around critical issues identified by the NSP such as HIV and AIDS and vulnerable groups such as sex workers, herd boys, Men who have sex with other men (MSM), Prisoners, people with disabilities and migrant workers;
- Where studies have been completed, dissemination has been slow and ad hoc. Some of the studies have not been disseminated at all beyond the stakeholders where the findings were presented for the first time. Dissemination strategies are not adequately developed;
- Where research findings, have been disseminated, the use of research data and strategic findings has been a challenge for many stakeholders;
- There is a general lack of HIV and AIDS research capacity at all levels and within sectors.

Recommendations

- Advocate for adequate funding for HIV research in all appropriate sectors;
- Strengthen research coordination at NAC with other sectors;
- Popularise the research agenda (disseminate it to all stakeholders);
- Commission research on the vulnerable groups identified by the NSP;
- Conduct a Knowledge, Attitudes, Practices and Behaviour (KAPB) study among key populations such as youth to determine why the levels of awareness and current knowledge of HIV and AIDS is not translating to behaviour change;
- Roll out sentinel surveillance to all 10 districts;
- Under the DHS 2009 survey;
- Strengthen a national capacity for HIV and AIDS research;
- Strengthen existing strategies for disseminating research findings while at the same time exploring new ways, especially at district level;
- Lesotho should consider holding an Annual HIV and AIDS Research Conference. The conference would become a national platform for disseminating and sharing research findings, given the importance to generate empirical evidence for use in the next NSP generation using the Results Based Management approaches.

Objective 3: Establish and implement a monitoring and Evaluation system for the HIV and AIDS by 2006

The objective of the NSP M&E system was provide evidence based information and data for use in decision making and planning for the national response. The M&E information was generated

through routine data systems, in addition to specialized and technical studies such as the Demographic and Health Survey or the Sentinel Surveillance.

The Lesotho National M&E Framework was developed and costed in 2006. Some partner and implementing organisations have since then harmonised their M&E systems with the national framework.

Achievements

The following achievements were identified:

i. The National M&E Unit within NAC became operational in 2006/07;
ii. The National M&E Framework was developed and adopted in 2006;
iii. The national M&E plan was operationalised and a mid-term review was conducted in 2008;
iv. The M&E system has been decentralised to districts and sectors and M&E Data officers appointed and posted to each of the 10 districts by NAC and Ministry of Health and Social Welfare. The officers have also been trained in data collection, analysis and compilation skills. The MOHSW has also appointed District Health Information Officers and District HIV and AIDS Officers among others who are also playing a key role in monitoring and evaluation of HIV and AIDS activities at district and community levels;
v. The Health Management Information Systems (HMIS) have been strengthened;
vi. The M&E technical working groups have been formed at national and district levels;
vii. A draft Manual on Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) was initiated and has since been reviewed by key stakeholders. The manual articulates the categories of indicators and data to be collected at various levels and outlines the data flow systems;
viii. A central M&E database – the Country Response Information System (CRIS) has been established. The MOHSW has a functional Health Management Information System (HMIS) that is used to capture HIV and AIDS data;
ix. Training on M&E has been conducted for M&E personnel at district level, NAC, NGO's, and Line Ministries. Some staff of NAC has also been trained on Geographic Information Systems (GIS), and has obtained the software. However, the MTR noted that the software is not been utilised;
x. MOHSW is strengthening its existing QA system. A National Quality Assurance Committee has been established. Trained Clinical Auditors have also been posted in every hospital. A Quality Assurance Board for Accreditation has been constituted and as system of accrediting trainers has been developed.

Challenges

- Sectors or programme specific (Global Fund) indicators are not fully harmonised with the NSP indicators.
- Reporting by implementing partners not funded by NAC was found to be ad hoc. Under reporting has also been noted. Under reporting has been associated with lack of capacity to collect, analyse and compile data for reporting;
- The National M&E framework within the context of 3-Ones has not been adequately mainstreamed in all sectors;
- Access to M&E information and data has been found challenging. Data is not readily and publicly available electronically, although NAC has a functional website;
- There is a general lack of capacity in M&E. Many people who are assigned to do M&E work are not necessarily M&E trained personnel especially among civil society organisations;

- The quality of some M&E data has been questionable given the technical competence of most people collecting data especially non-health related data.

Recommendations

The following recommendations are made:

- Harmonise national indicators for HIV and AIDS, between programmes, sectors and development partners;
- Strengthen the capacity of the national M&E system by (a) strengthening the skills of the M&E staff in all sectors through modulated training, (b) institutionalising M&E in all sectors, and (c) implementing the GIS system. Standardise M&E training for all sectors – i.e. civil society. Public and private sectors in particular;
- Assist sectors and civil society organisations to integrate the national M&E framework into their operations. This will provide a standardised M&E framework within the context of the 3-Ones principles;
- Improve the quality of data by establishing a quality assurance system. The process should be linked to or integrated with the on-going MOHSW initiative.

4.3 Strategic Focus 2: Prevention

4.3.1 Background Information

Prevention is considered the key strategy in the fight against the spread of HIV in Lesotho. Adequate investment in prevention has long term collateral benefits in treatment, care and support, and in impact mitigation. The prevention interventions have been designed to contribute to increased levels of awareness and comprehensive knowledge of HIV and AIDS. In turn the expectation is that awareness and comprehensive knowledge would translate into adoption of key HIV prevention behaviours.

This section of the review report focus on the NSP prevention interventions that include behaviour change, HIV Testing and Counselling (HTC), blood and tissue safety, Post Exposure Prophylaxis (PEP), management of and Sexually Transmitted Infections (STIs).

4.3.2 Behaviour Change Communication

The NSP BCC interventions focused on influencing behaviour change at personal and societal levels. The targeted risky behaviours included unprotected casual sex, having multiple concurrent sexual partners, inter-generational sex, starting having sex at an early age (below 15), and having sex with high risk partners.

It is evident that behaviour change is influenced by the totality of individual, social, cultural and community factors. This includes the key role played by power relationships and gender inequality and hence addressing behaviour and social change simultaneously may be the turning point for achieving the desired behaviour change.

Objective 1: To increase % of men and women who have correct knowledge about prevention of sexual transmission of HIV infection from 23% to 80% by 2011

This objective is aimed at empowering young people to adopt prevention strategies that would complement their level of awareness and knowledge of HIV and AIDS, and influence behaviour change.

Achievements

i. Lesotho has developed a comprehensive National Behaviour Change Communication (BCC) Strategy. The strategy is being translated into Sesotho;
ii. Although the implementation of the BCC strategy has not commenced, a number of activities are being carried out both at national, district and community levels. Key campaigns going on are the “Know Your Status” and the community advocacy work on reduction of stigma and discrimination. A communication strategy to support the implementation of KYS campaign was developed in 2007;
iii. By 2007 the level of comprehensive knowledge of HIV and AIDS among young people 15-24 years was estimated at 18.4% for men and 25.8% females;
iv. IEC materials were produced and disseminated. Most of the materials were produced by MOHSW and NGOs. Among the materials produced include a fact sheet on youth and HIV and AIDS, a Sunday pack, and brail and picture messages for people with disability;
v. In 2007 an assessment of existing HIV/AIDS educational materials for young people was completed. The survey involved 15 organisations;

vi. 35 youth leaders were trained on HIV and AIDS prevention strategies. The training was premised on the youth section of the BCC.

Challenges

i. The level of awareness and knowledge of HIV and AIDS has not translated into desired behaviour change as demonstrated by the increase in new infections. In 2008, Lesotho experienced 62 new HIV infections daily;
ii. The stakeholders' consultations noted that prevention interventions remains fragmented, generic in nature, are not informed by consumer acceptability surveys, and more than often lack institutional synergy. A key factor is the failure to reach individuals and targeted communities with the level of coverage and intensity required to make an impact;
iii. The delayed implementation of the BCC strategy has consequences in planning and service delivery;
iv. Most IEC materials are produced in English and are inaccessible to minority and marginalised groups such as the Phuthi Xhoza;
v. While the use of television should continue for BCC, other channels should be found in order to reach a wider target that does not necessarily have access to TV;
vi. Lesotho has a wide range of stakeholders involved in BCC interventions. Some of them produce their own BCC materials. Given the weak system for quality control some communication materials give the wrong messages. These confuse people and often compromise the effectiveness of interventions.

Recommendations

i. Strengthen the National BCC Committee to provide adequate leadership in prevention and in particular in quality control of messages being communicated;
ii. Disseminate and operationalise the BCC strategy;
iii. Develop target specific HIV prevention materials;
iv. Engage civil society more intensively to carry out BBC interventions;
v. Specific materials targeting sex workers, herd boys, migrant workers, and prisons should be developed;
vi. Given the popularity of mobile phones with young, the BCC committee should explore the possibility of sending prevention messages through mobile phones.

Objective 2: To reduce % of young men and women who have had two or more sexual partners in the last 12 months to 20% for men and 15% for women by 2011

Young people are considered as the "Window of Hope" of hope in halting the epidemic. There is evidence of a decline or stabilisation of infection among young people aged 15-19 and 20 -24 years. However, the MOT study has observed that young people have "multiple longer term partnerships between single young people as well as between married and co-habiting adults as the major driver of HIV transmission, happening in a context of relaxed social norms and low risk perception.''

Achievements

A number of strategies have been put in place to empower young people reduce to multiple sexual partnerships. The review noted the following

i. In and out of school young people have received life skills training. The table below shows the number of out of school reached with life skills based HIV and AIDS training;
ii. By September 2008, 408,529 youth had received life skills training[18];

[18] NAC, 2008 "Overview of the National with specific focus on Prevention",- Power present

iii. Teachers were trained to teach life skills based HIV and AIDS education in schools;
iv. Guidelines for provision of youth friendly services have been developed with technical assistance from UNICEF;
v. Adolescent Health Centres are being established to provide youth friendly health and HIV and AIDS services. LPPA has trained staffs in these centres on how to provide youth friendly services.

Table 9: Number of out of school reached with life skills HIV/AIDS based education

District	Male	Females	Total
Maseru	383	423	806
Berea	188	182	370
Leribe	98	101	199
Botha – Bothe	270	251	521
Mokhotlong	75	83	158
Qacha's nek	45	107	152
Quthing	173	237	410
Mohale's hoek	138	304	442
Mafeteng	56	80	136
Thaba-Tseka	37	41	78
Total	**1463**	**1809**	**3272**

Source: Partnership forum Reports Dec. 2008

Challenges

i. Not all schools have teachers who are adequately trained in life-skills-based HIV and AIDS education;
ii. The focus of life-skills-based HIV /AIDS education has been schools. Life skills training for out of school youth is sporadic;
iii. Fifty thousand out of school youth trained on life skills[19];
iv. While youth friendly centres or corners are being established they are inadequately manned, and hence their utilisation compromised despite the investment. The centres are said to be under-utilised;
v. The current strategies have not adequately addressed cultural barriers that make it difficult for parents and young people to discuss sex, sexuality and reproductive health issues;
vi. The challenge of child headed families has not been addressed, especially in the context of child sexual exploitation in return for care and support;
vii. The NSP has focused on young people.

[19] Ibid (13)

Recommendations

i. Develop targeted BCC materials that address the specific challenges of specific target groups (in and out of school young people). Such materials should address critical socio-cultural issues that influence young people in taking risk behaviours. 60,000 young people reached with HIV messages through the "string game"[20];
ii. Operationalise the BCC strategy and ensure its decentralisation to all sectors i.e. public and private sectors ,and civil society);
iii. Finalise the translation of the BCC strategy and disseminate the strategy document to all stakeholders especially at district and community level;
iv. Intensify targeted interventions to make meaningful impact;
v. Develop strategies to address prevention in child headed households;
vi. Train peer educators and support them to provide BCC.

Objective 3: To reduce % of young men and women who commence sexual intercourse before the age of 15 to 15% for men and 10% for women by 2011

This objective to a large extent targets young people of school going age of whom many are already in schools.

Achievements

i. Young people are being taught life skills based HIV and AIDS education. Most schools have teachers trained to teacher life skills. The life skills training is being offered by groups such as the Girls and Boy Education Movement (GBEM), Scripture Union, LPPA, Kick for Life, Lesotho Red Cross Society, MGYSR, CRS, PSI, and Cross Roads;
ii. Peer Education related to life skills is being promoted through youth centres, Kick for life, and Monna ka khomo among others.

Challenge

i. Not all schools have teachers trained in life-skills-based HIV and AIDS education;
ii. Literature review indicated a 68% decrease in the number out of school youth provided with life skills;
iii. In the absence of a standardised training manual, the quality and comprehensiveness of life skills trained may be compromised;
iv. There are no established role models for young people.

Recommendations

i. Intensify life skills training for both in and out of school youth. Recent studies indicate that delay of sexual-debut alone may not prevent HIV infection. It is important that the approach be comprehensive enough to include training in social and behaviour change;
ii. Train a critical mass of peer educators to work with in and out of school youth to have an impact;
iii. Identify and promote community based role models that can play a strategic role in influencing the behaviours of young people.

[20] Ibid (13)

Objective 4: To increase usage of condoms in higher risk sexual intercourse among young men and women to 80% by 2011

Correct and consistent use of condoms have proved potential to reduce exposure and hence infection. The level of condom knowledge has increased significantly. However, the use of male and female condoms remains low. There is no empirical evidence that condoms are being used correctly and consistently. Lesotho has a combined condom strategy i.e. condoms are provided for free by government while others are provided distributed through social marketing. The review were also being sold from pharmacies and retail shops

A**chievements**

The following achievements were identified

i. 48.6% of men and 41.9% of women aged 15-49 who had more than one sexual partner reported having used a condom;
ii. LENEPLWHA conducted community discussions on condoms with the intention of reducing the fears;
iii. 90% of Basotho aged 15-49 reported ever been taught to use a condom;
iv. A National Condom Management Strategy was developed;
v. Development of a National Condom Policy is underway being led by MOHSW with technical support from UNFPA;
vi. An Inter-agency Condom Promotion Task Force (committee) was established with oversight responsibility for monitoring condom promotion and distribution;
vii. A Condom Technical Working Group was also established;
viii. A survey (inventory) on condom availability was conducted by PSI & Khanya, NAC, MOHSW;
ix. In 2006 an estimated 17 million male condoms were procured. Of these 12 million were procured by MOHSW in collaboration with UNFPA, while 5 million were procured by PSI, Red Cross and LPPA. 25,372 female condoms were also procured and distributed. Condom procurement is supported by the Government of Lesotho, Global Fund, and USAID;
x. Condom distribution points have been increased at community level. Condoms are also being distributed through the Community Councils.

Challenges

i. While the overall condom distribution points have increased, coverage of distribution points is still low. There is need to increase distribution points especially at community level;
ii. The implementation of the Condom Management Strategy has remained inadequate. Consequently distribution systems have not been adequately strengthened and expanded. The findings of the condoms Inventory study by PSI and MOHSW found many packs of the condoms with the NDSO, an indication of logistical and management coordination problems;
iii. Female condom is not widely available at the community level. Promotion of the female condom has lagged behind the male condom. Female condom has not achieved universal acceptability in the country.

Recommendations

i. Intensify condom education and promotion in rural communities and in particular female condoms;
ii. Increase condom outlets. Ensure that some outlets are youth friendly to increase their access;

iii. Develop a public private partnership with private sector to promote and distribute both female and male condoms.

4.3.3 HIV Testing and Counselling (HTC)

A number of strategies including provider and client initiated, mobile services and door-to-door are being used to scale up the provision of HTC. HTC is being provided for a wide range of reasons from knowing your status, as part of clinical care and disease prevention, for PMTCT to survivors of sexual violence. The NSP strategy was to ensure adequate coverage, accessibility, scaling up services in health facilities and in the community, management of client initiated HTC, confidentiality and quality of services.

Evidence indicates that provider-initiated testing and counselling in health facilities contribute to early disease diagnosis and treatment and hence increasing clinical benefits. On the other hand it has demonstrated the potential to reduce stigma.

Objective 1: To increase the proportion of Basotho aged 12 years and above who know their HIV status from 5.9% in 2005 to 80% in 2011

Achievements

i. The HTC policy was developed and adopted in 2006;
ii. HTC is provided at health facilities and community levels;
iii. By the September 2008, 429,405 people were reached with HTC information and 95% tested for HIV[21];
iv. By 2007, 229,092 (cumulative) people had been reached with HTC and knew their status. This represents only 12% of the population;
v. Approximately 3800 people were trained to provide HTC services;
vi. By September 2008 HTC services were available from 191[22] out of 214 listed public and private hospitals and health centres;
vii. HIV Testing and Counselling uptake among females is considerably higher than in males with 19,816 (69% of total tested) females testing between December 2006 and November 2007 compared to 9,086 males (31% of total tested).

[21] Ibid (13)
[22] Ibid (13)

The following table illustrates the availability of HTC by districts

Table 10: HTC service in Lesotho

District	2005	2007	# of health facilities offering HTC	# of professional counsellors providing HTC in Health facilities	# of community lay counsellors trained
Berea	2023	9012	21	9	282
Botha-Bothe	1704	12432	12	8	192
Leribe	8845	26047	29	11	490
Mafeteng	8991	38600	19	9	335
Maseru	14046	40141	52	49	828
Mohales Hoek	3085	15191	15	7	310
Mokhotlong	859	4114	14	5	162
Qachas Nek	2196	9532	11	7	270
Quthing	1718	7211	11	5	301
Thaba-Tseka	18	6672	23	6	420
Totals	43,485	168,952	207	116	3,590

Source: MOHSW Annual Joint Review Report 2007/08 / Partnership forum Report Sept, 2008

Challenges

i. Testing sites experienced stock outs of testing kits.
ii. The monitoring of people counselled and testing was found to be inadequate and could contribute to double counting. Equally the review found some signs of under-reporting especially when testing is done outside of health facilities.
iii. There are fewer men undertaking voluntary counselling and testing compared to women.
iv. Stigma remains a barrier to HTC uptake.
v. Although there are signs of increased uptake of HTC, the absolute number in 2008 declined by an almost one third.

Recommendations

i. Expand and strengthen community based VCT facilities;
ii. Develop a national stigma reduction strategy;
iii. Improve monitoring and reporting of HTC services from all sites;
iv. Intensify the KYS campaign;
v. Strengthen procurement and distribution of HTC test kits.

4.3.4 Treatment of Sexually Transmitted Infections (STI)

Objective 1: To ensure that by 2010, 80% of women and men attending health facilities for STI are appropriately diagnosed, treated and counselled

Available epidemiological data indicates that the presence of STI in HIV negative person especially genital ulcerations increases the risk of sexually transmitted HIV as interruption in skin continue to enhance infection. STI patients with genital ulcers are more likely to get HIV infection compared to the other STIs. The challenge is that many countries are more focused on treating bacterial STI as opposed to viral STI. Furthermore research has proved that HIV infected women are at a higher risk of acquiring cervical cancer, which in 99% of the time is caused by the human papiloma virus. In 2007, the prevalence of HIV in Lesotho among STI patients was high at 56.2%. The sentinel HIV/Surveillance (2007) shows that 1.4% of ANC clients and 2.3% of STI clients had syphilis.

Regional surveys indicate that treatment of STI is not a very effective HIV prevention strategy. However the findings should not detract from the fact that STI treatment is an important public health intervention and as such STI control for the general population should be a priority intervention as part of sexual reproductive health.

Achievements

Lesotho has achieved the following in the management of STIs

i. During the review process a STI study was going on. It is anticipated that the study will be finalised in 2009;
ii. The STI management guidelines were reviewed and updated. The finalisation of the update is waiting for the finalisation of the STI Study;
iii. The MOHSW continued to provide syndromic management of STIs within the context of HIV prevention. STI services are available in all public health facilities;
iv. The STI and HIV/AIDS curriculum has been incorporated in the updated nurses and midwives curricullum;
v. The SADC STI treatment guidelines, protocols, standards and surveillance tools are currently being adopted by the STI, HIV and AIDS Directorate at the MOHSW;
vi. With the increase of viral STIs (herpes simplex virus) the government has introduced *acyclovir* (antiviral);
vii. In 2006, STI surveillance was integrated into the HMIS routine data system.

Challenges

i. There isn't sufficiet empirical data to support the argument that treating STIs will reduce the infection rates;
ii. Only two STI sentinel sites are functional out of the designated eight sites;
iii. There is increasing stigma associated with STI and HIV that prevent people from seeking early diagnosis and treatment;
iv. There is a general low level of awareness of STI in the community;
v. In most rural communities people will seek the services of a traditional health practitioner in treating STI before seeking care at a health facility.

Recommendations

i. Facilitate the finalisation of the STI surveys to determine the extent of the problem and its implications on HIV prevention;

ii. Strengthen the capacity of health facilities to provide STI services. At least one health worker in each health facility should be adequately trained and familiar with the treatment of both bacterial and viral STIs;
iii. Intensify community education and awareness of STIs.

4.3.5 Prevention of Mother to Child Transmission of HIV

The risk of mother to child transmission (MTCT) can be reduced to less than 2% by interventions that include antiretroviral (ARV) prophylaxis given to women during pregnancy and labour and to the infant in the first weeks of life, as well as obstetrical interventions including elective caesarean delivery, and safer infant feeding practices[i]. Provision of other sexual and reproductive needs of HIV positive persons increase the opportunities for achieving a comprehensive HIV response. Persons living with HIV continue to be sexually active, and therefore needs services to support them to (a) use contraceptives to avoid unwanted pregnancies; and (b) giving practical advice on how they could negotiate for safer sex in their sexual partnerships (Eisele et al, 2008

The review found that PMTCT interventions included the use of antiretroviral prophylaxis, safe delivery in a health facility and safe infant feeding practices. In addition, HIV infected women and exposed infants were being followed on regular basis for clinical care and treatment including family planning to prevent unwanted pregnancies.

To ensure uptake, service providers were addressing the challenges associated with male participation in PMTCT, gender inequality particularly with regard to decision making, stigma, and insufficient public awareness around PMTCT. The review noted that PMTCT services were integrate in the MCH setting, as a strategy of ensuring that services are available country wide.

Objective 1: To increase the proportion of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT to 80% by 2011

The plan for scaling up PMTC was developed in 2007. Since then the following progress has been made.

Achievements

i. The coverage for PMTCT has increased significantly from 5.9% in 2005 to 31% in 2007. The number of health facilities providing PMTCT has increased from 22 in 2005 to 136 in 2007 and 166 in 2008. This number includes 19 hospitals and 117 health centres and private clinics[23];
ii. The proportion of pregnant women who accepted an HIV test also increased from 5,459 in 2005 to 9,277 in 2006, to 23,965 in 2007. Of those who tested 5539 were found to be HIV positive and 3966 were provided with ART (2799 on ARV prophylaxis and 1167 on HAART). The increase in the number of women accepting testing is attributed to the "opt out strategy";
iii. A total of 3261 (68%) of pregnant mothers received combination therapy during labour and delivery and 1480 (30%) received HAART for PMTCT, 18(0.1%) received single dose nevirapine and 111 (2%) received AZT only for MTCT;
iv. PMTCT programmes have been integrated into routine maternal & child services;
v. A Joint Review by an Inter Agency Task Team in 2007 found that only 600 children (16.5%) were on ARV;
vi. The PMTCT policy guidelines and data collection instruments were finalised;

[23] Ibid (13)

vii. 3600 community-based caregivers providing community PMTCT under KYS. Currently village health workers are being trained on community PMTCT. Community PMTCT has been incorporated into village health care manual;
viii. Number of new ANC clients has increased by 10 000.

The table below provides statistics on PMTCT since the launch of the NSP in 2006.

Table 11: PMTCT basic data

Indicator	2006	2007	2008
# of facilities providing PMTCT	37	136	179
# of new ANC clients	11952	24651	31346
# of clients pre-test counselled	13047	26293	32190
# of clients tested counselled	9277 (71%)	23965 (91%)	30661
# of clients post test counselled	7168 (77.2%)	23196 (96.8%)	30785
# of clients HIV positive	2592 (19.2%)	5539 (43.3%)	8028
# of clients who received ARV prophylaxis	2005	2799	3134
# of clients who received ART	219	1167	1184
# of clients who received ARV prophylaxis and HAART	2224 (85.8%)	3966 (71.6%)	4318
# of deliveries		17656(35.3%)	20843
# of HIV positive mothers delivering live births		3584 9 (27.8%)	4887
# of babies who received ARV prophylaxis	1839 (82%)	2767 (77.2%)	4111
HIV test uptake	71%	91%	95%
PMTCT coverage	16.5%	31%	36%

Source: slide presentation on prevention (stakeholders consultations meeting)

Challenges

i. Monitoring of babies on ART still remains problematic;
ii. Stigma tends to compromise the quality and sustainability of the infant feeding of HIV+ babies born of HIV + mothers;
iii. A weak referral system between PMTCT and ARV for infants;
iv. 24.4% of women who knew they were HIV positive got pregnant. While this is seen as part of their rights, it also problematic. First unmet need for reproductive health services or the strong desire to have children with the hope that PMTCT would work;
v. Private sector is inadequately involved in the provision of PMTCT. Reporting by private practitioners is considered inconsistent;
vi. Lack of male friendly health services to support male involvement in PMTCT.

Recommendations

i. Strengthen capacity for PMTCT at all levels (public and private health facilities, and in the community);
ii. Encourage and support private medical practitioners to provide PMTCT treatment on the basis of public private partnership arrangements. Accredit private practitioners providing PMTCT and develop a memorandum of understanding of their responsibility to report on women receiving PMTCT services from them;
iii. Strengthen database of community health workers involved in PMTCT activities;

iv. Establish male friendly PMTCT service points.

4.3.6 Blood Tissue and Safety

Transmission of HIV through blood transfusion is considered a very efficient way. Hence blood screening for HIV has become a universal best practice and an essential public health intervention as it reduces accidental exposure to HIV. Lesotho screens 100% of all donated blood for HIV. Blood units are screened for ABO (cell and serum) and RhD grouping, HIV Ag/Ab Combo through ELISA, HBsAg through ELISA, HCV using ELISA, and Syphilis through RPR. An External Quality Assessment Scheme for HIV screening is in place where samples are periodically sent to the National Institute for communicable Diseases in South Africa for quality assurance

Objective 1: To ensure that the proportion of transfused blood screened for HIV remains 100%

Achievements

i. 100% of all blood is screen for HIV and STIs
ii. By 2007, the prevalence of HIV among blood donors declined from 4.6% in 2006 to 4.5% in 2007.

Challenges

i. Although blood screening has intensified and strengthened in 2007 4.5% of blood units screened were found to be infected with HIV infection. The WHO standard is 1% or less;
ii. Capacity of the Lesotho Blood Testing Services LBTS as it had inadequate personnel, limited transport and general lack of appropriate infrastructure. By 2007, the LBTS had not independent blood budget and consequently its activities were constrained due to lack of funds. The LBTS services are also centralised. There are efforts to have an independent budget for blood transfusion services;
iii. The demand for safe blood supply is not met.

Recommendations

i. Maintain 100% blood screen and safety by strengthening human resources and technological equipment for blood screening;
ii. Conduct community mobilisation especially among young people to expand and increase the blood donor pool;
iii. Decentralise the blood screening and transfusion services to other districts;

4.3.7 Post Exposure prophylaxis

Post-exposure prophylaxis (PEP) is a necessary secondary prevention measure in health care settings, and among some occupations that pose a higher risk of HIV infection by virtue of the services being provided. The vast majority of incidents of occupational exposure to blood borne pathogens, including HIV, occur in health care settings. PEP for HIV consists of a comprehensive set of services to prevent infection developing in an exposed person, including: first aid care; counselling and risk assessment; HIV testing and counselling; and, depending on the risk assessment, the short term (28-day) provision of antiretroviral drugs, with follow up.

With regard to PEP services, the challenges have been related to low levels of awareness of accidental exposure to HIV, insufficient availability of protective materials, insufficient roll out of services to all health facilities. A key concern is lack of community awareness of PEP and its potential in preventing HIV infection among victims of sexual abuse in particular rape.

Objective 1: To provide access to 80% of all those occupationally exposed to HIV infection by 2007

And

Objective 2: To provide access to 80% of those exposed through rape, occupational exposure and accident situations requiring PEP by 2007

The review noted that not much had been done to achieve this objective. However the following was noted:

Achievements

i. PEP is part of the overall infection control strategy;
ii. National infection control policy is available;
iii. PEP registers and kits have been distributed to health facilities.

Challenges

i. Inadequate awareness of PEP at community and district levels;
ii. PEP was not rolled out to all health facilities in the country;
iii. Availability of PEP test kits at health facilities;
iv. Lack of adequate training of health workers on provision of PEP to victims of rape.

Recommendations

i. Develop a national strategy for the provision of PEP. The strategy would among others address issues of health workers capacity, rolling our PEP to all health facilities and community education on PEP;
ii. Strengthen the capacity of health facilities to provide PEP services – provide PEP kits, drugs and train staff;
iii. Integrate PEP report in the current M&E monitoring and reporting frameworks.

4.4 Strategic Focus 3: Treatment, Care and Support

4.4.1 Background information

The overall goal of this strategic focus area is to reduce morbidity and mortality due to HIV and AIDS. The core target group is PLHIV. The NSP identified four interventions i.e. management of opportunistic infections, provision of ART, treatment and management of the TB/HIV co-infection, and home based care.

4.4.2 Opportunistic Infections,

The NSP recognised that providing prevention and treatment of opportunistic infections had the potential to reduce the degree of vulnerability to HIV infections. People with advanced HIV infection are more vulnerable to opportunistic infections because of the weak immune system. The review notes that TB is the most common opportunistic infections in Lesotho. In 2007/08, 80% of TB patients were also HIV positive. Other noted opportunistic infections chronic diarrhoea, herpes zoster, pneumocystis, pneumonia, Kaposi sarcoma, oral pharyngeal candidiasis, generalized pruritic dermatitis, cytomegalovirus and toxoplasmosis.

Although anecdotal information indicates that Lesotho has made significant progress in address opportunistic infections, access to documentary evidence was limited. Hence the review could not conclusively identify the achievements and challenges.

Objective 1: To ensure that by 2007, 80% of patients attending primary health care centres are managed in accordance with the national technical guidelines and protocols

In the absence of information and data related to the work done to achieve the above objective, the review could not establish the extent to which the objective has been implemented.

4.4.3 Antiretroviral Therapy (ART),

The ART programme is seen as the core intervention in mitigating the impacts of HIV and AIDS on PLHIV. The focus of interventions is three fold.

i. Ensuring that as many people in need of ART including children receive treatment
ii. Ensuring treatment compliance and consequently increasing the survival rate
iii. Preventing emergence of drug resistance and in particular making sure that as many people as possible remain on the first line of treatment.

Lesotho has made significant progress in achieving these broad and long term objectives of the ART programme.

Objective 2: To increase the proportion of women and men with advance HIV infection who receive ART combination therapy to 80% by 2010

Achievements

A review of the ART programme identified the following achievements since launch of NSP in 2006.

i. The coverage for ART services was 25% for adults and 26% for children. The cumulative number of people on ART increased from 1,536 in 2006 to 57,460 in 2008. The number

of adults on ART increased from 13,393 in 2006 to 53,261 in 2008 while for children the number increased from 1143 in 2006 to 4,310 in 2008;

ii. By the end of 2008, ART services were available from 104 sites which included hospitals, health centres and private practitioners;
iii. A total of 81,260 were in need of ART by January 2008;
iv. ART guidelines were developed (2007) and aligned to the new international guidelines developed by WHO. Under new guidelines people with CD4 count below 350 are eligible for treatment, compared to the previous level of 200;
v. World Food Programme (WFP) was providing nutritional support to approximately 5,510 households with PLHIV. Approximately 25,158 people were benefiting. Food distribution was through health facilities once a month;
vi. With support from UNICEF Baylor Centre of Excellence provided training in paediatric HIV care and treatment mentoring staff in 5 hospitals and filter clinics in 5 districts;
vii. Health workers from all hospitals received in service training on DNA- PCR. The DNA – PCR testing was rolled out from 5 hospitals in 2006 to 17 hospitals in 2007. Lesotho plans to expand coverage to 165 health centres;
viii. Testing in children using the DNA-PCR was introduced in 2007 and 1400 children were tested in 2006, and 3,437 in 2007;
ix. UNICEF provided PMTCT and Paediatric HIV supplies including 200 Haemoglobino-meters, 65,000 HIV rapid testing kits for HIV testing of pregnant women, and 1,000 midwifery kits and 50 sterilization kits. The kits were meant to expand safe delivery services to 50 additional maternity sites;
x. 155 health workers were trained on ART delivery. Training was also provided to nurses on diagnosis and management of ART and the management of opportunistic infections;
xi. The Village Health Care Workers training manual and curriculum were reviewed and updated.

The table 11 below illustrates the number of health facilities providing ART, and compares the number of people who were on ART in 2005 and 2007.
2005

Table 12: ART coverage by district and year

District	# of facilities providing ART	2005	2006	2007	2008
MASERU	41	2402	5690	11950	15520
BEREA	10	218	880	1809	3457
LERIBE	13	1203	2710	4289	6786
MOKHOTLONG	8	39	193	567	1647
QACHA'S NEK	8	39	229	935	1489
QUTHING	10	65	490	1173	2831
MOHALE'S HOEK	15	273	897	2374	4868
MAFETENG	19	723	2221	4294	2877
THABA TSEKA	13	18	335	1386	3830
BUTHA BUTHE	11	175	698	1634	3030
	148				**46,335**

Source: MOHSW Annual Joint Review Report 2007/08

Challenges

The following challenges were identified

i. Lack of adequate and skilled manpower. The current Doctors providing ART services are overstretched;
ii. ART services are not available in all health facilities;
iii. Inadequate follow up/ monitoring of patients (adults and children) enrolled on ART
iv. Inadequate supply testing kits and drugs in some of the ART sites;
v. During the consultations PLHIV also noted the changing of package of drugs, that sometimes confused them or had some drugs replaced with new ones;
vi. Results for children testing for HIV take long time to be received back.

Recommendations

i. Roll out ART (include paediatric ART) to all health facilities in the country (taking cognisance of the criteria for selecting ART sites);
ii. Ensure no stock outs of ART drugs at health facilities;
iii. Expand provision of ART to private sector health facilities through Public Private partnership modality;
iv. Streamline ART monitoring and reporting systems in line with the National M&E system framework.

Objective 3: To ensure that HIV drug monitoring system is established by 2011

Achievements

i. The procurement guidelines for both MOHSW and those being used for Global Fund have articulated guidelines for quality assurance in the procurement of drugs and other diagnostics;
ii. A Quality assurance committee and system has been established in the Ministry of Health and Social Welfare;
iii. The collaboration between the MOHSW, ICAP and WHO has focused on providing support for tracking people receiving ARV's, monitoring drug resistance and conducting operational research.

Challenges

i. Inadequate skilled human resources;
ii. With the increasing demand for ART, a weak procurement system and the drug monitoring system, some health facilities have experienced stock-outs.

Recommendations

i. Strengthen the capacity of existing procurement, distribution and monitoring systems for ART drugs. The procurement system should improve quality control systems;
ii. Train staff responsible for procurement and drug controls in quality assurance strategies.

4.4.4 The Management of TB/HIV co-infection

The key NSP concern with the TB was the high levels of HIV/TB co-infection, limited access to food and micro-nutrients to complement treatment, and lack of integration of TB and HIV services particularly at the diagnosis stage. In the last couple of years Lesotho has identified both MDR and XDR – TB. Given that TB continues to be a leading cause of death of PLHIV MDR and XDR – TB is a major concern for HIV prevention and treatment.

Objective 1: To establish mechanisms for collaboration between programmes for tuberculosis and those for HIV and AIDS

Achievements

The review identified the following achievements:

i. By end of 2007, there were 5413 HIV positive TB patients, 1004 were on ART and 3743 on CPT;
ii. By end of 2007, 12201 cases of all forms of TB were reported of these, 5767 (47%) took a HIV test. 88% was found HIV positive;
iii. A draft policy has been developed to facilitate the management of TB/HIV co-infection
iv. A National TB/HIV Coordinating Committee has been established to coordinate TB/HIV activities;
v. The bi-annual survey of HIV prevalence among TB patience was on-going at the time of review;
vi. MOHSW has initiated joint internal TB/HIV planning process, as a strategic for integration.

Challenges

i. Although the both MDR and XDR – TB have been identified in Lesotho, there is no sufficient data to establish the extent of the problem;
ii. The referral system between TB and HIV sites is weak;
iii. Fast track the process and improved capacity to diagnose HIV and TB in respective sites;
iv. Delays in finalisation of the TB/HIV policy.

Recommendations

i. Conduct research to establish the extent of the MDR and XDR –TB;
ii. Strengthen human resources capacity to provide comprehensive services include appropriate referrals;
iii. Inadequate dissemination of information on TB/HIV co-infection;
iv. Need to decentralise laboratory services to ensure that capacity for all districts to adequately diagnose and treat TB/HIV co-infection.

Objective 2: To decrease by 100% the burden of TB in PLHIV

Achievement

The following achievements were made.

i. TB Control Policy was developed and adopted in 2007;
ii. The National TB/HIV Strategic Plan for 2007-2010 was developed and approved to guide the development of interventions and service delivery;
iii. In 2007 the National TB programme (NTP) registered 14,300 TB cases. 13,286 were new and relapse cases notified to WHO. 47% of all TB patients accepted to test for HIV after being counselled. Of these 5101 (88%) were found to be HIV positive (one of the highest TB/HIV co-infection rates in the world;
iv. Treatment rate has remained at 73%;
v. The Global Drug Facility provided two years first line anti TB drugs for Lesotho;
vi. TB laboratory capacity to detect and treat drug resistance was strengthened;
vii. Funding from Global Fund through Round 8 will focus on MDR-TB;
viii. TB Officers were appointed to coordinate the decentralisation of TB services with closer linkages to HIV and AIDS control programme.

Challenges

i. HIV testing still not mandatory for TB patients. This has compromised the speedy detection of HIV and early treatment;
ii. The burden of TB disease is on the increase.

> "In 2006 It was estimated that 76% of patient suffering from TB in the country are also infected with HIV according to the WHO TB Global Report (2006). The 635 incident Tb cases per 100,000 population in 2006 places Lesotho 5th among the 15 countries in the world with the highest rates per capital incidence (2008 WHO Global TB report). 87 MDR-TB cases were enrolled in 2007 of which 44 were under the green light committee. MDR-TB/HIV co-infection rate was 65%. MDR-TB deaths in 2007 were 8. By the end of 2007 – 2 cases of XDR-TB were also detected. Currently the is no isolation for MDR or XDR –TB patients.

Recommendations

i. Improve treatment rate from 73% to WHO international standards;
ii. Improve case detection rate to or above 80%;
iii. Strengthen collaboration between TB and HIV/AIDS programmes especially in the areas of testing, case detection and referral;
iv. Advocate for HIV testing for TB patients as part of routine medical diagnosis to improve service delivery and treatment.

4.4.5 Home Based Care

The increased patient load faced by hospitals as a result of chronic illnesses including the HIV and AIDS related conditions has necessitated the provision of home based care. However the programme has faced a number challenges that tend to compromise the quality, effectiveness and efficiency of home based care. The review noted a weak patient referral system, limited access to HBC materials and supplies, a weak referral and patient discharge planning, the absence of clear linkages between the home based care givers and health facilities.

The NSP intended to support interventions that will address these challenges with the hope of improving the quality of services.

Objective 1: To improve the quality of home based care services so that by 2008, all home based care is in accordance with prescribed national standards

Achievements

Through the consultations and a comprehensive literature review the following achievements were identified**.**

i. By September 2008, the number of people receiving home based care had increased to 35,090. Of these 15,360 were men and 19,730 women. Majority of the people were in three districts i.e. Maseru (10187), Berea (13161) and Leribe (7905);
ii. The number of people needing home based care has increased significantly between 2006 and 2008;
iii. Community Support Groups have been trained on HBC skills;
iv. A tool for HBC monitoring has been developed and operationalised.

Challenges

Home base Care experienced the following challenges

i. The coordination of HBC services at community level was found to be weak and not adequately mainstreamed in community structures;
ii. Community caregivers are not adequately trained in home based care skills and in particular palliative care;
iii. High levels of attrition and burn out, affecting resource absorption capacity;
iv. There is no programme for care carers at community level;
v. The HBC guidelines need to be revised to align them with current standards of service;
vi. Inadequate and inconsistent reporting on home based care services.

Recommendations

i. Strengthen the overall coordination of HBC services at district and community levels.
ii. Strengthen resource absorptive capacity of HBC service providers;
iii. Update and standardise HBC guidelines are outdated;
iv. Develop guidelines for palliative care. Care givers also need training in palliative;
v. Develop a comprehensive plan for HBC that also integrates palliative care services;
vi. Consider incentives for community caregivers e.g. allowances, gifts, awards, recognition or training among others;
vii. Develop a programme for care of carers (community based), that will provide psychosocial support among other services;
viii. Develop and operationalised advocacy strategy for male involvement in home based care;
ix. Review the monitoring and reporting of home based care services to ensure consistency.

4.5 Strategic Focus 4: Impact Mitigation

4.5.1 Background Information

Impact mitigation has been used as a strategy to address the socio-economic and psychological challenges posed by HIV and AIDS on vulnerable households and individual persons. Such challenges include HIV and AIDS related stigma and discrimination, the loss of bread winners, leaders, knowledge and skills necessary to sustain livelihoods. The epidemic has negatively impacted on the traditional family and community coping mechanisms (safety nets) and household food security.

The socio-economic impacts on vulnerable people are emerging as their inability to meet their basic needs such as food, clothing and shelter. The elderly and the girl child are assuming the roles of caregivers and parenting. The impact on girls as they assume the role of caregivers or become heads of households, is more visible in the lost opportunity to attend school.

At macro level the epidemic has is reversing the socio-economic gains, thereby compromising investment in health, education, agriculture and human capital. This has a trickle effect as Lesotho's capacity to absorb resources ear marked for HIV and AIDS and economic development declines.

The NSP targeted vulnerable groups including OVC, PLHIV, prisoners, herd boys, women and girls, sex workers, people with disabilities and migrant populations. The NSP focus was three fold, first,

the impact of HIV and AIDS on these vulnerable groups, second, the role of the groups in spreading HIV, and third, their access and utilisation of HIV and AIDS services.

The following is a mid-term review of the extent to which the targets of the NSP objectives were realised. The review also identifies gaps and challenges encountered during the implementation process.

4.5.2 HIV affected Households, Orphans and Vulnerable Children

Objective 1: To ensure that legislation and policies to protect the rights of OVC are implemented by 2007

Orphans and vulnerable children are the most obvious manifestation of the impacts of HIV and AIDs. The estimated total number of orphans due to HIV has grown from 88,500 in 2005 to 108700 in 2008. Available evidence indicates that OVC are more vulnerable than any other group in the society. Their rights are violated and abused by some of the people who assume the role of caregivers. Some of the OVC become caregivers and parents in OVC headed households. This compromises the rights of the OVC to attend school. Property is often grabbed by relatives under the pretence of traditional customs. NSP noted that these challenges can only be addressed by ensuring adequate and comprehensive legislation and policies to protect the rights of the OVC.

Achievements

The review recorded the following achievements

i. The National OVC Policy and strategy were developed in 2006. Guidelines to operationalise the policy have also been developed;
ii. The draft Child Protection Welfare Bill was developed in 2007. It is yet to be finalised;
iii. The National OVC Coordinating Committee (NOCC) was established with the responsibility of coordinating the implementation of the OVC National Policy and the National OVC Action Plan. At district level the committee works closely with the District Child Protection Teams. The teams are responsible for district and community level coordination of the implementation of the National OVC Action Plan;
iv. With regard to education Lesotho has maintained the school attendance ratio of orphans to non-orphans at 1:1. This ratio has not changed since the Lesotho Demographic and Health Survey was conducted in 2004;
v. Programmes that keep children in school such as school bursaries, free primary education and food programmes have been introduced. The implementation of these interventions is by different stakeholders based on their mandate and comparative advantage;
vi. The Lesotho Red Cross introduced the OVC mentorship and coaching programmes through the Home work clubs;
vii. OVC registers were introduced in 2007 and the Orphan Register database established. The Ministry of Local Government and Chieftainship is facilitating the implementation of the OVC registration. Registration guidelines were developed and distributed to all districts and data collectors have been trained;
viii. In facilitating alternative livelihoods for OVC, poultry farming, vegetable production and small livestock initiatives were introduced. These activities are also anticipated to contribute to improve food and nutritional security for OVC households;
ix. The process of establishing a child helpline commenced in 2007. Apart from providing help to OVC, the helpline will improve children's access to HIV and AIDS information in addition to serving as educational tool for the children's awareness of their basic rights.

Challenges

The following challenges were identified.

i. Lesotho has not domesticate the UN Convention on the Rights of the Child;
ii. The delays in finalising the Child Protection Welfare Bill have a negative impact on provision of services and in particular the protection of their basic rights;
iii. In-spite of the efforts being made including having primary education free, not all children of school going age are in school. Community mobilisation and sensitisation to send children to school is lagging behind;
iv. The estimated total number of OVC continued to grow as the epidemic unfolds and more people succumb to AIDS. The number of orphans increased from 88,500 in 2005 to 108 700 in 2008;
v. The NSP has not clearly defined the "basic support package" for OVC. Provision has therefore been inconsistent depending of the capacity and resources of the service provider. The implementation of the National OVC Action Plan was said to have been inadequately coordinated and monitored. Interventions were fragmentation and in some cases quality was compromised;
vi. The stakeholders' consultation noted that child trafficking and adoption were not adequately articulated in the Child Protection Welfare Bill;
vii. Inadequate implementation of the OVC register. Currently there is no standard figure for OVC. Data vary from one institution to another, and hence strategic national planning for OVC has often been compromised.

Recommendations

i. Carry policy advocacy to influence policy makers on the need to domesticate the UN Convention on the Rights the Child (CRC). These could be achieved by reviewing and consolidating the Child Protection Welfare Bill. This will help to harmonise the different approaches in ensuring protection of the rights of the children in addition to providing a comprehensive legal framework on the welfare of the child. The Act would also mainstream provision of the CRC that are not currently covered under national legislation. Key issues for consideration in consolidated Act would include protection against sexual abuse, trafficking, being forced into sex work, character humiliation, child labour, and inheritance;
ii. Train the members of the National OVC Coordinating Committee (NOCC) on leadership, project management and monitoring skills;
iii. Intensify policy advocacy work to influence decision makers on the need to accelerate the finalisation and implementation of outstanding bills and policies that have impact on the welfare of children;
iv. Carry out advocacy work at community level for communities to send and keep children in schools;
v. Review the Education policy to make school attendance by all school age going children. The responsibility should be transferred to parents and communities to ensure that children attend school;
vi. Train communities on the rights of the child including the OVC.

Objective 2: To increase the proportion of OVC households receiving free basic external support to 80% by 2011

The universal definition of free basic external support includes the following list. However, over the years individual countries have modified these listing to suit country specific needs by making additions in the respective areas.

a) **Medical** – medical care, supplies and medicine
b) **Emotional support**: companionship from a trained counsellor, or spiritual support for which there is no payment
c) **Social and materials support**: help with household work, training for caregivers, legal services, clothing,food, or financial support for which there is no payment
d) **School related assistance**: allowances, free admissions, books and or supplies

Psychosocial support is provided as an integral component of emotional (c) or Social (d) support. The NSP did not have a specific programme component for the provision of psychosocial support.

Achievements

The review noted the following achievements.

i. 32% of OVC were reported to have received at least one free basic support. In addition to external support received in form of medical, emotional, social and material support and school related, support was also provide in terms of assisting OVCs to establish alternative livelihoods through farming and development of income generating activities, such as poultry, and small stock rearing;
ii. In terms of empowering OVC, life skills based education is being provided for in and out of school youth. Teachers have been trained to teach life skills in schools while similar services are being provided for out of school youth by civil society organisations;
iii. District Child Protection Teams (DCPT) has been established in all the 10 districts. However only 9 of the teams are functional;
iv. In 2008, alone 10 new orphanage homes were established and registered bringing the total registered orphanage homes to 29;

Challenges

The following challenges were identified

i. There are no clear guidelines for a minimum package for OVC external support. This leaves decision to be made in an ad hoc manner based on a case by case basis;
ii. The definition of vulnerability has not been clearly defined, making the identification and registration of OVC exposed to subjectivity. This also applies to OVC households that need external support in caring for them;
iii. Anecdotal information tend to show that external support if not properly managed could lead to a dependency syndrome by those benefiting from the services;
iv. The effectiveness of the external support has not been evaluated and hence the investment value cannot be determined at the moment;
v. Poor or inadequate monitoring of OVC and fragmentation of activities addressing OVC issues and needs.

Recommendations

The following are made.

i. Define the minimum package for external support for OVC and OVC households;
ii. Clarify the selection criteria for who qualifies to be an OVC, and for OVC households;
iii. Conduct a "Quality of Impact Mitigations Services" to determine the effectiveness and gaps in service delivery;
iv. Develop national guidelines for provision of "external support". Such guidelines should include provision for determining the kind of support and extent or quantity of the required support;
v. Strengthen community systems for responding to impacts of HIV and AIDS as a strategy to move vulnerable homes from dependence to self –sustaining status;

vi. Improve monitoring of OVC activities. This should also include review of the monitoring tools to align them with national M&E system. The process should also focus on consolidating the existing fragmentation of interventions across all stakeholders.

Objective 3: To ensure that 80% of OVC have access to care and psychosocial support by 2010

OVC are exposed to long term trauma associated with living with sick parents and eventually seeing them die. This problem is compounded by being stigmatised and often discriminated in school, in the community and in some of the very homes that takes the role of care giving. The challenge becomes even more mentally challenging when OVC are subjected to abuse including violence, sexual abuse, and child labour among others.

The NSP recognised the need to address these challenges through the development and provision of psychosocial services.

Achievements

The review has not been able to identify significant interventions that have been carried to psychosocial support to OVCs either at operational or policy levels, with the exception of noting that in 2007, 23 people were trained as trainers in play therapy, and were expected to train other people.

There is no documented evidence that this activity has been carried.

Challenges

The extent to which psychosocial service has reached the targeted OVC, the quality of the service, sustainability was difficult to review given the lack of appropriate information

Recommendations

There is need to strengthen psychosocial support training to ensure that services are available both in and out of school. To ensure expansion of services, partnerships could be established with community based organisations to accelerate the provision of psychosocial support. In the same vain issues of quality, sustainability, ethical consideration should be taken into account.

4.5.3 People Living with HIV and AIDS

The needs of PLWHA vary from one to another depending on their individual health status, skills of the caregiver, and resources available. What is common among all PLHIV is the need for sustained psychosocial support. Provision of psychosocial support includes spiritual, supportive and bereavement counselling. It also includes emotional support that may in itself not constitute formal counselling such as companionship when feeling distressed, hopelessness or loneliness.

The lack of exhibition of love or solidarity by caregivers or relatives may contribute to immense psychological distress

Objective 1: To ensure that 80% of PLWHA have access to care and psychosocial support by 2010

Achievements

Anecdotal information suggests that a lot is being done especially at community level with regard to provision of psychosocial support by a number of service providers. However, there is no documentary evidence of any activities having been carried out.

Challenges

There is no documentary evidence of psychosocial services being provided to PLWHA. The Quarterly Partnership Forum reports have not reported on this objective. The review therefore could not make a realistic assessment the extent this objective has been addressed.

Recommendations

Develop an inventory of all stakeholders providing psychosocial support to PLHIV. The inventory should also include the kind and nature of service, the target group i.e. women men or children living with HIV and AIDS, geographical coverage and the number of people receiving psychosocial support preferably presented by gender and districts.

Objective 2: To provide support to alleviate deterioration of living conditions of 80% of PLHIV by 2010

Achievements

The following achievement were identified

i. Between 35-40% of support groups registered with LENEPWA were trained in alternative livelihood and income generating skills;
ii. Community Based Organizations (CBOs), NGOs, FBOs as well as government ministries continue to support PLWHA in developing income generating activities and alternative livelihoods;
iii. LENEPWHA has placed officers in six districts to facilitate coordination of PLHIV driven livelihood activities and provide linkages with District and Community Councils

Challenges

The review identified the following challenges.

i. Inadequate access to land has been a major barrier for PLHIV in establishing income generating activities or alternative livelihoods;
ii. Financial disbursement from LENEPWA and other government institutions to PLHIV support groups was said to experience delays comprising their ability to start and implement activities on time.

Recommendations

i. Strengthen the capacity of LENEPWHA to support PLHIV support groups to establish sustainable alternative livelihoods. The LENEPHWA officers at the district level could be trained to be trainers in alternative livelihoods or income generating activities;
ii. Strengthen financial management and disbursement systems especially to reduce delays in funds disbursement. The process should also strengthen financial tracking mechanisms;
iii. Accelerate the process of land allocation especially to PLHIV support groups intended to establish alternative livelihood and income generating activities.

4.5.4 Women and Girls

The epidemic has had a gender bias. Women and girls infected with HIV compared to their male counter parts. They are also disproportionately vulnerable to the impact of the epidemic due to their lower socio economic position in both traditional and legal settings. In most cases their basic rights

are often violated making them more vulnerable or dispossessed of their inheritance. With regard to care they are the majority of caregivers. Girls have increasingly become caregivers compromising their opportunity to attend school. Despite of Lesotho ratifying the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), empowerment of women has been slow in terms of legal reform on gender equality, prevention of sexual abuse and domestic violence.

The NSP interventions are aimed at reducing the vulnerability to HIV infection and mitigating the impact of HIV and AIDS on women and girls.

Objective 1: To ensure that by 2008 legislation and policies and programmes are in place to address issues of girls education, violence against women, ,property and inheritance rights, putting value to women's care work and access to HIV and AIDS treatment and care

Achievements

The NSP review noted the following achievements

i. The government developed and adopted the Legal Capacity of Married Peoples Act in 2006. The Act provides equal powers between men and women in decision making in matters that affect individual life;
ii. The government is holding public consultations that may lead to the development of a human rights bill in Lesotho;
iii. Lesotho has ratified the CEDAW, and has put in place legal mechanisms that prevent gender based violence. Implementation and monitoring is on-going by such groups as, CGPU, DCPT, Child helpline;
iv. WILSA in partnership with Habitat for Humanity trained 20 people in Botha-Bothe district on paralegal skills. The training focused on widows and OVC's rights such as inheritance, land, marriage and gender based violence;
v. Young people in Maseru and Berea were trained on policy and legal issues and gender mainstreaming;
vi. The Ministry of Gender, Youth Sports and Recreation (MGYSR), in collaboration with other stakeholders, held a 16 Days of Activism Against Gender based violence. Although the campaign was launched in Botha-Buthe activities were held in all the districts;
vii. With regard to equal access to services, the principle in service delivery is equitable distribution and access by gender and geographical. For women access to ART has been higher than men;
viii. Basotho have access to legal assistance in matters relating to property grabbing and provide for custody disputes through such schemes as legal aid, FIDA, or the master of high court

Challenges and Gaps

The review process identified the following challenges and gaps:

i. The implementation and enforcement of existing policies and legal instruments remains weak. There not adequate mechanisms for monitoring the implementation;
ii. The level of awareness of the Legal Capacity of Married Peoples Act is considered low among women in rural areas and those with a low education level. Dissemination of such instruments to the general public has not been clearly articulated;
iii. Although the ratio of school attendance between boys and girls is equal, girls tend to drop out of school for a variety of reasons including teenage pregnancy, early marriages or to provide care for relatives. Culture also prohibits girls who have become mothers to go

back to school. Similarly schools that are run by religious groups also do not allow teenage mothers girls to return to school.

Recommendations

i. Ensure implementation and enforcement of legal instruments and policies by all stakeholders. Carry out advocacy work and community education outreach to publicise the instruments;
ii. Put in place adequate and effective monitoring mechanisms both at national, district and community level;
iii. Provide life skills for girls to take control of their sexuality;
iv. Advocate for religious organisations to change their policy on teenage mothers with regard to returning to school;
v. Accelerate the finalisation and enactment of the Gender Based Violence;
vi. Accelerate the domestication of CEDAW and CRC;
vii. Provide paralegal training for community volunteer and caregivers.

4.5.5 Prisoners

Objective 1: To ensure access to HIV and AIDS services for prevention, treatment, care and support and impact mitigation for inmates in all correctional institutions by 2007

The Government of Lesotho acknowledges the rights of the inmates to HIV prevention, treatment care and support, and impact mitigation services. As result, different partners are collaborating with the Department of Correctional Services to develop interventions that address the needs of Correctional service men and women, and the inmates.

Achievements

The following progress was noted

i. The development of a strategic plan and policy has been initiated;
ii. Two staff a nurse and a nutritionist have been recruited to support the health unit of the Correctional Services;
iii. Psychosocial services are also being provided.

Challenges

i. The delays in the finalisation of the strategic plan and the policy prevent a systematic approach to services delivery in correctional facilities. This also has delayed implications on resource mobilisation to support such interventions.

Recommendations

i. Accelerate the finalisation of the strategic plan and the policy.
ii. Implementation of the policy and strategic plan once finalised
iii. Facilitate training of peer educators from among the Correctional Service men and women and from among the inmates.

4.5.6 Sex Workers

The extent of sex work in Lesotho has not been adequately established. However, literature review indicates that sex work is on the increase. In 2004 the LDHS noted that 1.7% of men reported having paid sex in the last 12 months preceding the report. Of these 58% acknowledged having used a condom in the most recent sexual encounter. Anecdotal information suggests that there are also men sex workers.

Objective 1: To ensure access to HIV and AIDS services for prevention, treatment, care, support and impact mitigation for male and female sex workers by 2007

Achievements

i. Interventions on targeting sex workers have primarily focused on HIV prevention. There is little known about their access to treatment, care and support or impact mitigation services. A number of NGOs including CARE, PSI and the 7th Day Adventist have carried out some interventions. Most of the interventions have since stopped;

ii. The plan to form a task team that will spearhead the development and coordination of interventions targeting sex workers is being discussed by stakeholders. WILSA in collaboration with the MGYSR and PAVE conducted a one day meeting with sex workers to discuss issues of HIV and AIDS;

iii. In the absence of national survey on sex work in Lesotho it is difficult to plan let alone delivery services. Like other vulnerable groups issues of stigma and discrimination play a major role in preventing them from participating in HIV prevention activities.

Recommendations

i. Conduct a comprehensive national survey on the extent and challenges of sex workers in the context of HIV prevention and impact mitigation of those already living with HIV. The survey should cover both female and male sex workers;

ii. Establish one stop shop (user friendly) especially in urban centres where sex workers could freely report cases of abuse and access services including awareness of HIV and AIDS;

iii. Develop a multi-sectoral action plan (inclusive of all stakeholders) that harmonises interventions by the various stakeholders. The plan should also articulate modalities for coordination and monitoring;

iv. Develop and distribute target specific (sex workers) social and behaviour change communication materials.

4.5.7 Migrant Populations

The review could not identify any activities initiated targeting migrant populations. Consequently the assessment of the extent to which the following objective was implemented could not be established.

Objective 1: To ensure access to HIV and AIDS services for prevention, treatment, care, support and impact mitigation for migrant workers by 2007

Recommendations

The following recommendations have been made.

i. Conduct a comprehensive national situation analysis on migrant workers and HIV and AIDS. The survey should also consider issues of knowledge, attitudes and practices among migrant workers;
ii. Develop a national policy and action plan to address challenges identified by the situation analysis;

iii. Support the establishment of HIV and AIDS workplace programmes in the public and private sectors as a strategy of expanding availability, access, and utilisation of services by migrant workers.

4.5.8 People with Disabilities

Over the years people with disability have not been a key focus of HIV and AIDS interventions. It is only in the last five years that civil society organisations started addressing HIV and AIDS and people with disability. Our knowledge of on the impacts of epidemic on people with disability is limited to a few studies. Current caregivers have been trained to provide care and support to the general populations, but in most cases the special needs of people disability have not been considered. This is primarily the case of people with severe physical or mental disabilities. The extent of HIV prevalence among people with disability is not known given that data has not been collected disaggregated by health condition such as disability. It is for these reasons that the NSP identified people with disability as a key target population.

A number of organisations including the following - Lesotho National League of Visually Impaired Persons (LNLVIP), Lesotho Society of Mentally Handicapped Persons (LSMHP) and National Association of the Deaf LNFOD are providing HIV and AIDS services to people with disability. These organisations are affiliate to Lesotho National Federation of Organizations of the Disabled (LNFOD), an umbrella organisation with the mandate to activities for people with disability including HIV and AIDS interventions.

Objective 1: To ensure access to HIV and AIDS services for prevention, treatment, care, support and impact mitigation for people with disabilities by 2007

Achievements

The review identified the following achievements

i. A needs and capacity assessment on HIV and AIDS and disability was conducted in 2008;
ii. Joint programmes between LNFOD and NAC are running in a number of districts with implementation being carried out by LANFOD affiliates;
iii. HIV and AIDS BCC materials were produced in Braille and distributed to stakeholders working with people with visual disability;
iv. LSMHP conducted training in 7 of their branches in 4 districts of Mafeteng, Mohale's Hoek, Maseru and Leribe. The training aimed at enhancing understanding of parents of children with disabilities' knowledge on HIV and AIDS issues. Parents were also sensitized about the Sexual Offences Act of 2003;
v. LNFOD held public gatherings in different local councils in Mafeteng and Mohale's Hoek not only to engage people with visual disability in the national response but also to sensitise communities on HIV and AIDS and people living with disability.

Challenges

i. There are no policy guidelines or a strategic plan on HIV/AIDS and disability. The development of the policy and the strategic plan are budgeted for in the 2009/10 budget.
ii. Current HIV and AIDS interventions and disability are few and fragmented;
iii. Many of the organisations of people with disability lack adequate capacity in planning, M&E, resource mobilisation (including proposal writing) and project management.

Recommendations

i. Strengthen the capacity of organizations of people with disability or service providers to ensure that services are comprehensive and meet the national minimum standards;
ii. Conduct a comprehensive national KAPB situation analysis on people with disability and HIV and AIDS;
iii. Ensure workplace programmes take cognizance of the needs of people with disability within such environments.

4.5.9 Herd Boys

Herd boys are among the vulnerable groups that are not only difficult to reach but also sustaining targeted interventions is problematic.

Objective 1: To ensure access to HIV and AIDS services for prevention, treatment, care, support and impact mitigation for herd boys by 2007

The review could not identify any activities developed and implemented targeted the herd boys. Hence the assessment of the extent to which the above objective was implemented could not be done.

Challenges

During the consultations the following challenges emerged.

i. There is no data that helps to establish the people of people working as herd boys;
ii. Herd boys do not form part of any support groups and sustaining interventions will be challenging;
iii. It is not clear how the herd boys are accessing and utilising current services available at the community level;
iv. The level of awareness and knowledge of HIV and AIDS has not been established to inform development of interventions;
v. There are no policy guidelines on how to deal with herd boys and HIV and AIDS. Equally interventions are ad hoc and fragmented.

Recommendations

i. Conduct a comprehensive national situation analysis on herd boys and HIV and AIDS. The survey should also consider issues of knowledge, attitudes and practices among migrant workers. The survey should also explore what organisations are currently working with herd boys or would be willing to participate in service delivery to them.
ii. Improve access to basic services such as HTC, home based care, education and awareness.
iii. Encourage herd boys especially those in **METEBONG (Cattle posts),** to form some kind of organisations or support groups to serve as entry points for service delivery
iv. Develop a pilot plan for service delivery. The experience from the pilot programme would inform the policy development and a medium to long term strategic plan for Herd boys and HIV and AIDS.
v. Develop guidelines for service delivery among the herd boys
vi. Transform the Herd-boys Task Team to an institutionalised Technical Working Group to ensure effective coordination and implementation of planned activities.

4.6 HIV and AIDS in the Workplace

HIV and AIDS Workplace programmes usually constitute an internal response to the epidemic primarily helping employees prevent infection and cope with the impacts. They serve to expand availability of services and increase access and utilisation. Available information indicates that some private sector companies and government ministries in Lesotho have established workplace programmes. The primary focus has been the basic services related to prevention i.e. condom distribution, peer education and counselling and referral services to other service providers.

Objective 1: To increase the proportion of employers including government who have HIV and AIDS workplace policies and programmes to 80% by 2007.

Achievements

The following progress had been made:

i. The labour code was amended in 2006 to mainstream HIV and AIDS in the workplace. The amendment prohibits pre-employment testing, involuntary testing during the employment period, ensures confidentiality, involuntary disclosure of ones HIV status, and criminalises discrimination on the basis of one being HIV positive;
ii. National guidelines for workplace programmes were developed and BCC strategies for specific target groups articulated. The guidelines have been disseminated to relevant organisations and government institutions;
iii. A survey of work place programmes was completed in 2008. A report has been produced and disseminated;
iv. Training for supervisors and shop stewards was conducted by ALAFA in December 2008. Six labour inspectors have been trained on promoting HIV prevention at the workplace. Meetings were held with Managing Directors and their associates to discuss HIV/AIDS workplace policy development for large companies;
v. One of the largest workplace programmes is housed by the Apparel Industry, one of the biggest employers in the private sector accounting for nearly 80% of the workforce.
The Apparel Lesotho Alliance to Fight AIDS (ALAFA) was formally launched at Precious Garments in Maseru on 16 May 2006. A baseline survey has also been conducted. The programme reaches out to 20 factories benefiting approximately 30,000 workers out of an estimated 40,000. 9 factories have established workplace clinics;
vi. 9 factories funded under ALAFA had established workplace clinics, giving employees access to medical services;
vii. The Ministry of Trade, Industry, Cooperatives and Marketing (MTICM) is also in the process of developing IEC materials for use among the medium and small scale industries;
viii. The Association of Lesotho Employers have initiated several workplace programmes and undertaken advocacy with employers;
ix. The private sector is in the process of establishing a national business coalition to coordinate private sector HIV and AIDS response.

Challenges

i. Coordination of workplace programmes was found to be fragmented both within the public and private sectors;
ii. The provisions (preventing HIV testing for purposes of employment or forced testing while in employment) of the amended Labour code that mainstreamed HIV and AIDS seem not to be applicable to the public sector;

iii. The roll-out of HIV and AIDS services to factories in 2008 remained low. This was attributed to lack of resources, capacity and experience, and in understanding of the guidelines;
iv. HIV Testing and Counselling services are not readily available in the workplace. The potential for public private partnership in HTC and other HIV and AIDS services have not been adequately explored.

Recommendations

i. Accelerate the establishment of the Business Coalition on HIV and AIDS;
ii. Intensify the training of key focal point persons on workplace programmes with a focus on strategies of how to develop them;
iii. Explore the potential for public private partnerships in rolling out services to the private sector;
iv. Support private sector to establish HTC services in the work place or strengthen the referral system;
v. Encourage government ministries to adequately plan for the use of the 2% budget allocation for HIV and AIDS interventions;
vi. Develop standardised BCC materials for use in the work place programmes to avoid confusion and mixed messages;
vii. Ministry of the Public Service should take the lead in coordinating workplace programmes within the public sector.

5. Emerging Issues

Part of the review exercise was to identify emerging issues that had implications not only on the national response but also on the NSP. The review identified the following issues.

5.1 Male Circumcision

Male circumcision was not included in the NSP. At the time the NSP was developed, the evidence that male circumcision was an effective prevention strategy was still being considered. However, since the launch of MC by WHO, a number of countries have adopted the strategy and mainstreamed its implementation in their on-going national strategic plans.

In Lesotho MC has been incorporated in the Ministry of Health and Social Welfare Strategic plan 2008 – 2009. The Ministry has set a target of 60% males to have been circumcised by 2011. By 2008 only 15% of men in Lesotho were circumcised. Based on the cost analysis, the epidemiological impact and cost effectiveness, Lesotho has projected MC among males (ages 15-49) at 52.5% coverage between 2008 and 2020. It is estimated that one HIV infection will be averted for every 6.1 male circumcisions performed, and that the cost per infection averted is US$292 (about 2,136). This is potentially cost effective relative to other HIV prevention interventions. The scaling up of MC requires approx. 34,798 male circumcisions in 2008, increasing to 44,164 in 2015.

To ensure that this is achieved the ministry has planned to develop a national policy and guidelines on safe male circumcision by 2009. It is also anticipated that by 2011, all health facilities will be providing safe male circumcision. Progress reports on MC are included in the HIV and AIDS quarterly Partnership Forum.

5.2 HIV Testing and Counselling

Since the emergency of the epidemic, HTC has been perceived as an important component of the national response strategy. While HTC has paved the way for people to know their HIV status, there is no empirical evidence indicating that by knowing the status people would adopt key prevention behaviours or seek treatment early. Emerging evidence seems to indicate that HTC is not necessarily a very effective prevention strategy. However, on the other hand the "provider initiated" HTC is strategic in enabling health care providers provide quality and comprehensive treatment.

A recent meta-analysis of research about the effectiveness of VCT as an HIV prevention measure has shown that "VCT recipients were significantly less likely to engage in unprotected sex when compared to behaviours before receiving VCT, or as compared to participants who had not received VCT. VCT had no significant effect on the number of sex partners. While these findings provide only limited evidence in support of VCT as an prevention strategy, neither do they negate the need to expand access to HIV testing and counselling services" (Denison et al., 2007:363). Other studies have shown positive behavioural outcomes for HIV positive persons (Eisele et al., 2008), but negative outcomes for HIV negative persons who either increase or maintain their high risk behaviour after testing negative (Corbett et al., 2007; Potts et al., 2008). This raises the importance of ensuring that HTC quality control is ensured, so that all persons are given comprehensive information to reduce their high risk behaviour

5.3 HIV Prevention in Key Populations

Key populations at risk are those populations who have higher HIV prevalence and display behaviour that puts them at higher risk of HIV infection. From an epidemiological view, in a generalised epidemic, controlling HIV infections amongst these key populations at risk does not have a significant impact on reducing new infections or preventing the HIV epidemic from sustaining itself. However, as a human rights issue prevention interventions need continue being provided to key populations at risk. In Lesotho key populations at risk for which some evidence exist, are inmates, sex workers, and migrant workers with oscillatory migration patterns, and uniformed services. Other potential key populations at risk, for which no data exist but for whom new data need to be collected, are: men having sex with men (MSM) and injecting drug users

5.4 Treatment of STI as a HIV Prevention Strategy

Sexual reproductive health programmes consist of interventions focusing on sexual health, maternal health, family planning and STI management. Given that HIV is transmitted sexually in Lesotho, linking HIV services to sexual reproductive health programmes would be beneficial and support overall HIV prevention efforts as it provides yet another avenue for HIV prevention efforts. Whereas there is plausible biological evidence that STIs increase HIV transmission, some new findings in terms of STI control as an effective HIV prevention strategy has emerged.

Contrary to what observational studies suggested in earlier years and the randomized control trial in Mwanza, Tanzania in the 1990s, evidence from all other randomised controlled trials for STI control in the past ten years seem to question the efficacy of both bacterial and viral STI control as an effective HIV prevention strategy (Sangani et al., 2004; Gray and Waver, 2008; Watson-Jones et al. 2008; Celum et al., 2008). A recently-completed study amongst sex workers in Zimbabwe (Cowan et al., 2008), for example, showed that amongst HIV-1 positive and HSV-2 positive female sex workers, HSV-2 treatment suppressed HSV-2 viral shedding, but not HIV viral shedding – adding to the body of knowledge that HSV-2 treatment is not effective as an HIV prevention strategy.

Researchers have suggested that this is in part because "observational studies about the associations between sexually transmitted infections and HIV acquisition are susceptible to confounding, because both infections are transmitted by the same sexual risk behaviours" (Gray and Waver, 2008), and also because of the implementation challenges associated with the syndromic management approach to STI control (Sangani et al (2004)). It therefore seems that despite their common behavioural pathways, STIs and HIV are not necessarily highly correlated at the population level. We have numerous examples of countries with high STI rates that have not experienced commensurate HIV epidemics. The hypothesis that treating bacterial and viral STI infection reduces HIV transmission has been extensively tested and in seven of eight trials has found no effect. There is thus insufficient evidence to support STI treatment as an HIV prevention strategy.

That said, offering STI treatment to vulnerable populations, including sex workers and men-having-sex-with-men, who may have a high STI burden, may help to build rapport, trust and solidarity and as such may be a component of a comprehensive intervention for these populations. This evidence should not detract from the fact that STI treatment is an important public health intervention in their own right and as such STI control for the general population should be a priority intervention as part of sexual reproductive health services.

5.5 Coordinating UN Agencies working on HIV and AIDS at country level

Over the years countries have expressed concern of the lack of adequate coordination and harmonisation of UN support for HIV and AIDS at country level. This concern has resonated at the UN and was considered during the UN Reform Process. In 2005, the UN Secretary General requested all the UN agencies to establish Joint Teams on AIDS to further harmonise and consolidate the UN response to HIV and AIDS.

In Lesotho the team was constituted in 2006, almost the same time the NSP was being launched. This followed a mapping exercise to determine UN staff members working on HIV and AIDS in Lesotho. By March 2009, there were 21 UN staff working on HIV and AIDS from ten agencies[24]. The agencies have developed what has come to be known as the Joint UN Programme of Support on AIDS (JUPSA).

It is anticipated that JUPSA, will enhance coordination and harmonisation between the UN and the National Response and in particular align their interventions with NSP. However, the Team and the JUPSA modality are evolving and only over time can the modality be measured in terms of its effectiveness to improve support to national programmes.

It is not yet clear how, JUPSA will coordinate itself in am multi-sectoral environment where other key plays such as Global Fund, PEPFAR and EU among others.

[24] These agencies include UNICEF, UNDP, WFP, FAO,UNFPA, UNESCO, World Bank, and UNAIDS

6. Conclusion

The midterm review process has been comprehensive and thorough in assessing the state of the national response in relation to the implementation of the National HIV and AIDS Strategic Plan. It has been a highly consultative and participatory process with many stakeholders involved from Government Ministries and Departments in particular the Ministry of Health and Social Welfare, civil society organisations, PLWHAs, District AIDS Committees (DAC), Community Councils AIDS Committees (CCACs) and Development Partners. The review has resulted in the identification of areas in which the country is doing well and challenges that need to be addressed. The review has also outlined recommendations on dealing with the challenges. Emerging issues which were not interventions of major importance when the plan was developed and therefore not included such as male circumcision and positive prevention have since been recognised as key areas that will enhance prevention. This report forms the basis for the development of the Revised NSP, the two-year National Operational Plan and the comprehensive scenarios for financing the national response.

7. Annexes

Annex 1: Partnerships and Strategic Alliances

Partner	Area of Focus
Irish AID	• ARV roll out in remote mountains • Strengthening of ARV management and supply • Facilitating clinical mentoring and training (pre-art and patient management • Human resource (100 nurses were recruited) • Supported the NAC to develop the NSP 2006-2011 and the M&E plan • Supports 9 CSO and international NGOs (PSI and ALAFA) • Supported MoE with OVC school bursaries support (3600 OVC benefited)
Clinton foundation	• Roll out of ARV in remote mountain areas
USG - PEPFAR	• Prevention of sexual transmission of HIV • Prevention of mother to child transmission • Integration of TB and HIV service delivery, including laboratory services • Strengthening universal access to counselling and testing • Strengthening human resources • Roll out of the M&E plan • Strengthening of the procurement and supply chain management • Works with MCC in coordination of the health component of the USG Millennium Challenge Corporation
DFID	• Support workplace programmes (i.e. in the garment sectors) • Support for know your status campaign
European Union (Commission)	• Support for OVC (12 Million Euro) – project being implemented by UNICEF and MOHSW • Support ALAFA (500,000 Euro) • Support for OVC households (home based care) through German and Lesotho Red Cross) – 1.9 million Euro • Through the 10th European Development Fund (2008-2013) has earmarked 27.2 million Euros for human development
German Development Corporation (GTZ)	• Decentralised rural services – (getaway services??) • Support Ministry of Local Government and Chieftainship and the Local Government Councils with HIV and AIDS competency, development planning and accessing funds to implement these plans. • Strengthening capacity to implement plans i.e. HIV and AIDS action plans, the Essential HIV and AIDS Services Package development involving 128 community councils , mainstreaming HIV and AIDS in development projects • Training of civil servants in HIV mainstreaming
Joint UN Team on AIDS	• Coordinated UN technical support and resource mobilisation for HIV and AIDS in Lesotho
UNDP	• Supported the operationalisation of the NAC Operational Business Plan • Support the joint review initiatives • Trained key planning officers on HIV mainstreaming • Supported the publication of the booklet – "roles and responsibilities of the public service in the response to HIV and AIDS in Lesotho" • Supported the KYS campaign (2007) • Supported the development of the National GIEPA Action Plan / the training manual for capacitating theLENEPWA District Executive Committees
UNICEF	• Support PMTCT scaling up through training health workers in 17 hospitals + 165 health facilities in 10 districts • Supports paediatric AIDS care for children • Support for OVC impact mitigation (11.3 million Euros) – used to set crucial structures including National OVC Coordinating Committee, responsible for coordination of the OVC NAP / development of the national OVC Policy / • Social mobilisation for KYS • Contributed to the development of the MOET HIV and AIDS Sector policy • With UNFPA supported the development of life skills education curriculum for grades 4 – 7 and forms A to C. (curriculum not finalised – consensus on contents)

	• Supported MoHSW to finalise the National Plan on Drug and Substance Abuse among Youth and Adolescents (2006)
UNFPA	• Supported the development of the National BCC strategy. Through the Medical Care Development International (MCDI) and Academy for • Educational Development (AED) • Working with UNAIDS to explore interventions with sex workers • Conducting a situation analysis and needs assessment of young people aged 10-24 years • Supported the development of the Legal Capacity of Married People's Act of 2006; • Support the finalisation of the Reproductive Health Policy (2006) • Supported MOHSW to procure male and female condoms for dual protection
WFP	• Provides nutritional support to vulnerable people. 2600 TB patients have benefited / 4,258 families hosting OVCs, 1785 PLHIV / 115 000 children in 585 primary schools • Provides rations to school children
Who	• Strengthening of the health sector capacity to respond to demand for ART, PMTCT, HTC, TB/HIV co-infection, safe blood, and STI management • supported MOHSW to implement innovative approaches such as integrated management of adult, adolescent and child illnesses (IMAI & IMCI); Know Your Status Campaign, Syndromic management of STI and community home-based care
FAO	• support the the Agricultural Emergency Relief and Rehabilitation Programme and OVC livelihood project
ILO	• Support the Ministry of Labour in strengthening workplace programmes
UNCESCO	• Worked with MOET in developing the sector HIV and AIDS policy / the curriculum and training of teachers

Annex 2: Implementing partners collaborating with NAC

The following are partners collaborating with NAC to implement the NSP

(a) Government Line Ministries

Ministry	Area of interest
Ministry of Agriculture and Food Security	Impact mitigation and Prevention
Ministry of Constitutional and Parliamentary Affairs	Governance and Management and Coordination
Ministry of Defense and National Security	Prevention
Ministry of Education	Prevention
Ministry of Finance and Development Planning	Prevention
Ministry of Foreign Affairs	Prevention
Ministry of Forestry Conservation	Prevention
Ministry of Gender, Youth, Sports and Recreation	Prevention
Ministry of Health and Social Welfare	Impact mitigation and Prevention
Ministry of Home Affairs and Public Safety	Prevention
Ministry of Justice and Human Rights	Management and Coordination
Ministry of Labour and Employment	Prevention
Ministry of Law	Prevention
Ministry of Local Government	Management and Coordination and Governance
Ministry of Natural Resources	Impact mitigation, Prevention
Ministry of Public Service	Prevention, Impact mitigation
Ministry of Public Works and Transport	Prevention, Impact mitigation
Ministry of Science and Technology	Prevention, Impact mitigation
Ministry of Tourism, Environment and Culture	Prevention, Impact mitigation
Ministry of Trade and Commerce	Prevention, Impact mitigation and Treatment, Care and support
Ministry of Works	Prevention

(b) Umbrella Organizations

Umbrella Organization	
FIDA	
LNFOD	
NGOC	
AGSA	
LSRC	
LFYE	
ALE	
LIRAC	
LENEPWA	
TEBA	
LENASO	
Office of the 1st Lady	Impact mitigation
Tsoanelo Care	Impact mitigation
Healthy Life Styles	Prevention
Scripture Union	Prevention
Catholic Relief Services	Impact Mitigation
10 District Councils - District AIDS Committees	
128 Community Councils AIDS Committees	

Annex 3 :Terms of Reference for the Review Process

The review process was informed and guided by the following Terms of Reference (TOR):

i. To collect any new evidence on the drivers of the epidemic in Lesotho that have emerged in the past 3 years (to assess whether HIV services provided and target groups reached are relevant to the drivers of the epidemic)
ii. To assess which HIV services (those defined in the NSP and those not originally defined in the plan) have been delivered by stakeholders from various sectors in the past 3 years;
iii. To assess the coverage of HIV services in Lesotho (to determine whether the HIV response is of an appropriate scale);
iv. To assess the extent to which HIV services have been provided to most at risk populations;
v. To assess the extent to which an enabling environment is in existence for implementing the NSP;
vi. To assess the effectiveness of managing the HIV response in all sectors at all levels;
vii. To assess the resources mobilised and utilised by all sectors since the start of the NSP and the resources committed for the remainder of the NSP implementation period;
viii. To assess the challenges and gaps in terms of HIV service delivery, the enabling environment, and M&E of the national response; and
ix. To assess whether HIV stakeholders are collecting, capturing, storing, processing, disseminating and using appropriate information about HIV response, the drivers of the epidemic, and the outcomes of the HIV response
x. To identify and indicate any emerging issues relevant to HIV and AIDS and need consideration in revised National Strategic Plan