Draft Document

Ver-2: (10/03/2011)

National HIV and AIDS Strategic Plan
2011/12 – 2015/16

National AIDS Commission
10th March 2011
Foreword

The National Strategic Plan (NSP) 2006-2011 was launched in 2006. The mid-term review (MTR) was conducted in 2009 and the NSP was accordingly revised in line with the findings of the midterm review. The midterm review provided a great opportunity for Lesotho to shift the HIV and AIDS planning paradigm from business as usual to evidence and results based. Consequently the revised NSP used evidence and results based management (RBM) approaches in articulating interventions for the remaining period until March 2011/12.

The development of the third generation of the NSP 2011/12 to 2015/16 has further consolidated Lesotho’s efforts to use evidence, focus on specific results for the national multisectoral response, mainstreamed gender and human rights in the design, implementation, monitoring and evaluation of the response. The NSP constitutes a multi-sectoral, multi-layer and decentralised response to HIV and AIDS and provides opportunities for all stakeholders to actively participate based on their institutional mandate and comparative advantage. The involvement of civil society organisations and PLHWA in particular will be strengthened. With regard to districts and community involvement the NSP has set out the framework for a decentralised implementation.

Through the implementation of the NSP, Lesotho hopes to halt and start reversing the epidemic. Our aim is to reduce the rate of new infections by 30% by 2015/16. The NSP will also support national efforts to improve the quality of life of people living with HIV and AIDS, through a comprehensive and quality treatment, care and support programme. To support this, Lesotho has changed its eligibility criteria for enrolment on ART from CD4 200 to CD4 350 so that people in need of ART or pre-ART services can get enrolled early enough. The comprehensive ART programme will also contribute to HIV prevention and delay of orphanhood. In line with international efforts, Lesotho is committed to virtual elimination of mother to child transmission of HIV by 2015/16. During the period of the outgoing NSP, the PMTCT programme was strengthened and services rolled out throughout the country. During the period of the incoming NSP these services will be significantly scaled up.

The NSP III will strengthen the enabling policy and legal environment to ensure that services are equitably distributed and accessible regardless of gender, age and vulnerability. National policies will be reviewed to ensure consistency with basic human rights and gender sensitivity. Specific efforts will be made to expand coverage and intensify interventions targeting vulnerable and most at risk populations.

Lesotho is also committed to fulfilling its regional and international obligations on HIV and AIDS including UNGASS, Millennium Development Goals (MDGs), Africa Union and SADC protocols while at the same time consolidating and expanding strategic partnerships and alliances.

Lesotho has also taken note of the lack of empirical and baseline data in certain areas of the national response to objectively inform evidence based planning. In this regard the National M&E systems and HIV research will be strengthened and adequately resourced.

It is my sincere hope that all stakeholders shall join and sustain the fight against HIV and AIDS epidemic and together we can win the battle.

Chairperson
National AIDS Commission, Lesotho
Acknowledgements

The development of the NSP has been a joint effort between the Government of the Kingdom of Lesotho and the many and diverse stakeholders and development partners. Through their concerted efforts the joint epidemiological and national response review generated the data and information that has formed the basis for evidence and results based planning of the NSP. The National AIDS Commission wishes to acknowledge with gratitude the valuable contribution of these stakeholders and development partners who made it possible for the NSP development possible.

In particular, the NAC wishes to express its special thanks and appreciation to the members of the NSP Review Forum, and the various technical working groups that provided technical and policy oversight and advice. NAC further wishes to thank all the organisations and individuals who have participated in the peer review of the NSP to ensure its quality and comprehensiveness. The support has resulted in the strategic articulation not only of the response in general but in particular of the results (impact, outcome, output) strategies and activities.

Finally we would like to express special thanks to the Joint United Nations Programme on HIV and AIDS (UNAIDS), JSI, WHO and Technical Support Facility (TSF) for Southern African for their support in providing technical and financial assistance to support the review process. We further want to acknowledge the contributions and dedication by the team of consultants’ who worked on the NSP, Dr Simon Muchiru (Lead consultant), Dr. Thandie Hlabana, and Mr. Mokete Khobotle (M&E), and Dr. Edwin Limbambala (Treatment care and support). NAC wishes also to acknowledge the technical support provided by the M&E consultants in developing the M&E framework.

Finally I want to express my gratitude to the staff of the National AIDS Commission who were involved in this process at various levels and in particular the Directorate of Policy, Strategy and Communication (DPSC) for their commitment and dedication to the process. Without them, the development of the NSP, NOP and the M&E framework would not have been possible.

Chief Executive
National AIDS Commission, Lesotho
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<td>AIDS</td>
<td>Acquired Immuno-deficiency Syndrome</td>
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<td>ANC</td>
<td>Anti-natal Clinic</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>AU</td>
<td>African Union</td>
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<td>CCAC</td>
<td>Community Councils AIDS Committees</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination Against Women</td>
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<td>CHBC</td>
<td>Community Home Based Care</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>EU</td>
<td>European Union</td>
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<tr>
<td>GTT</td>
<td>Global Task Team</td>
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<tr>
<td>HIV</td>
<td>Human Immune Virus</td>
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<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<tr>
<td>KYS</td>
<td>Know Your HIV Status</td>
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<td>LDHS</td>
<td>Lesotho Demographic and Health Survey</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MC</td>
<td>Male Circumcision</td>
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<td>MCP</td>
<td>Multiple Concurrent Partners</td>
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<td>MDG</td>
<td>Millennium Development Goals</td>
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<td>MDR-TB</td>
<td>Multi-Drug Resistance Tuberculosis</td>
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<tr>
<td>MOT</td>
<td>Modes of Transmission (study)</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with other Men</td>
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<tr>
<td>MTR</td>
<td>Mid-Term Review</td>
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<td>NAC</td>
<td>National AIDS Commission</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organisation</td>
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<tr>
<td>NSP</td>
<td>National Strategic Plan</td>
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<tr>
<td>OPD</td>
<td>Out Patient Department</td>
<td></td>
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<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
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<tr>
<td>PEP</td>
<td>Post Exposure prophylaxis</td>
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<tr>
<td>PEPFAR</td>
<td>President’s Emergency Programme for AIDS Relief</td>
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<tr>
<td>PLWHA</td>
<td>People Living with HIV and AIDS</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission (of HIV)</td>
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<td>PNC</td>
<td>Post Natal Clinic</td>
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<td>RBM</td>
<td>Results Based Management</td>
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<tr>
<td>S&amp;BCC</td>
<td>Social and Behaviour Change Communication</td>
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<td>SADC</td>
<td>South African Development Community</td>
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<td>STI</td>
<td>Sexually Transmitted Infections</td>
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<tr>
<td>SW</td>
<td>Sex Worker</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>TSF</td>
<td>Technical Support Facility</td>
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<tr>
<td>UNAIDS</td>
<td>United Nations Joint Programme on HIV and AIDS</td>
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<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<tr>
<td>XDR-TB</td>
<td>Extreme Drug Resistance – Tuberculosis</td>
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The Structure of the NSP

The NSP is structured in 8 sections that complement each other. The following is a summary of each section of the NSP

**Executive Summary**
The Executive Summary section provides a synopsis of the NSP by highlighting the key issues and milestones of each section.

**Section 1:** The Background information: The section provides contextual information of the NSP, the country context, the priorities and the purpose of the NSP and the process of developing the NSP.

**Section 2:** Strategic orientation of the national multisectoral HIV and AIDS response
The section provides the strategic orientation of the national HIV and AIDS response, and the NSP itself. The section discusses the policy orientation, the shift in planning paradigm and the alignment of the national HIV and AIDS response with other national strategic policy frameworks such as Vision 2020, Millennium Development goals and national efforts on poverty reduction.

**Section 3:** The section on Situation Analysis provides a summary of the epidemiological, national response review and gap analysis.

**Section 4:** Section four focuses on strategic interventions for the NSP 2011/12-2015/16. The section presents the issues and problems that need to be addressed, articulates the strategies, and anticipated results for the national multisectoral response. The section covers prevention, treatment care and Support, impact Mitigation and response management.

**Section 5:** Monitoring, Evaluation and HIV Research: This section articulates the National M&E framework, the HIV research and research agenda initiatives.

**Section 6:** Sustainability of the National Multisectoral and Decentralised Response: This section articulates the need for Lesotho to develop a National Sustainability Strategy for the national HIV and AIDS response.

**Section 7:** Implementation of the National Strategic Plan: This section articulates the strategic institutional arrangement and systems for the implementation of the national multisectoral and decentralised response.

**Section 8:** Costing of the NSP: The section explains the methodology used to cost the NSP, identifies the financial resource needs and gaps

**Annexes**
This section carries the most relevant attachments to the NSP.
Executive Summary

Introduction

The National Strategic Plan (NSP) is a five year multisectoral HIV and AIDS plan that covers the period from April 2011 to March 2016. In developing the strategic plan Lesotho has shifted the planning paradigm from business as usual to evidence and results based approaches and have mainstreamed gender and human rights. The NSP planning process has taken cognisance of lessons (positive and negative) learnt during the implementation of the outgoing strategic plan 2006-2011. The NSP has identified and articulated national priorities and has set out measurable impact and outcome results.

The process of developing the NSP was participatory involving a wide range of stakeholders ranging from civil society organisations (CSO), faith based organisations (FBO), organisations of people living with HIV, sexual minority groups such as men who have sex with other men (MSM and sex workers, hard to reach populations such as herd boys, private sector, district and community councils, Members of Parliament, women’s organisations, to development partners, government agencies and ministries. The form of participation varied from stakeholders’ consultative workshops, representation in technical working groups, to reviewing and validating draft plans and situation analysis report. Stakeholders also provided documents that were used for desk review for the epidemiological and national response analysis.

Synopsis of the epidemiology of HIV in Lesotho

The epidemic remains the most important obstacle to sustainable socioeconomic development in Lesotho. HIV prevalence seems to be stabilising at a high prevalence of 23%\(^1\) with an annual incidence of 21,000 new infections in adults and 1,300 in children\(^2\). Death rate associated with HIV remains at a high figure of 12,000 annually\(^3\). The epidemic has a gender bias with women having a higher prevalence (26.7%) compared to men (18%). Prevalence is lowest (3.5%) among young people aged 15-19 years. It is higher among women aged 35-39 years (42.3%) and men aged 30-39 years (40%) respectively. Similarly prevalence is higher in urban (27.2%) compared to rural (21.1%) areas\(^4\).

The National HIV and AIDS response in the context of National Development

The HIV epidemic is now considered a health, development and human rights issue that demand a multisectoral and decentralised response. It is for this reason that the NSP has anchored the national HIV and AIDS response within the broader national socio-economic and political development framework. The priorities of the national response are aligned with the goals of Vision 2020, Poverty Reduction Strategies and will address strategic issues that constitute the core of the National Development Plan (NDP) that is currently being developed. By aligning the national response to these policy frameworks, NSP has expanded the opportunities for stakeholders and in particular the non-health sectors to participate and respond to the epidemic. This is particularly important given the urgent need to address structural epidemic drivers, deal with the root causes of HIV and AIDS risk factors and vulnerability at an individual, household levels and community level.

Through effective implementation of the NSP, Lesotho will be better positioned to respond to its international and regional commitments including the Millennium Development Goals (MDGs), United

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\(^{1}\) MOHSW (2009): Demographic and Health Survey, Ministry of Health and Social Welfare.


\(^{4}\) Ibid (1&2)
The Purpose of the NSP

The NSP has been developed to
i. Provide a strategic framework that will guide and inform the planning, coordination, implementation, monitoring and evaluation of the national multisectoral and decentralised HIV and AIDS response based on the three-ones principle, evidence and results based management, gender and human rights approaches.
ii. Articulate national priorities, results and targets that all stakeholders and partners will contribute towards.
iii. Provide the basis for consolidating strategic partnerships and alliances especially with civil society organisations and the private sector.
iv. Establish the foundations for Lesotho to move towards HIV and AIDS financial and services sustainability.

Priorities for the NSP

The stakeholders through intensive and participatory process have identified the following as priorities for the national multisectoral HIV and AIDS response in Lesotho.
i. To accelerate and intensify HIV prevention in order to reduce new annual HIV infections by 30% by 2015/16.
ii. To scaling up universal access to comprehensive and quality treatment, care and support
iii. To strengthen coping mechanisms for vulnerable individuals, groups and households.
iv. To improve the efficiency and effectiveness of coordination and management of the national multisectoral HIV and AIDS response i.e. “doing better and more of the rights things at the right time and scale”

National Impact Level Results

The NSP has set out the following specific and measurable results that will be achieved through the implementation of activities that address the above national priorities:

Table 1: National and thematic level – impact results

<table>
<thead>
<tr>
<th>Area</th>
<th>Impact results</th>
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<tbody>
<tr>
<td>National</td>
<td>Lesotho human development index (HDI) is improved from 0.427 in 2010 to 0.55 in 2015/16.</td>
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<tr>
<td>Prevention</td>
<td>The number of HIV new infections is reduced by 30% from 21,000 in 2010 to 14,700 by 2015/16.</td>
</tr>
<tr>
<td>Treatment, care and support</td>
<td>% of adults and children with HIV known to be on treatment 12 months after the initiation of ART is increased from 80% in 2010 to 98% in 2015/16</td>
</tr>
<tr>
<td>Impact mitigation</td>
<td>% of vulnerable households is reduced from 62,555 in 2010 to 47,859 in 2015/16</td>
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<td>Response coordination and Management</td>
<td>An effective, well managed national HIV and AIDS response which prevents infection, mitigates the impact of the epidemic and enhances the care and support of Basotho</td>
</tr>
<tr>
<td>Strategic Information Management (M&amp;E)</td>
<td>Lesotho has addressed the existing strategic information gaps by scaling up operational research (surveys, studies) and 2015/16</td>
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The National Multisectoral HIV and AIDS response

The National Strategic Plan (III) 2011/12 to 2015/16 has prioritised interventions in prevention, treatment, care and support, impact mitigation and response management. The NSP aims at ensuring an effective and efficient implementation of the prioritised interventions to accelerate universal access to HIV and AIDS services. The implementation is multisectoral and decentralised based on individual stakeholder’s institutional mandate and comparative advantages, strategic partnerships and alliances.

(a) Prevention of new Infections

The prevention of new infections remains the national priority. Lesotho hopes to reduce annual new infections by 30% in 2015/16. To achieve this, Lesotho will implement a combination prevention strategy that will include interventions aimed at reducing sexual transmissions, mother to child transmission (MTCT) and prevention of blood borne infections in addition to addressing sexually transmitted infections (STIs). Among the key interventions intended to reduce sexual transmission will include reduction of Multiple and concurrent partnerships (MCP), promoting consistent and correct use of condoms, HIV Testing and Counselling (HTC), working with discordant couples, addressing sexual and gender based violence, social norms and cultural practices that fuel the spread of HIV, alcohol and drug abuse, promoting HIV prevention in the workplace including provision of post exposure prophylaxis (PEP), and among most at risk populations (sex workers, MSM, inmates and their partners) and vulnerable groups.

The interventions will be targeted, intensified and coverage expanded. Efforts will be made to reduce fragmentation and improve coordination at all levels. The linkages between prevention and treatment will be strengthened. Although the implementation of the NSP will be premised on the National Operational Plan, for prevention the implementation will also be guided by the National Prevention Strategy. The strategy has been aligned to the NSP.

(b) Treatment Care and Support

The priority for treatment, care and support is to improve the quality of life of PLWHA including life expectancy (PLWHA living longer after the initiation on ART). To achieve this Lesotho has changed the eligibility criteria to CD4 350\(^5\) for all adults and children aged five years and above. Lesotho also offers a ART to all children who are HIV positive and are below twenty four (24) months. During the period of the NSP, pre-ART interventions will be strengthened and scaled up with the aim of retaining more people on pre-ART for long periods before being initiated on ART. Community home base care (CHBC) services will be reviewed and aligned to emerging needs for care and support. The management of TB/HIV co-infection will be strengthened including integration of TB/HIV services in health facilities.

(c) Impact Mitigation

The priority for impact mitigation is to strengthen the coping capacity and mechanism for vulnerable households and communities, and help them move from dependency to self-reliance. While addressing the broader issues of vulnerability stakeholders will focus on implementing strategic interventions targeting OVC and vulnerable households. The strategic focus on vulnerable households creates a unique opportunity for stakeholders to consolidate their support given that one or more vulnerable persons live in the same household. Some of the key interventions include development of alternative livelihoods (income generating activities), improving food security, ensure equitable access to basic needs such as clean water, sanitation, and decent shelter among others.

\[^5\] MOHSW (2010) National Guidelines for HIV and AIDS Care and Treatment, third edition
To better understand the extent of need for impact mitigation Lesotho will conduct the Quality of Impact Mitigation Services (QUIMS) survey. The survey results will inform the development and scaling up of sustainable livelihoods that have the potential to move vulnerable households towards self-reliance. Such interventions are cognisant of gender and human rights dimensions.

Key considerations in scaling up OVC services through the National OVC Action Plan will include social protection, ensuring that OVC are enrolled and retained in schools, have access to basic needs (food, shelter and clothes), psychosocial support and family care.

(d) Coordination and Management of the national response

An effective and efficient coordination and management arrangement of the national response are strategic to the achievement of the national priorities and priority impact and outcome results. This is crucial given the increased number and diversity of stakeholders involved in the multisectoral and decentralised response.

During the implementation of the NSP stakeholders will seek to strengthen and consolidate the enabling policy and legal environment. Existing policies and legislation will be reviewed to mainstream HIV and AIDS, gender and human rights issues. New policies or legislation will be developed as need emerges. Advocacy work will be intensified to promote effective implementation and enforcement of existing instruments including those that address stigma and discrimination, empower women and girls, and provide opportunities for access to services by most at risk populations (MARPs) and vulnerable groups.

Capacity developed and strengthened will be premised on health and community systems strengthening. A comprehensive capacity needs assessment will be conducted, and where such assessment has already been done, advocacy will be intensified to implement identified strategies.

The capacity of coordinating structures at all levels will be strengthened and roles and responsibilities will be clarified. Adequate resources (human, financial infrastructure and technological) will be provided to enable coordinating structures become functional and effective. Political and community leaders will be mobilised to provide effective leadership.

Resource mobilisation (human, financial, and technological) will be intensified. In the context of human resources, issues of adequacy, competence and retention will be addressed. In the case for financial resources the donor base will be diversified while at the same time addressing long term sustainability. HIV and AIDS related services including health facilities will be refurbished and adequately equipped to provide comprehensive integrated services. Lesotho will establish an HIV and AIDS Fund as part of the sustainability strategy.

Strengthening of the M&E system has been prioritised for two reasons. First Lesotho has adopted “evidence and results based planning” that require empirical data. Second, evidence based decision making during the NSP (II) 2006-2011 was largely compromised by inadequate and reliable data especially baselines. Consequently the success of NSP (III) 2011/12 to 2015/16 will depend on how fast data is generated to inform establishment of baselines and review of existing targets where appropriate.
Section 1: Background Information

1.1 Introduction

The national multisectoral and decentralised HIV and AIDS response is guided by National Strategic Plans. The current strategic plan (2006/07 to 2011/12) comes to an end in March 2011. This document represents the successor National Strategic Plan (NSP) that covers the period starting from April 2011 to March 2016. The development of the NSP is guided by the National HIV and AIDS policy (2006) and draws its inspiration from the National Vision 2020. The NSP has also taken cognisance of the HIV and AIDS issues raised in the situation analysis report for the National Development Plan (NDP) currently being developed. The NSP is evidence and results-based and has mainstreamed gender and human rights.

The implementation of the NSP is premised on the involvement of many, diverse and multi-layered stakeholders at all levels of the response based on their mandate and comparative advantage. The joint review and planning process has emphasised the need for stakeholders to focus and contribute to national priorities and in particular to commonly agreed national outcome and output results.

1.2 The Country Context

The Kingdom of Lesotho is landlocked (surrounded by South African) with a surface area of 30,355\textsuperscript{6} square kilometres. The population is estimated to be 1,876,633 people (51% women, and 49% men)\textsuperscript{7}. Seventy seven (77%) percent and 23% of the population live in rural and urban areas respectively. Fifty eight percent (58%) of the population is under 19 years. Women make up 51% of the total population. Among them 36% are living below the poverty datum line and more than half of households are female headed\textsuperscript{8}. The male to female ratio is estimated to be 95:100\textsuperscript{9}. The population growth rate has declined from 1.5% in 1996 to 0.08% in 2996. This is the lowest population growth rate in Southern Africa. By 2010, life expectancy at birth was estimated at 45.9 year\textsuperscript{10}. The epidemic has changed the population structure with the number of older people increasing and that of young people declining\textsuperscript{11}.

UNDP estimates the Human Development Index (value) for Lesotho to be 0.427 (2010) compared to 0.55 in 2005. Gross Domestic Product (GDP) currently stands at US$1.6 billion with an estimated growth rate of 4.4% in 2010\textsuperscript{12}. The richest 20% of the population controlled 60% of the income while the poorest 20% shared 2.8% of the total income in 2010\textsuperscript{13}.

The adult literacy rate is estimated at 89.5%, with 13% of the people aged 25 years and older having at least a secondary education. Despite the socio-economic progress made in the last decade approximately 56.3% of the population continue to live below the national poverty datum line\textsuperscript{14}. In 2008, the Bureau of Statistics (BOS) estimated 22.7% people were unemployed. Agriculture contributes 7% of the GDP while manufacturing contributes 17%. Diamond mining and quarrying contribute approximately 9% of the GDP.

\textsuperscript{6} MOHSW (2009): Lesotho Demographic and Health Survey, Ministry of Health and Social Welfare, Lesotho
\textsuperscript{7} GOL (2006): Population and Housing Census, Government of Lesotho
\textsuperscript{9} MFDP (2007) Lesotho Bureau of Statistics
\textsuperscript{14} UNDP (2010): Human Development Report – The Real Wealth of Nations
The contribution of service industry is estimated at 60%. The average growth rate of imports has stagnated at 2% since 2009\textsuperscript{15}.

The main sources of revenue for Lesotho have been remittances from Basotho employed mainly in South Africa and other foreign countries, revenue from the Southern African Customs Union (SACU), and royalties from the export of natural resources such as water and diamonds. These exports were affected by the global credit crisis at the end of 2008. The Government of Lesotho, the mining sector in South Africa and the Lesotho textile industry are the major sources of employment\textsuperscript{16}.

The epidemic in Lesotho is fuelled by behavioural, biomedical and structural drivers. Although Lesotho has made significant progress in the fight against the epidemic, HIV prevalence remains high at 23%\textsuperscript{17} compared to 23.2% in 2008\textsuperscript{18}. This data show that the epidemic seems to have stabilised at a high prevalence rate of 23%. The annual incidence is estimated at 1.7%.

The epidemic was declared a national emergency in 2000 by His Majesty the King Letsie III. In 2003 Lesotho published the scaling up strategy “Turning a Crisis into an Opportunity” and launched the “Know Your Status” campaign operational plan. The campaign has improved access to treatment, care and support. The multisectoral and decentralised approaches in the implementation of the national response have galvanized the country and its development partners to clearly articulate what needs to be done to reduce the spread of HIV and mitigate the socioeconomic.

1.3 The Purpose of the NSP

The NSP has been developed to

i. Provide a strategic framework that will guide and inform the planning, coordination, implementation, monitoring and evaluation of the national multisectoral and decentralised HIV and AIDS response based on the “three ones” principle, evidence and results based management, gender and human rights approaches.

ii. Articulate national priorities, results and targets that all stakeholders and partners will contribute towards.

iii. Provide the basis for consolidating strategic partnerships and alliances especially with civil society organisations and the private sector.

iv. Establish the foundations for Lesotho to move towards HIV and AIDS financial and services sustainability.

1.4 Priorities of the national multisectoral HIV and AIDS response

The priorities of the national response are “need driven” based on the understanding that Lesotho, as a matter of urgency needs to turn off the taps of new infections, and improve the quality of life of its people. This demands innovative strategies, strong political leadership and strengthening the efficiency and effectiveness of the operational systems. The following have been identified as the priorities for the national multisectoral HIV and AIDS response.

i. To accelerate and intensify HIV prevention in order to reduce new annual HIV infections by 30% by 2015/16.

ii. To scaling up universal access to comprehensive and quality treatment, care and support

\textsuperscript{15} MOHSW (2009): Lesotho Demographic and Health Survey, Ministry of Health and Social Welfare.


\textsuperscript{17} MOHSW (2009): Lesotho Demographic and Health Survey

iii. To strengthen coping mechanisms for vulnerable individuals, groups and households.

iv. To improve the efficiency and effectiveness of coordination and management of the national multisectoral HIV and AIDS response i.e. "doing better and more of the rights things at the right time and scale"

Effective and efficient implementation of these priorities is expected to contribute to the impact level results outlined in table 1 (pg. xi) above

1.5 The Process of Developing the NSP and Stakeholders participation

The developed of the NSP adopted a two pronged strategy. The first strategy involved conducting the epidemiological and national response situation analysis. The second strategy involved holding extensive stakeholders consultations at all levels.

The process started with a series of studies and surveys that informed the epidemiological and national response situation analysis19. They also generated the evidence required to inform evidence and results based planning for the NSP.

Stakeholder consultations had four objectives. First to get the perception of stakeholders on the extent to which they believe the national response was implemented. Second identify specific programmes or interventions that worked well and contributed to the achievement of intended results. Third, identify strategies that failed, and the reasons why they failed, in addition to services that were not delivered to desired scale. Finally, the consultation where intended to get stakeholders opinions on what should be the national priorities, areas of focus and what results (impact, outcome and output) they would like to achieve in five years time.

Consultations were held with diverse stakeholders ranging from government institutions, civil society organisation (NGOs, FBOs), organisations of people living with HIV and AIDS, traditional leaders, traditional health practitioners and the private sector. Further consultations were held at district level where District AIDS Committees (DAC), Community Councils AIDS Committees (CCACs) and other community based organisations (CBOs) participated. Young people, women and vulnerable groups such as people with disability and sexual minority groups participated through their umbrella organisations or by representation by a service provider organisation.

Development partners participated through bilateral consultations, representation in the NSP Forum or through the review and validation mechanisms. Inputs from the Members of Parliament (National Assembly and the Senate) were sourced through consultative sessions with their Portfolio Committees on HIV and AIDS. These consultations were complemented by earlier inputs generated during the development of the Parliamentary HIV and AIDS Strategic Plan in 2010.

All stakeholders had representation in the NSP forum and the Technical working Groups.

19 include: Demographic and Health Survey (DHS,2009), HIV Prevention Response and Modes of Transmission Analysis (MOT 2009), The Prevention Strategy Situation Analysis (2010), the National Estimates and Projections (2009), the Sentinel HIV/Syphilis Survey (2009), Situation analysis of OVC (2010), Situation analysis of People with Disability and HIV/AIDS, the Private sector knowledge, Attitudes and practice (KAP) in 2009, and the midterm review (2009) and end term rapid review of the implementation of the NSP 2006-2011.
Section 2: Strategic Orientation of the National Multisectoral HIV and AIDS Response

2.1 NSP Strategic Orientation

Lesotho has shifted the HIV and AIDS planning paradigm to evidence and results based strategic planning that infuses gender and human rights. The planning has moved from vertical programming to the use of combination strategy, especially in prevention where one or more interventions will contribute to common results. The combination strategy will further strengthen the synergy between interventions, and enhance coordination and monitoring.

Strong political and traditional leadership have been identified as prerequisites for the implementation of the NSP given the complex nature of the epidemic drivers, the nature of impact mitigation, the need to sustain community engagement and maintain the HIV and AIDS on the national socioeconomic and political agenda.

It is evident that most interventions are not new to Lesotho. The challenge for Lesotho is “doing better and more of the rights things at the right time and to the right scale”. This calls for a multisectoral and concerted effort, strong and meaningful political leadership, civil society, community and PLWHA involvement. The strategy further calls for stakeholders to individually and collectively appreciate their comparative advantage. The implementation of the NSP will place emphasis on strategically targeting interventions, intensifying implementation, and expanding coverage. Efforts will be made to reach out with sufficient intensity and coverage to most at risk and vulnerable groups. While doing so, stakeholders will be expected to align and harmonise their institutional operational plans with the national priorities, results and targets as defined in the NSP.

Lesotho, will investment more resources in prevention with the aim of “turning off the taps” of new HIV infections and in the long term reduce the number of people living with HIV and AIDS. By so doing effective prevention strategies will reduce the number of people needing ART, CHBC, and even delay orphanhood. In the long term the strategy will be key to the sustainability of the national HIV and AIDS response. The capacity of stakeholders’ will be strengthened within the context of the health and community systems to ensure effective and efficient implementation of the

2.2 Vision of the National Response

The national response draws its inspiration from the national Vision 2020 that hopes to see a Kingdom free of AIDS and people living productive and healthy lives. In this context the stakeholders have articulated the vision of the national multisectoral response as

“The Kingdom with significantly reduced new infections; people on treatment living long & productive lives with strong social safety nets for OVCs and vulnerable households.”
2.3 The Guiding Principles

The implementation of the NSP will be guided by the following principles.

a) **Evidence Based Planning**: Stakeholders will use evidence in decision making and in HIV and AIDS planning.

b) **Results Based Management**: HIV and AIDS planning and implementation will focus on measurable impact, outcome and output results (annex 1)\(^{20}\).

c) **3-Ones principle**: During the implementation of the NSP, the *three-ones*\(^{21}\)s will be mainstreamed and consolidated at all levels.

d) **Human rights**: Stakeholders will respect human rights for all people affected or living with HIV and AIDS. Specific attention will be paid to eliminating all forms of stigma and discrimination associated with HIV and AIDS.

e) **Multi-sectoral approach**: The multisectoral approach will be consolidated and institutionalised at all levels. Stakeholders' participation will be based on their mandate, resources, capacity and comparative advantage.

f) **Gender sensitivity**: Stakeholders will mainstream core gender issues that influence the gender biases of the epidemic in planning and implementation of the response.

g) **Cultural sensitivity**: Stakeholders will support cultural practices that support and promote HIV prevention. They will advocate for changes in cultural practices that fuel the spread of HIV.

h) **Greater involvement of PLWHA (GIPA)**: Strategies will be developed and implemented that promote meaningful involvement of PLWHA at all levels and aspects of the national response.

i) **Decentralised approach**: The decentralised implementation of the response will be strengthened. Communities and other stakeholders will be mobilised and engaged in the implementation of the response. The National Coordination Framework will be reviewed to clearly define the roles and responsibilities of the various stakeholders and coordinating structures.

2.4 Alignment with National, Regional and International Development and Policy Frameworks

The NSP has anchored the HIV and AIDS response within the broader national social and economic development framework. Its priorities and results contribute to the achievement of the goals of Vision 2020, and Poverty Reduction Strategies. Overall the NSP will address strategic issues that will be the subject of National Development Programme (NDP) – that is currently being developed. By aligning the NSP to these policy frameworks, NSP has expanded the opportunities for a multi-sectoral response and in particular within the context of some of the structural epidemic drivers and impact mitigation initiatives. The alignment will ensure that Lesotho will be responsive to its international commitment in addressing Millennium Development Goals (MDGs), UNGASS, three-ones, and Universal Access. The alignment further ensures fulfilment of regional commitments such as the African Union Abuja Declaration to increase health funding to 15% of national budget, and Maseru declaration of reduction of HIV infections by 2015/16, and accelerating of universal access

In defining its outcome results, the NSP has taken cognisance of other strategic plans that will contribute to the NSP results. Such plans include the MOHSW Strategic Plan, the National Action for OVC and The National Action plan for Women and Girls, and the National Prevention Strategy.

\(^{20}\) See the Results Framework for details on impact, outcome and output results

\(^{21}\) Three-ones refer to one national coordinating authority, one national strategic framework, and one national M&E framework.
Section 3: Situation and Response Analysis

The following section is a synopsis of the epidemiology of HIV in Lesotho and the review of the national multisectoral HIV and AIDS response.

3.1 Epidemiology of HIV in Lesotho

Prevalence, Trends, and Heterogeneity

HIV prevalence among people aged 15-49 is estimated 23%\(^{22}\). Approximately 21,000 new adult infections and 4000 new infections among children occurred annually (2008/09). Eleven thousand (11,000) women are infected annually compared to 10,000 men. However, available evidence indicates that the annual HIV incidence in adults (15-49) has stabilised at approximately 1.7% (2008), having dropped from 2.35% in 2007\(^{23}\) and a peak of 3.6% in 1995. Annual HIV incidence in children has halved in the last 8 years to 0.17% (2008)\(^{24}\). Between 2007 and 2008, new infections in children 0-14 years dropped from 1,700 (2007) to 1,300. The decrease in incidence is associated with a number of reasons including a decrease in adult incidence, reduction of the risk of mother to child transmission, and the increased uptake of PMTCT and ART. PMTCT uptake has increased rapidly to 71% in 2009\(^{25}\).

The DHS (2009) data show that HIV prevalence is lowest (3.5%) among young people aged 15-19 years (women - 4.1%; men- 2.9%). Among young people aged 20-24 years prevalence is estimated at 16.3% (women- 24.1%, men – 5.9%)\(^{26}\). Prevalence is highest among people aged 30 – 39 years (+40%). Overall prevalence is higher in Women (26.7%) than in men (18%)\(^{27}\) aged 15-49 years\(^{28}\). It is highest (42.3%) among women aged 35-39 years and men (40.2%) aged 30-34 years. The Modes of Transmission analysis (2009) indicates that the prevalence differentials between women and men could be due to biological susceptibility, age of sexual debut and age-mixing patterns in sexual relationships\(^{29}\).

HIV prevalence is high in urban areas (27.2%) compared to rural areas (21.1%). Equally prevalence is higher in some districts compared to others. The DHS (2009) found that Maseru District had the highest prevalence (26.5%) with Thaba Tseka having the lowest prevalence (15.9%). In terms of ecological zones prevalence was found to be highest in lowlands (23.6%) and lowest in Sengu River valley (21.1%). The high urban prevalence may be attributed to a number of factors including rural urban migrations where most people settle in informal settlements where they are more vulnerable and exhibit higher risk taking such as transactional sex. The Modes of Transmission (2009) analysis report noted that both urban and rural prevalence seems to be stabilising.

HIV is higher among people who have completed primary education (27.9%) followed by those who have no education (26.6%) and lowest among those who have completed secondary education (20.9%). The LDHS (2009) data analysis shows that, as education increases the probability of being HIV positive decreases. It is evident that education predicts preventive behaviours like condom use, the absence of non-marital sex, delayed sexual debut, HTC use and knowledge about HIV.

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\(^{22}\) MOHSW (2009) Lesotho Demographic and Health Survey
\(^{23}\) NAC, (2008), Overview of the National Response with specific focus on prevention – power point presentation
\(^{24}\) NAC, UNAIDS (2009): Modes of Transmission report
\(^{26}\)MOHSW (2009). Lesotho Demographic and Health Survey 2009, Table 13.3 pg. 203 Ministry of Health and Social Welfare - Lesotho, ICF Macro, USA
\(^{27}\) Lesotho Demographic and Health Survey 2009
\(^{28}\) MOHSW (2009) – Lesotho Demographic and Health Survey,
\(^{29}\) Modes of Transmission report 2009
People who have never married exhibit the lowest HIV prevalence (11.1%), while prevalence (59.95) is highest among widowed persons. Among divorced persons prevalence is estimated at 50.5% (female – 59.2%, and men 30.8%).

A third of all couples are HIV positive with at least one of the two partners infected. More than 40% of these couples are discordant couples where only one partner is HIV positive. Furthermore, 14% of all infected couples are “discordant female”, where the woman is infected and not the man, and 27% are “discordant males”. Concordant positive couples (both are HIV positive) are often urban and educated. Overall discordance in men is estimated at 7.2% and 9.2% in women. Discordance is highest in Qachas’s nek (14%) followed by Berea (12%) districts.

HIV prevalence among people in the lowest quintile is estimated at 18.5% while that of the people in the highest quintile is 23.3%. The DHS found that people in second highest quintile had the highest HIV prevalence (26.4%). Working men had a 60% higher risk of being HIV infected than those who are not employed\(^{30}\). Prevalence among the employed people was rated 21.8% compared to 9.4% for those unemployed. For people who slept away from home more than five times while on duty, prevalence was highest in women (30.9%) compared to men (22.0%). The Modes of Transmission report has noted that female labour migration has been on the rise in recent years with increasing numbers of women participating in both internal and cross border migration.\(^{27}\) Internal female migrants are often young (15-29) and migrate from rural to urban areas in search of employment.

The 2007, Sentinel HIV/Syphilis Surveillance shows a decline in prevalence among ANC clients from 27% in 2005 to 25.7% in 2007. The survey further shows a downward trend in prevalence among young women aged 15-24 years with prevalence dropping from 11% in 2005 to 8.9% in 2007. Approximately 1.4% of ANC clients and 2.3% of STI clients were infected with syphilis\(^{31}\). In 2006, STIs were among the top ten causes of frequent out-patient department (OPD) consultations at health facilities by 2006\(^{32}\). In 2007, the prevalence of HIV among STI patients was found to be 56.2%.\(^{33}\) Among young people aged 15-19, and 20-24 HIV prevalence among STI clients was around 20% and 40% respectively compared to young people (7.7%) in the same age group surveyed in 2004 (LDHS, 2004).

Sources of new HIV infections\(^{34}\)

The Modes of Transmission data analysis shows that the bulk of new infections are likely to come from individuals with one sex partner 48.5% (35.2% - 61.8%). Individuals with more than one sexual partner will contribute 23.75% (16.5%-21.0%) while partners with individuals with more than one sex partner will contribute 21.5% (15.3% - 27.7%). Sex workers will contribute 0.5% while partners of clients of sex workers are expected to contribute up to 1.75% (1.7%-1.8%) and clients of sex worker will contribute 0.7%.

An estimated 3-4% of all new infections may arise among men having sex with men (MSM) and their female partners while a very small number of new infections may be attributable to unsafe medical injections. There is no data on injecting drug users (IDU), but circumstantial evidence suggests that hardly any IDU takes place in Lesotho. It is assumed that blood transfusion will not contribute to new infections given the 100% routine screening of all donated blood.

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\(^{30}\) MOHSW (2009): Lesotho Demographic and Health Survey

\(^{31}\) MOHSW (2007) HIV/Syphilis survey


\(^{33}\) MOHSW (2007) HIV/Syphilis survey

\(^{34}\) Information in this section is generated from the Modes of Transmission report (2009).
Drivers of the epidemic and other factors that influence the spread of HIV

The epidemic in Lesotho is being driven by behavioural, structural and biomedical drivers of the epidemic. The Modes of Transmission (2009) DHS (2009) and the Lesotho HIV Prevention Strategy (2011), have identified the following drivers of the epidemic35.

Table 2: Drivers of the epidemic

<table>
<thead>
<tr>
<th>Biological</th>
<th>Behavioural</th>
<th>Social</th>
<th>Structural</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Low and incomplete male circumcision</td>
<td>- Incorrect and inconsistent, and low use of condoms</td>
<td>- Peer pressure</td>
<td>- Gender inequality, income disparities</td>
</tr>
<tr>
<td>- Having STIs</td>
<td>- Multiple and concurrent partners</td>
<td>- Inter-generational sex</td>
<td>- Erosion of traditional values</td>
</tr>
<tr>
<td>- Age of sexual debut for young females</td>
<td>- use of alcohol</td>
<td>- Transactional sex</td>
<td>- Labour migration</td>
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<tr>
<td>- Partner’s viral load</td>
<td></td>
<td>- Male dominated gender norms</td>
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3.2 National Response Analysis

The following is a synopsis of some of the achievements made in prevention, treatment care and support, impact mitigation and response management and coordination.

PREVENTION

i. **HIV awareness and knowledge**: By 2009, 38% of women and 29% men36 aged 15-49 had comprehensive knowledge of HIV and AIDS.

ii. The **National Behaviour Change Communication** (BCC) Strategy was finalized. A variety of BCC outreach interventions were undertaken and approximately 23,450 IEC37 materials were developed and distributed in 2008.

iii. **HIV Testing and Counselling and testing**: In 2009, 60% (787,813 of 1,316,461)38 of people aged 12 years and above had tested for HIV. The HTC policy was revised in 2009 to include provisions of HTC at community level. HTC training manuals were revised and service providers were trained.

iv. **Violence against women**: The Lapeng Center was established to provide care and support services for survivors of rape and domestic violence. The centre is part of the implementation of the sexual offences Act adopted by Government in 200339.

v. **Sexually Transmitted Infections**: MOHSW continue to provide prevention and syndromic management of STIs. The STI and HIV/AIDS has been incorporated in the updated nurses and midwives curriculum. The SADC STI treatment guidelines, protocols, standards and surveillance tools are currently being adopted by the MOHSW.

vi. **Condoms**: in 2009, 1,442,427 male condoms and 82,044 females were distributed. In 2008, 7.2 million (72%) male condoms and 50,000 female condoms were procured through National Drug Services Organization (NDSO)40

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35 Note: Detailed analysis of these epidemic drivers are contained in the situation analysis of the Prevention Strategy. However the following drivers have been single out as the most important for the NSP to address
36 MOHSW (2009): Lesotho Demographic and Health Survey, 2009
vii. **Prevention of Mother to Child Transmission (PMTCT):** PMTCT services have been rolled out throughout the country with 186 facilities providing PMTCT. 90% of women attending ANC have tested for HIV. 71.6% of PMTCT clients received ARV prophylaxis and HAART. 94.3% of babies received ARV prophylaxis by 2009.41

viii. **Blood and Tissue Safety:** 100% of all blood units are screened42 for HIV and STI infections. In 2009, 3319 blood units were collected and screened.

ix. **Most at Risk Populations and Vulnerable groups:** In 2009, HIV and AIDS Policies and Strategic Plans for inmates (prisoners) and Herd boys were developed and are being implemented. Civil society organisations continued providing services to sex workers and sexual minority groups (e.g. MSM). 30% of inmates living with HIV are enrolled on ART.

x. **Post Exposure Prophylaxis (PEP):** Seven hundred and forty six (746) people were provided with PEP in 2009. Among them were 607 women, 137 men and 242 children.

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**TREATMENT, CARE AND SUPPORT**

i. **Antiretroviral Therapy (ART):** 148 health facilities were accredited to provide ART by 2008. The total number of people enrolled on pre-ART in 2009 was 49,642 of whom 7% were children under the age of 14 years. By the end of 2009, 62,190 adults and children had been enrolled on ART. In a cohort study conducted in 2009, 39,247 (80.07%)44 PLHWA were found to be alive twelve months after the initiation of ART. In 2007, Lesotho changed its eligibility criteria from CD4 200 to CD4 350 for all PLWHA aged 5 years and above.

ii. **Tuberculosis (TB):** In 2008, the TB case detection rate had reached 80% and treatment success rate was estimated at 74%. Seventy eight percent (78%) of individuals with TB were also tested for HIV (2009). 95% were put on cotrimoxazole prophylaxis and 27.6% were enrolled on ART. All TB patients who test HIV positive are immediately enrolled on ART regardless of their CD4 count.

iii. **Community Home Based Care (CHBC):** By 2008, approximately 43,513 received home based care. Among them were 24,315 women and 19198 men. CHBC services are available in all the districts.

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**IMPACT MITIGATION**

i. **Orphans and vulnerable children:** The total number of OVC in Lesotho is estimated at 180,000. Of these, 122,000 are attributed to AIDS.46

- By 2008, 57,172 OVC were receiving care and support. Support for OVC range from nutritional, income generating activities, education support, life skills training, psychosocial support and social protection
- 24,725 OVC received bursaries.
- Lesotho is in the process of finalising the situation analysis on the status of OVC, and plans are underway to develop the National OVC Action Plan.

ii. **Social protection:**

- District Child Protection Teams (DCPT) and orphanages have been established at district levels to monitor and enforce social protection for OVC and vulnerable people.
- Child and Gender Protection Units were strengthened to improve and expand their services coverage.
- The Child Protection and Welfare Bill has been drafted but has not been adopted.

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42 NAC 2009: Mid Term Review of the National Strategic Plan 2006-2011
iii. **Birth registrations**: registration of births was expanded through the Ministry of Local Government and Chieftainship

**COORDINATION AND MANAGEMENT:***

i. The National HIV and AIDS Policy and the National HIV and AIDS Strategic Plan for 2006 – 2011/12 were translated into Sesotho.

ii. The Legal Capacity of Married Persons Act was also translated into Sesotho and has been widely disseminated.

iii. A HIV and AIDS policy and strategic plan for inmates (prisoners) and Herd Boys were developed and are being implemented through the Department of Correctional Services and the herd boys network - Monna Ka Khomo

iv. A HIV and AIDS strategic plan for Parliament was developed in 2010. The plan is intended to promote strong leadership, commitment and participation in the national response.

v. The Ministry of Labour and Employment (MoLE) developed guidelines for the Labour Code Amendment that provides policy guidance on HIV and AIDS response in the workplace.

vi. NAC continued to support the umbrella organizations with financial and technical support. Capacity is being developed to strengthen their coordination functions.

vii. Decentralised coordination structures have been established and strengthened. These include District Partnership Forums, District AIDS Committees (DACs), Community Council AIDS Committees (CCACs) and District M&E Technical Working Groups (TWG). Available evidence indicates that 75% of CCACs have been established.

viii. NAC commissioned the development of workplace policies and programmes for both the Private and Public Sectors.

ix. CCACs have been trained on the implementation and monitoring of essential services package (ESP) and the Gateway Approach adopted in all the districts to facilitate the scaling-up of the response.

x. The National HIV and AIDS Research Agenda was implemented. It is currently being reviewed.

xi. Several major research and studies were conducted including the second Demographic Health Survey (2009), An MCP qualitative study (2009), the Modes of Transmission Analysis (2009), The Sentinel HIV/Syphilis Surveillance (2009), National AIDS Spending Assessment (NASA) among others.

xii. The Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) was developed in 2010 and is in the process of being operationalised. The assessment of the M&E framework was conducted in 2008.

xiii. HIV situation analysis was conducted for Lesotho Mounted Police Services (LMPS) and Lesotho Correctional Services (LCS).

xiv. ALAFA conducted a Knowledge, Attitudes and Practices (KAP) study in 2009 among the private sector institutions.

### 3.3 National Response – Summary of Gaps and Challenges

The following is a summary of gaps and challenges of the national multisectoral response presented by thematic areas.

**Prevention:**

i. Inadequate prioritisation of prevention interventions based on available empirical evidence of their efficacy.

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ii. Inadequate coverage, intensity and appropriate targeting of interventions. In most cases coordination and implementation processes are fragmented.

iii. Lack of consistency on standards and messages for social and behaviour change.

iv. Low male medical circumcision. Only 17.7% of all circumcised males have gone through medical circumcision procedures.

v. Not all HIV positive pregnant women get PMTCT services. Only 18648 health facilities provide PMTCT services.

vi. Although 100% of donated blood is screened for HIV and other infections, not all has been found to be safe to use and hence demand for safe blood is more than supply. In 2009, 3319 blood units were collected against a target of 9000 units.

vii. Insufficient targeting prevention services for MARPs especially MSM and sex workers.

viii. Low and inconsistent condom use, especially in stable relationships.

ix. Slow development and implementation of HIV and AIDS workplace programmes.

x. Inadequate targeting of epidemic drivers.

Treatment, Care and Support:

i. Coverage of ART for both adults and children is still low. Not all people in need of ART are getting ART.

ii. Inadequate linkages between prevention and treatment for HIV prevention.

iii. Transport costs have been identified as a key barrier to ART access and adherence especially for rural communities.

iv. Slow integration ART with other health services.

v. Inadequate human resources capacity.

vi. Inadequate provision of nutrition for PLWHA.

vii. A weak referral system.

Impact Mitigation:

i. Lack of empirical data to inform policy formulation and planning.

ii. Impact mitigation services are inadequate, fragmented and implementation is largely uncoordinated. With the exception OVC services, monitoring of other services has been found to be weak and ad hoc.

iii. Service delivery systems are weak.

iv. Many of the impact mitigation services are welfare based and have not mainstreamed sustainability strategies.

v. Provision of Life skills for out of school youth is still low.

vi. Success rate for income generating activities has been compromised by lack of capacity and resources.

Coordination and Management of the National Response:

i. Many stakeholders are not clear of their roles and responsibilities.

ii. There is confusion and lack of appreciation on the different mandates, roles of responsibilities between NAC and the MOHSW.

iii. Slow rate of mainstreaming and institutionalising the 3-Ones principle at all levels of the response.

iv. Inadequate skilled and experienced human resources for the implementation of the national response. Retention strategies are weak as demonstrated by high levels of staff attrition in different sectors.

v. Poor use of evidence to inform policy, planning and resource allocation.

vi. Insufficient implementation and enforcement of existing policies and legislation.

vii. Although there is some degree of improvement in leadership, it has not reached sufficient scale to influence how communities and stakeholders respond to HIV and AIDS.

viii. Lesotho is yet to develop a sustainability strategy for the national HIV and AIDS response.

ix. Coordinating structures lack sufficient financial, human and technological resources to enable them effectively coordinate the response.

x. Civil society organizations are largely under resourced (financial and human)

xi. The capacity of health and community systems remains weak given the demand for services.

xii. The capacity for gender and human rights mainstreaming is lacking.

**Monitoring, Evaluation and HIV Research:**

i. The National M&E system is not clearly defined and in particular operationalisation is weak.

ii. There are not baselines and targets for several NSP results. Data collection and analysis has been compromised by inadequate capacity and weak M&E systems.

iii. Results and indicators are often not...?

iv. Inadequate and competent M&E human resource capacity. In most sectors people managing M&E are not M&E specialists.

v. Not all districts have functional districts M&E TWG.

vi. The national response is poorly monitored (no baseline, no biological markers)

vii. Insufficient organizational structures to support M&E at all levels

viii. Capacity for operational research is lacking

ix. Reporting by stakeholders is weak and inconsistent.

x. Slow uptake of HIV mainstreaming in workplace and development projects

xi. Inadequate mainstreaming of gender dimensions in HIV and AIDS activities beyond disaggregating data by gender

xii. Stakeholders’ have not aligned their M&E systems with the national M&E systems. This is partly because their understanding and appreciation of the national
Section 4: NSP Strategic Interventions

4.0 Overview – NSP Strategic Interventions

The NSP 2011/12 to 2015/16 interventions, strategies and results are developed around the four thematic pillars of prevention; treatment, care and support; impact mitigation; response coordination and management. However, given the importance and the urgency to strengthen evidence based decision making in policy formulation and results based management (RBM) and planning, an additional pillar – “Monitoring, Evaluation and HIV research” has been included. In the outgoing NSP M&E and HIV research were components of the response coordination and management.

The selection of NSP interventions and strategies was based on their evidence based efficacy and their potential to contribute to prioritised impact and outcome results. The impact level results are articulated in table 1 (page xi) while the outcome results are included in the relevant service delivery areas outlined in this section of the plan. The planning process has applied the “SMART” concept and taken cognisance of the feasibility and sustainability of the various interventions. The implementation of the NSP is premised on the combination strategy especially in prevention, treatment, care and support. It is anticipated that the implementation will also strengthen synergy between interventions. The table below outlines the thematic coverage and the specific service delivery areas of the NSP.

Table3: Priority areas of the NSP

<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Service Delivery Area (SDA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of new infections</td>
<td>i. Reduction of sexual transmission</td>
</tr>
<tr>
<td></td>
<td>[Social and behaviour change; multiple and concurrent partnerships, condoms, HTC,</td>
</tr>
<tr>
<td></td>
<td>safe male circumcision, MARPS, Youth, Discordant couples, Gender based violence,</td>
</tr>
<tr>
<td></td>
<td>Alcohol abuse and STIs]</td>
</tr>
<tr>
<td></td>
<td>ii. Reduction of mother to child transmission</td>
</tr>
<tr>
<td></td>
<td>iii. Prevention of blood borne transmission</td>
</tr>
<tr>
<td></td>
<td>iv. Prevention Systems Strengthening</td>
</tr>
<tr>
<td>Treatment, Care and Support</td>
<td>i. Scaling up antiretroviral therapy (ART) services</td>
</tr>
<tr>
<td></td>
<td>ii. Management of TB/HIV co-infection</td>
</tr>
<tr>
<td></td>
<td>iii. Community home based care services</td>
</tr>
<tr>
<td>Impact mitigation</td>
<td>i. Support for orphans and vulnerable children</td>
</tr>
<tr>
<td></td>
<td>ii. Support for vulnerable groups and households</td>
</tr>
<tr>
<td>Response management</td>
<td>i. Advocacy, public policy, and legislation</td>
</tr>
<tr>
<td></td>
<td>ii. National response management and coordination</td>
</tr>
<tr>
<td></td>
<td>iii. Health and community systems strengthening</td>
</tr>
<tr>
<td></td>
<td>iv. Capacity development</td>
</tr>
<tr>
<td>Monitoring, Evaluation and HIV</td>
<td>i. Monitoring the national response</td>
</tr>
<tr>
<td>research</td>
<td>ii. Evaluating the National response</td>
</tr>
<tr>
<td></td>
<td>iii. HIV research</td>
</tr>
<tr>
<td></td>
<td>iv. Strengthen the use of M&amp;E and HIV research data and information for</td>
</tr>
<tr>
<td></td>
<td>evidence based decision making and response planning</td>
</tr>
</tbody>
</table>

The specific interventions, strategies and outcome results for each of the above service delivery areas are articulated in the section below. The section is organised by thematic areas and interventions in each area are prioritised.
4.1 Prevention

4.1.1 Overview – the case for prioritizing and investing in HIV prevention.

Prevention remains the key national strategy in the fight against HIV and AIDS. It is envisaged that an effective prevention programme will enable Lesotho to “turn off the taps” of new HIV infections. The benefits of reducing new infections are enormous including the possibility of an AIDS free generation (virtual elimination of mother to child transmission), improved quality of life as more PLWHA live longer and delayed in orphanhood (contribution by an effective ART programme). Prevention will contribute significantly to reducing the burden and cost of care. As more people remain HIV negative, the burden on health systems will be lessened and provision of health care in general will improve focusing on other pressing health issues such as maternal health care, child mortality and malnutrition that will enable Lesotho meet its Millennium Development Goals (MDG) commitments. Resources currently committed for treatment, care and support will be freed for use in other socioeconomic development initiatives such as education, overall health care, improving food security, addressing poverty alleviation and developing human capital. Human resources will be more productive with significant impacts on the achievements of Vision 2020 goals and the proposed National Development Programme (NDP).

To achieve significant results in prevention, Lesotho will make drastic changes – moving away from an evolutionary process to revolutionary process in the response. In revolutionising prevention, Lesotho will adopt and implement effective strategies. First interventions are prioritised based on available evidence of their efficacy. Second, priority will be to address prioritised behavioural, structural and bi-medical epidemic drivers and targeting most at risk population groups. Finally the implementation strategy will be based on the “combination prevention strategy” coupled with improvement in coordination and strategically focusing on results. The combination prevention strategy will promote and support dynamic, rights-based and evidence-informed mix of structural, behavioural and biomedical interventions that are tailored to meet local needs that are community owned, and coordinated. Specific interventions will work synergistically on immediate risks and underlying vulnerabilities so as to have the greatest sustained impact on reducing new HIV infections. The Table below illustrates the NSP interventions in the combination prevention strategy.

Table 4: The Combination prevention Approach

<table>
<thead>
<tr>
<th>A Combination Prevention Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural</td>
</tr>
<tr>
<td>Reduction of sexual transmission</td>
</tr>
<tr>
<td>HIV testing and counselling</td>
</tr>
<tr>
<td>Reduction of substance abuse</td>
</tr>
<tr>
<td>MCP</td>
</tr>
<tr>
<td>Sexual debut</td>
</tr>
<tr>
<td>Inter-generational sex</td>
</tr>
<tr>
<td>Low and inconsistent use of condoms</td>
</tr>
<tr>
<td>MARPS</td>
</tr>
<tr>
<td>Vulnerable groups</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Across all areas:
Social and behavioural change communications; Service delivery; Policy, legislation, and advocacy
Measurable referrals; Coordinated management of programmes and stakeholders
Capacity building; Resource mobilisation
The combination strategy will be applied to reduce exposure to HIV through interventions that address issues of sexual debut, multiple and concurrent partners, intergenerational and age-disparate sex, male circumcision, and correct and consistent use of condoms and substance abuse especially alcohol. In addition the strategy will address stigma and discrimination associated with HIV and AIDS. From a biomedical perspectives, the strategy will promote a four-pronged strategy to prevent MTCT, promote male circumcision, condom use, management of sexually transmitted infection (STI), reproductive health and family planning (RH/FP), and positive health, prevention and dignity (positive prevention). The strategy will also prevent HIV transmission in health and work place settings. Structural interventions will include addressing harmful social norms relating to gender, sexual and gender-based violence (SGBV), stigma and discrimination, and sexuality.

Implementation will be accelerated, with a focus on intensifying targeted interventions and increasing coverage. Strategic partnerships and alliances will be strengthened to ensure improved coordination and harmonisation of interventions. Given the nature of behavioural and structural drivers of the epidemic, political and traditional leadership will be strengthened and consolidated. Health and community systems will be strengthened to support a comprehensive multisectoral and decentralised implementation of prevention programme. Communities and PLWHA will be adequately mobilised to effectively participate in the prevention initiatives at all levels of the response. At an operational level, gender and human rights issues will be translated into appropriate actions with specific and measurable results. It is anticipated that the process will build demand for effective prevention interventions.

The operationalisation of the prevention component of the NSP will be guided by the National Prevention Strategy 2011/12-2015/16, the Health Sector Policy on Comprehensive HIV Prevention, and the Essential HIV and AIDS Services Package. The NSP HIV prevention strategy will focus on reduction of sexual transmission, mother to child transmission and prevention of blood borne transmission. These strategies are presented below.

4.1.2 Reduction of Sexual Transmission of HIV

In Lesotho, the primary mode of HIV transmission is through sexual intercourse. Reduction of HIV transmission through this mode is therefore strategic to reducing new annual infections. To effectively reduce the risk of sexual transmission of HIV, interventions must target behavioural and structural drivers of the epidemic. Some of the behaviours are deep rooted in cultural practices, are embedded in societal norms and are equally influenced by economic factors. In addition risky sexual behaviours are associated with inadequate comprehensive knowledge of HIV and AIDS, sexual gender based violence and substance abuse such as alcohol.

The following are the key strategies for reducing sexual transmission articulated in the NSP

- Reduction of multiple and concurrent partnerships,
- Promoting consistent and correct use of condoms,
- Promoting HIV testing and counselling
- Promoting medical male circumcision
- Targeting most at risk and vulnerable populations, youth and OVC and discordant couples
- Implementing strategies that reduce the possibilities of sexual and gender based violence, alcohol and drug abuse,
- Promoting prevention at the workplace,
- Strengthening prevention of sexually transmitted infections.

The implementation will focus on improving knowledge of critical issues and associated risks, improving personal risk perception, and implementing interventions that reduce or eliminate sex networks.
Interventions will also target and address underlying issues such as social tolerance of multiple partnering, gender norms, couples communication, sexual and gender based violence (SGBV), stigma and discrimination and economic vulnerability factors. Efforts will be made to ensure implementation and enforcement of policies and legislation regarding women, legal rights, and economic opportunities. A combination of implementation strategies will be used including community dialogue and conversations, use of mass media (radio, billboards, print media, and television, drama), interpersonal communication (IPC), and social mobilisation and advocacy.

4.1.2.1 Social and Behaviour Change

At the individual level, much work has been done to educate individuals about HIV and AIDS and improve personal risk perceptions. Anecdotal evidence suggests that behaviour change communication (BCC) programmes that focused on individuals have not been very successful in influencing personal or society behaviour changes among others. While BCC interventions are necessary they are not sufficient in themselves to contribute to the desired impact. The inclusion of social change interventions in BCC strategies is therefore critical in achieving those desired results.

The NSP has identified interventions that will address social norms [i.e. chobeliso (eloping) or ho kenela (wife inheritance)], beliefs, values and individual behaviours and attitudes that expose a person to HIV infection. These interventions include those that promote reduction of multiple and concurrent sexual partners, alcohol and drug abuse, and inter-generational sex. NSP will further support interventions that promote safe sex through condom use, abstinence, prevention of STIs and providing life skills based HIV and AIDS education for in and out of school youth.

The role of traditional and political leaders will be critical for the success of social and behaviour change interventions. Consequently leaders will be mobilised and sensitised on critical issues that require their sustained participation.

Social and behaviour change interventions have significant impact on all other interventions related to reduction of sexual transmission of HIV and AIDS including medical male circumcision.

Gaps and Challenges:

i. Inadequate focus on epidemic drivers
ii. Low levels of personal HIV risk perception
iii. Inadequate targeting, intensity and coverage of interventions that focus on society norms, values and practices that influence the spread of HIV
iv. Low level of comprehensive knowledge of HIV and AIDS.
v. Lack of sustained community and religious leaders in HIV prevention

Key strategies

To achieve the desired results, the following strategies will be used -

i. Engage community and political leaders to address social norms and practices that make people vulnerable to HIV infections.
ii. Address stigma and anti-discrimination by embedding strategies into behavioural, biomedical, and structural HIV prevention initiatives
iii. Embed gender, cultural norms, and male involvement elements into behavioural, biomedical, and structural HIV prevention initiatives
The above strategies will inform the choice and development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

**Table 5: Social and behaviour change outcome results**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2013/14</td>
<td>2015/16</td>
</tr>
<tr>
<td><strong>OC1</strong> Women and men 15-49 years with comprehensive knowledge of HIV and AIDS increased from 37.6% for women and 28.7% for men in 2010 by 50% in 2013/14</td>
<td>W=37.6% M=28.7%</td>
<td>W=50% M=40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>W=60% M=50%</td>
</tr>
<tr>
<td><strong>OC2</strong> Youth and adults (15-49) with accepting attitudes to PLHWA has increased from 42.3% for women and 32.9% for men in 2009 to 55% for women and 45% for men in 2013/14 and to 70% for women and 65% for men by 2015/16</td>
<td>W=42.3% M=32.9%</td>
<td>W=55% M=45%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>W=70% M=65%</td>
</tr>
</tbody>
</table>

**4.1.2.2 Reducing multiple and concurrent partnerships (MCP),**

MCP has been identified as key epidemic driver in Lesotho. Available evidence indicates that even a small reduction in MCP would break extensive sexual networks and could significantly slow the spread of HIV. It is evident that communities disapprove the MCP practice, however society norms tacitly acknowledge and tolerate the practice. Migratory labour is a major contributor to MCP.

Stakeholders will develop and implement targeted interventions that address MCP based on a variety but complementary strategies. Such strategies will include community leaders playing a major role in advocacy work and addressing social norms, promoting correct and consistent use of condoms, providing medical male circumcision and prevention of STIs. Stakeholders will intensify social and behaviour change interventions that improve risk perceptions and promote safe prevention behaviours.

**Gaps and Challenges**

i. Cultural conflicts around MCP  
ii. Lack of adequate political leadership to address MCP  
iii. Inadequate interventions resulting in poor intensity and coverage

**Key strategies**

To achieve the desired results the following strategies will be use

i. Review, implement, and assess social and behaviour change interventions targeting MCP  
ii. Mainstreaming MCP interventions into existing behavioural, biomedical, and structural HIV prevention programmes.  
iii. Increase the number of programmes providing training and income generation to females to reduce their economic dependence on men, or from engaging in transactional sex.  
iv. Address the cultural, policy and legislative barriers that prevent females from being economically empowered

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49 Epidemiological modelling (Morris and Kretzschmar, 2000, 1995; Hellinginger et al., 2007; Mah and Halperin, 2008)
v. Incorporate elements addressing intergenerational sexual relationships into all prevention programmes.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results.

**Table 6: Multiple and concurrent partnerships outcome results**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC3</td>
<td>New result</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>OC4</td>
<td>M=44.8% W=25.9%</td>
<td>M=40.3% W=23.3%</td>
<td>M=22.4% W=12.9%</td>
</tr>
</tbody>
</table>

### 4.1.2.3 Condoms: - Promoting correct and consistency use,

Global evidence indicates that when used consistently and correctly, condoms have a 90% efficacy. In Lesotho, despite the high levels of awareness and increased condom distribution, condom use and acceptance remains low. According to the LDHS (2009), only 37.5% of women and 50.5% of men who had two or more sexual partners reported using a condom during the last sexual intercourse. The consistent and correct use of condoms, especially during higher risk sexual intercourse and widespread availability of condoms are key interventions that will be promoted.

Lesotho will continue condom distribution through the public sector for free and through social marketing. To ensure efficiency in condom distribution, distribution services will be outsourced by MOHSW. Additional outlets will be established in urban and rural areas, and in areas where most at risk groups such as sex workers congregate. Stakeholders will be mobilised to participate in condom education and awareness in addition to actual distribution at community level. The National Condom Management Strategy and the condom policy will be finalised and implemented.

**Gaps and Challenges:**

The following gaps and challenges will be addressed:

i. Low levels of availability and acceptability of the female condoms.

ii. Low male and female condom use. Among men and women aged 15-49 years only 44.8% men and 25.9% women who had more than one sexual partner reported using a condom during the last sexual intercourse (LDHS 2009).

iii. Stock out of condoms at community and district levels

iv. Inadequate access to condoms by young people

v. Monitoring of condom distribution and usage is weak.
Key strategies

To achieve the desired results the following strategies will be used

i. Increase availability of condoms in urban, rural, and “high-risk” outlets and through community distribution
ii. Increase condom accessibility through friendly outlets for youth, PLWHA, people with disabilities, and other most at-risk populations
iii. Promote female condom acceptability and use.
iv. Increase availability of female condoms.
v. Conduct a condoms availability survey
vi. Integrate condom use in all HIV and AIDS related programmes coupled with adequate education and awareness.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

Table 7: Condom use outcome results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC5</td>
<td>Men and women aged 15-49 who had 2 or more sexual partners in the last 12 months who reported using a condom during the last sexual intercourse increased from 52.3% for men and 37.5% for women in 2009 to 60% for men and 50% for women by 2013/14 and 80% for men and 70% for women by 2015/16 (disaggregated by age: 15-24 and 25 and above)</td>
<td>M=52.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>W=37.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M=80%</td>
</tr>
</tbody>
</table>

4.1.2.4 HIV testing and counselling (HCT)

HTC is considered as a strategic entry point not only for treatment care and support, but as beginning point for individuals to make informed decisions and choices about their sexuality.

HTC will be offered as provider initiated testing and counselling (PITC) at health facilities and client initiated testing and counselling (CITC) at Voluntary Counselling and Testing (VCT) centres and health facilities. PITC will be provided as part of clinical care and disease prevention while CITC will be offered in response to individual basic rights to know their HIV status. Testing and counselling services will be offered as a package to enable individual choose safe behaviours. HTC services will be integrated with other services including PMTCT, PEP, prevention of STIs, male circumcision and ART among others.

Interventions addressing stigma and discrimination that are critical barriers to HTC will be intensified and coverage increased with emphasis on reaching out to people most at risk of HIV infection. Accessibility will be greatly increased through the utilisation of innovative delivery models, such as household testing through expert clients (clients who have already been identified as HIV-positive and have granted permission to disclose status), mobile services, and moonlight testing, or after-hours services. HTC is an excellent entry-point to expand male involvement and partner communication in HIV prevention.
Performance will be measured against people who have tested in the last twelve years and have received their results, and hence know their HIV status.

**Gaps and challenges:**

1. **Low levels of HIV testing and counselling.** In 2009, only 42% women and 24.7% men tested for HIV and knew their results. Recent reports show that men are not testing in sufficient and community mobilisation and education programmes are not generating sufficient demand for HTC.
2. **HTC services are not easily accessible by most at risk populations (sex workers and MSM).**
3. **Inadequate scaling up of HTC services.** In 2009, there were 214 HTC sites in 10 districts.
4. **Stigma associated with HIV and AIDS, remains a critical barrier to HTC uptake.**
5. **Quality assurance: stakeholders’ consultations show a growing concern on the quality of HTC services especially pre and post counselling.**
6. **Inadequate integration of HTC services with other prevention and public health interventions.**

**Key strategies**

To achieve the desired results the following strategies will be used

1. **Expand HTC coverage both in the community and health facilities, including scale up of HTC services to MARPS, hard to reach populations and targeting for men.**
2. **Intensify HTC in the workplace and among mobile populations.**
3. **Embed comprehensive HTC communications into existing prevention strategies.**
4. **Expand HTC accessibility to segmented targeted audiences through innovative delivery modules.**

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

<table>
<thead>
<tr>
<th>Table 8: HIV Testing and Counselling outcome results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome Level Result</strong></td>
</tr>
<tr>
<td>OC6</td>
</tr>
</tbody>
</table>

### 4.1.2.5 Safe Facility Based Male Circumcision

Safe male circumcision has been adopted as a key strategy for HIV prevention in Lesotho. This follows a situation analysis to establish the effectiveness of the strategy in helping to reduce HIV infection in the country. Randomised controlled trials and other studies have proven that complete male circumcision has the potential to reduce the probability of HIV infection from HIV positive females to HIV negative males by over 60%. In Lesotho, out of the 52% of men aged 15-59 years who are circumcised (LDHS, 2009) only 17.7% have gone through medical male circumcision.
Male circumcision in Lesotho marks the passage from youth to manhood. Traditional circumcision does not include a complete foreskin removal and hence falls short of WHO standards for MC as a HIV prevention strategy. A male circumcision policy and strategy have been developed. Capacity will be developed to ensure that medical male circumcision services are readily available and accessible to people in need. Education and awareness on male circumcision will be carried out and integrated in all other prevention interventions. Male circumcision services will be integrated with other services especially STI, PMTCT and HTC. The male circumcision policy has articulated the roll out plan that includes a comprehensive package of services including HTC, STI management, infection control, risk reduction counselling, condoms, RH/FP services, and referrals to other social support services. Patient follow up will include an assessment of counselling effectiveness, monitoring of adverse effects, and sero-conversion status.

Gaps and Challenges

i. Slow pace of roll out of male circumcision to health facilities
ii. Lack of standardisation of the MC procedure (i.e. complete skin removal or partial)
iii. Targeting infants only is a long term (10+ years) investment will not yield. There is urgent need to intensify adult male circumcision
iv. The role of traditional health practitioners (circumcisers) if not clearly defined.
v. Lack of capacity (human resources and well equipped facilities) in the health system to manage MC services if communities were adequately mobilised.
vi. Integration of MC with other health services such as STI, condom use, or PMTCT is not adequately done

Key strategies

To achieve the desired results the following strategies will be used for
i. Strengthen capacity (human, infrastructure and technological) for the health facilities to provide medical adult and neonatal male circumcision
ii. Integrate male circumcision in other programmes such as PMTCT, condoms use, STIs, social and behaviour change, and HTC.
iii. Intensify education and awareness of male circumcision in the general populations
iv. Outsource MC services to competent and accredited private sector and civil society organisations to complement government efforts.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

Table 9: Medical male circumcision outcome results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC7</td>
<td>17.7%</td>
<td>40%</td>
<td>80%</td>
</tr>
<tr>
<td>OC8</td>
<td>No baseline</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

50 the 40% is of men who were not medically circumcised (438,144) by 2010, and the 80% is cumulative of the midterm figure and the additional figure for period between mid and end term
4.1.2.6 Most at Risk Populations (MARP) and Vulnerable Groups

Most at risk populations in Lesotho include sex workers, men who have sex with other men (MSM), injecting drug users (IDUs), inmates (prisoners) and migrant workers. Vulnerable groups include people with disability, OVC, herd boys, women and girls, PLHWA and mobile populations. Although the Mode of Transmission report confirmed the presence of MSM and IDU, there is very little data on them. This is attributed to the fact that MSM and sex work remains illegal. In the case of sex work, the DHS (2009) found that only 2.6% of men paid for sex in the last twelve months preceding the survey.

MARP and other vulnerable groups display social behaviours that tend to put them at a higher risk of HIV infection. In Lesotho, MSM and sex work is illegal. Vulnerable groups and MARPs have limited access to HIV and AIDS related services and are often stigmatized and discriminated against. They are open to exploitation and harassment.

The NSP will focus on key priority population groups that will include sex workers, men having sex with men, migrant labour, and inmates (prisoners). Strategic information on these population groups and their HIV prevalence will be generated through a series of studies to inform the prevention and care and treatment responses.

Available epidemiological evidence indicates that in a generalised epidemic such as the case for Lesotho, controlling HIV infection amongst the key populations at risk will not necessarily reduce the overall number of new infections significantly at population level, or prevent the epidemic from sustaining itself. However, it is important to provide services based on a human rights approach. The design of the interventions will be based on the combination prevention strategy, while also linking such services with treatment, care and support and impact mitigation. The minimum package of services for most at risk populations would include at least:

- Policies and legislation that provide social and legal protection, reduce and mitigate stigmatisation and discrimination
- Provision of HIV and risk reduction counselling
- Distribution of male and female condoms
- Promotion of social and behaviour change interventions using a wide variety of delivery methods including IPC, social drama, and community conversations among others.
- Providing referral to other services such as ART, PMTCT, MC, PEP or STI.

Key strategies [MARPS]

To achieve the desired results the following strategies will be used

(a) For all MARPS and vulnerable groups:

i. Conduct nationwide surveys to estimate the size of MARPS and the extent of HIV infection
ii. Accelerate the development, and implementation of policies and strategic plan for each of the vulnerable groups and or MARPS
iii. Support the development of human rights and gender based targeted interventions for each of the vulnerable groups and MARPS
iv. Strengthen the capacity of service providers, and especially civil society organisations to reach out and serve key populations
v. Facilitate the formation of umbrella coordinating / networking groups or support groups within each of the vulnerable or MARPs
(b) **For Most at risk populations**

i. Establish and reinforce policy and legislation to enable most at-risk and vulnerable populations’ access to HIV prevention services

ii. Strengthen capacity for the provision of a minimum package of HIV services for at-risk populations within health facilities and communities

iii. Strengthen the capacity of district service providers to provide comprehensive services to MARPs and vulnerable groups.

(c) **For Migrant workers and their partners:**

i. Facilitate the establishment and strengthening of HIV and AIDS workplace programmes to cater for migrant workers and their partners.

ii. Conduct advocacy with government officials locally and regionally (especially with South Africa) to gain support for HIV prevention initiatives for migrant workers.

iii. Develop and implement a minimum package of social and behaviour change interventions that address risk and protective behaviours for “families left behind”

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

**Table 10: Most at risk populations’ outcome results**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most at risk individuals who reported using a condom the last time they had higher-risk sexual intercourse has increased <em>(disaggregated by the risk group)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migrant workers and their partners who reported using a condom the last time they had higher-risk sexual intercourse increased to 35% by 2013/14 and to 50% by 2015/16</td>
<td></td>
<td>35%</td>
</tr>
</tbody>
</table>

4.1.2.7 **Youth, Orphans and Vulnerable Children**

Available evidence indicates that HIV prevalence is lowest (3.5%) among young people 15-19 years. It is also clear that young people between 10-14 years are increasingly becoming sexually active. Majority of orphans 35.5% (35.6 men and 35.5 women) are aged 10-14 years. They also constitute the largest vulnerable group of orphans and vulnerable children (OVC) given their conditions of living. According to DHS (2009) only 24% of children under the age of 18 live with both of their parents. One in four Basotho children lives with no parents, and is considered to be “fostered”.

Stakeholders will identify and address the dynamics and behaviors that drive HIV infection among young people. Interventions will focus on sexual partnerships, sexual debut, sexual and reproductive health choices, sexual and gender based violence, intergenerational and transactional sex, structural issues such

as gender norms and cultural practices and peer pressure.

Addressing sexual and reproductive health (SRH) issues is critical in the context of promoting HIV prevention among young people. The National Population and Housing Census (2006) indicates that a high proportion of female orphans as compared to non-orphans fell pregnant and yet a low proportion gave birth. This implies that some pregnancies were prematurely terminated. The evidence points to the need for ensuring that sexual and reproductive health needs of orphans are met, including provision of HTC, Condoms, PMTCT, and appropriate forms of contraception.

While several initiatives are already being implemented for in school youth, there are limited effective and targeted out of school youth interventions. During the implementation of the NSP specific interventions will be developed including those that improve comprehensive knowledge of HIV, increases access to prevention strategies such as condom use, HIV testing and counselling, male circumcision, sexual and reproductive health education. In order to address transactional sex work among out of school youth, alternative livelihoods (income generating, vocational training etc) will be initiated. Advocacy for the implementation of the OVC Action Plan, and the Behaviour change strategy for young people will be intensified

Key strategies:

To achieve the desired results the following strategies will be used

i. Intensify provision of life skills based HIV education for in and out of school youth

ii. Integrate HIV prevention interventions in youth related recreational and sport activities.

iii. Integrate HIV prevention interventions in the OVC services package and in particular integrate those interventions in the National Action Plan for OVC in Lesotho.

iv. Support youth related and appropriate income generating activities

v. Support interventions that keep young people in schools or in vocational training centres.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

Table 11: Youth, and OVC outcome results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC11 Young people age 15-19 years who had sexual intercourse in the last 12 months with a partner 10 or more years older has decreased from 7.2% for women and 0.3% for men to less than 3% for women in 2013/14 and 0% for both men and women by 2015/16</td>
<td>W=7.2% M=0.3%</td>
<td>W=3%</td>
<td>W=0 M=0</td>
</tr>
</tbody>
</table>

4.1.2.8 Prevention among discordant couples

According to the DHS (2009) HIV discordance is prevalent in Lesotho. The survey noted that a third of all couples are HIV positive. More than 40% of these couples are “discordant couples” where one partner is HIV positive. Overall discordance in males is estimated at 7.2% while in women it is estimated at 9.2%.

In order to ensure that discordant couples remain HIV negative, stakeholders will develop and implement targeted interventions such as couple counselling, HIV testing, partner disclosure, adherence counselling, promoting consistent and correct use of condom, risk reduction (reducing MCP) and reduction in alcohol
and drug intake. Interventions will be integrated with other health services such as ART, PMTCT, antenatal clinics (ANC) and male circumcision among others.

**Gaps and Challenges**

- i. There are no targeted interventions for discordant couples
- ii. Inadequate monitoring of discordance
- iii. Insufficient research on discordance – answering the questions why discordance?

**Key strategies and activities:**

To achieve the desired results the following strategies will be used

- i. Intensify prevention interventions targeting discordant couples that are also integrated with other services.
- ii. Develop and implement interventions that empower discordant couples to live positively including partner disclosure, treatment adherence and communication
- iii. Strengthen the capacity of service providers to monitor discordance and respond timely on challenges experienced by discordant couples.
- iv. Ensure HTC services are readily available and accessible to discordant couples.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

**Table 12: Discordant couples outcome results**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC12 Discordant couples 18 years and older who remain discordant increased to 60% (12 months) in 2013/14 80% (24 months) by 2015/1</td>
<td>No baseline</td>
<td>12m=60%</td>
<td>24m=80%</td>
</tr>
</tbody>
</table>

**4.1.2.9 Sexual and Gender Based Violence,**

Sexual and gender-based violence are a common occurrence in society. However, given the nature of the offenses, the social and cultural norms around such acts prevent victims from seeking protection, care and support services. Many of such incidents go un-reported and un-attended. Sexual and gender based violence increases the risk and vulnerability of HIV infection especially among women and girls.

During the implementation of the NSP stakeholders will strengthen community systems to support interventions that address and mitigate sexual and gender based violence including rape. Education and awareness programmes will be intensified. Advocacy work will be carried with political and traditional leaders, and law enforcement officers to implement policy guidelines and enforce existing laws. Training will be conducted for community based service providers on the management of SGBV incidents including referral to legal assistance, law enforcement centres. Such interventions will include advocacy and education, training on GBV (and rape) case management including evidence preservation, referral to post exposure prophylaxis (PEP), legal assistance and law enforcement.

The CCACs and other community based organisations will facilitate the establishment of coalitions of community-based organisations that can provide primary services including legal aid, family-centred
trauma counselling and referral. The police, Child and Gender Protection Units (CGPU) will be strengthened to provide legal assistance, protection and referral services.

**Gaps and challenges**

i. Lack of awareness on the linkages between sexual and gender based violence with HIV
ii. Poor enforcement of policies and legislation that address gender and sexual violence
iii. Inadequate implementation of programmes that address SGBV including rape.
iv. The culture of silence by married women on violence and sexual abuse by a spouse or boyfriend.
v. Lack of awareness of existing services including legal assistance, protection and PEP at community level.

**Key strategies**

To achieve the desired results the following strategies will be used

i. Create awareness of available services available at the community and elsewhere
ii. Strengthen capacity of health facilities to provide comprehensive post violence services such as PEP and HTC
iii. Strengthen capacity of community based social and legal protection service providers to offer such services timely
iv. Advocate with community and political leaders on the need to enforce and implement existing policies and laws that mitigate SGBV.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

**Table 13: Sexual and gender based violence outcome results**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People aged 15 years and older who seroconvert decreased from X% in 2010, to 70% by 2013/14 and to 30% by 2015/16</td>
<td>Baseline to be developed</td>
<td>70%</td>
</tr>
</tbody>
</table>

**4.1.2.10 Alcohol and Drug Abuse,**

Although there are no country specific studies on the association of alcohol with the spread of HIV, available global and regional evidence shows a strong relationship. Most people who drink alcohol are also likely to engage in risky behaviours such as unprotected sex and multiple and concurrent partnerships. In Lesotho tackling substance abuse, specifically alcohol and cannabis, is critical in the fight against the spread of HIV. Alcohol abuse in particular is known to contribute to non-treatment adherence, reduces the effectiveness of ARV and increases toxicity\(^\text{52}\). Supply of alcohol has been used as a commodity for exchanging sex with casual partners, and promotes high incidence of concurrent partnerships.

**Gaps and Challenges**

i. Poor enforcement of laws relating to the sale of alcohol
ii. Low perceptions on the risks associated with alcohol abuse and HIV

\(^{52}\) Rene Adams, 2008: HIV risk and Alcohol use, (presentation )
iii. There are not many programmes that address HIV and alcohol, with the intensity and coverage required.
iv. Condoms are no readily available in alcohol drinking places.

**Key Strategies**

i. Accelerate the enforcement of local authority regulations and legal statutes governing the sale of alcohol. Advocate with leaders on the need to enforce such regulations, policies and laws

ii. Intensify education and awareness on the risks associated with alcohol and HIV

iii. Develop a national substance abuse and HIV prevention strategy.

iv. Develop and pilot community-based substance abuse programmes with addiction treatment centres.

v. Integrate alcohol and substance abuse education in all HIV prevention packages.

vi. Engage media in the public advocacy and education around alcohol and substance abuse.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results.

**Table 14: Alcohol and drug abuse**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC14</td>
<td>W=X% M=23%</td>
<td>W=10% M=15%</td>
<td>5% (for both)</td>
</tr>
</tbody>
</table>

**4.1.2.11 HIV prevention at 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. Workplace programmes expand availability, increase access and utilisation of services. The focus has been provision of basic services such as education and awareness, condom distribution, testing and counselling and referral services to other service providers. However a few large and well resourced companies are providing treatment.

HIV workplace programmes are largely lacking in small and medium enterprises. This is primarily associated with lack of resources and competent human resources to manage such services. Workers in small and medium companies access HIV and AIDS services in similar ways as the general public.

In order to improve HIV and AIDS workplace services, the Government has developed and disseminated national guidelines for HIV and AIDS that support the implementation of the Labour Code Amendment Act that has incorporated HIV and AIDS.

During the implementation of the NSP, stakeholders especially those representing non-health sectors will be capacitated to develop and implement a minimum package of HIV and AIDS workplace programmes.
Gaps and Challenges:

i. Inadequate implementation of the national guidelines on workplace programmes and the Labour Code.

ii. Few sectors have undertaken sectoral situation analysis of HIV and AIDS, to inform their policies and workplace plans.

iii. Lack of capacity in developing and implementing HIV and AIDS workplace programmes.

iv. There are no strategies that address small and medium companies.

Key Strategies:

The following strategies will be implemented:

i. Develop capacity for sectors to develop and implement HIV and AIDS workplace programmes.

ii. Provide technical and financial support.

iii. Facilitate the development of national guidelines for mainstreaming and align them to the SADC “simultaneous mainstreaming” approach.

iv. Support sectors to conduct sectoral assessments of HIV and AIDS, including socio and economic impacts.

v. Develop a monitoring and evaluation mechanism for non health sector response.

**Table 15: Prevention in the workplace**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public and private sectors, and CSO that have functional HIV and AIDS workplace programmes after having reviewed their sector policies and plans to mainstreamed HIV and AIDS has increased</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.1.2.12 Prevention of sexually transmitted infections

Available epidemiological and scientific data indicates that the presence of STI, especially ulcerative conditions, in an HIV-negative person increases the risk of acquiring HIV infection by a factor of ten (10)\(^53\). HIV-infected persons with STI, both ulcerative and inflammatory are at increased probability of transmitting HIV to their sexual partners due to increased genital shedding of HIV. Furthermore, there is evidence that HIV-infected women are at a higher risk of developing cervical cancer, which in 99% of the time is caused by the sexually transmitted human papiloma virus. In 2009 (LDHS) 14.7% of women and 13.2% of men reported having STI, genital discharge, sore, or ulcer in the past twelve months preceding the survey. The survey also shown that HIV prevalence among individuals diagnosed with STI was 54.5%\(^54\).

Treatment of STIs is, therefore, an important public health intervention in that, together with prevention interventions, will reduce the prevalence of STIs in the population, and thus reduce HIV infections attributable to STIs. Additionally, STI are important in their own right because they cause considerable disease burden and expenditure, particularly in women. Therefore, STI prevention and control for the general population should be a priority intervention as a component of sexual and reproductive health services that are important to HIV prevention. It is also evident that almost all measures for preventing sexual transmission of HIV and STIs are the same, so are the target audiences in most cases. In addition

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\(^{54}\) NAC (2009): Annual Report of the National Response to HIV and AIDS, January to December 2009
clinical services offering STIs care and support are important access points for people at high risk of HIV infection for testing, diagnosis, information and education.

Awareness of STIs at community level is considered low and hence in most case seeking care and support is often compromised. Stigma associated with STI and HIV is major contributor of people seeking health care late. On the other hand STI services have not been adequately integrated in other services such as male circumcision, condoms, HTC, sexual and reproductive health services (SRH).

During the period of the NSP Lesotho will review the syndromic management approach to STI management in order to include strategies that will address viral STIs and emerging drug resistance. STI microbiological or aetiological studies will be carried to generate the evidence necessary to inform policy and planning.

In service provision, targeted interventions will be developed and implemented targeting MARPS, migrant labourers and mobile populations in particular. Service providers will be trained in new strategies for managing STIs. STI services will integrate prevention strategies that promote partner reduction, condom use, male circumcision, HTC, and partner notification among others.

Gaps and challenges

The following gaps and challenges will be addressed

i. Inadequate capacity of health facilities to provide treatment of viral STIs
ii. Emerging drug resistance among patients with bacterial STIs
iii. Low levels of knowledge of STIs and their relationship with HIV. This has a negative impact on people seeking early diagnosis and treatment
iv. Late seeking of treatment and care especially in rural setting. Most people will first seek treatment from a traditional health practitioners before attending a health clinic
v. Inadequate integration of STI with other health services.

Key strategies:

To achieve the desired results the following strategies will be used for

i. Conduct a national microbiological survey (or aetiological study) to improve our knowledge of STIs and inform policy and planning of interventions
ii. Integrate STIs with other prevention strategies
iii. Intensify education and awareness of STIs as part of the prevention social and behaviour change programmes.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

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Table 16: Sexually Transmitted Infections outcome results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC16</td>
<td>*</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>OC17</td>
<td>54.5%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27%</td>
</tr>
</tbody>
</table>

4.1.3 Reduction of Mother to Child Transmission of HIV

It is estimated that there are 55,000 annual births in Lesotho. Approximately 15,235 children are born to HIV positive women each year resulting to an estimated 6,094 paediatric HIV infections annually\(^{56}\). HIV prevalence among ANC attendees is more than 30% among women aged 25-39 years and with prevalence being highest among women aged 30-34 years\(^{57}\).

Viral, maternal, obstetric, foetal and infant factors all influence the risk of mother to child transmission (MTCT). However the most significant of the risk factors is the amount of virus (viral load) in the mother’s blood. Most children get infected during labour and delivery and hence the importance of improving the quality of services\(^{58}\).

It is estimated that an effective PMTCT programme can reduce mother-to-child transmission (MTCT) of HIV to less than 2%. To achieve these Lesotho would require to, implement a comprehensive combination strategy that target all the four components of PMTCT. A national plan to scale up PMTCT was approved in 2007\(^{59}\) and National PMTCT guidelines were revised to support PMTCT Plus in 2010. PMTCT services are available in 186 health facilities (2009). PMTCT coverage has increased from 6% in 2005 to 52% in 2008 and 71% in 2009. 90% of women attending ANC had tested for HIV (2009). The PMTCT programme is integrated into routine maternal and child health care services and ANC.

Among the services being provided include antiretroviral (ARV) prophylaxis given to women during pregnancy and labour and to the infant during the first weeks of life; obstetric interventions including elective caesarean delivery, and; safer infant feeding practices. During the period of NSP, PMTCT services will include primary prevention of HIV among women of reproductive age, prevention of unintended pregnancies in HIV infected women, prevention of MTCT care for the infected woman, partner, and her family. Other services will include promoting safer sexual practices such as reduction of MCP, condom use, MC, prevention of STIs etc and support for discordant couples. The diagram below illustrates the four components of PMTCT.

\(^{56}\) National Guidelines for the Prevention of Mother to Child Transmission of HIV


\(^{59}\) GOL (2007): PMTCT Scale Up Plan, Maseru, MOHSW
Table 17: Four components of PMTCT

<table>
<thead>
<tr>
<th>Component</th>
<th>Target Population</th>
<th>Potential services</th>
</tr>
</thead>
</table>
| 1. Primary prevention of HIV infection                                  | Women and men who are sexually active                  | • Behaviour change (ABC, MC  
  • Counseling and testing - know ones HIV status  
  • Treatment for STIs (HW should screen and treat STIs according to syndromic approach)                                                                 |
| 2. Prevention of unintended pregnancies among women infected with HIV    | HIV infected women                                      | • Family planning at ANC, ART sites, maternal and postnatal care (PNC)  
  • Encourage clients to use dual family planning methods  
  Safe, consistent and effective contraception                                                                                                                        |
| 3. Prevention of HIV transmission from women infected with HIV          | HIV infected women                                      | • Provide ART prophylaxis according to national guidelines  
  • the more efficacious combination therapy (at antenatal, during delivery, and postnatal)  
  • To strengthen the systems necessary for effective To prevent blood borne transmission                                                                               |
| 4. Provision of treatment, care and support for women infected with HIV | HIV infected women, their children and their families   | • Treatment with ARV to those in need  
  • Family planning and reproductive health services  
  • Nutrition  
  • Counselling  
  • Supportive care and treatment of other diseases such as malaria TB and STI  
  |

Source: National Guidelines for the prevention of Mother to Child Transmission of HIV, September 2010

Gaps and challenges:

The following gaps and challenges will be addressed

i. Inadequate capacity to scale up of PMTCT services such that all women in need access and utilise the services.

ii. Some women continue (or prefer) to deliver at home

iii. Weak referral system especially from community to health facilities and to other services

iv. Inadequate participation by men

v. Lack of male involvement in PMTCT

vi. Stigma and discrimination associated with HIV and AIDS

vii. Inadequate participation and involvement of the private sector in provision of PMTCT.

Key Strategies

To achieve the desired results the following strategies will be used for

(a) Women of reproductive age

i. Implement strategies that empower partners to disclose their HIV status including among discordant couples.

ii. Integrate PMTCT services with other prevention strategies including MC, HTC, STI, ART etc..

iii. Integrate male involvement into all PMTCT interventions

iv. Accelerate the implementation of sexual and reproductive health services.
(b) Intended pregnancies

i. Intensify provision of reproductive health and family planning services including education and awareness.

ii. Strengthen linkages between ART clinics, Positive Prevention services, and PMTCT to RH/FP and “family friendly” HTC services

iii. Support community-based distributors and community health workers to promote and distribute condoms and work with clients to ensure family planning needs are being addressed.

iv. Develop and implement strategies that promote male involvement in reproductive health and family planning programmes

(c) Prevention of Mother to Child Transmission

i. Mobilise pregnant women and their partners to test for HIV and know their results

ii. Provide ART prophylaxis for HIV pregnant women and their infants in need

iii. Provide ART to HIV pregnant women and their infants in accordance with national ART guidelines

iv. Strengthen national capacity for paediatric ART including DNA PCR testing

v. Strengthen health systems capacity to provide and sustain a minimum PMTCT services package at health facilities and in the community.

vi. Accelerate the roll out of “mother/Baby Pack” to all health facilities

(d) Care and support for HIV-infected mothers, their children, and their families

i. Develop a minimum package of services for HIV+ mothers, their children and families

ii. Train community based service providers in supportive services for HIV+ mothers, their children and families

iii. Intensify community mobilisation to encourage women to seek and adhere to PMTCT services

iv. Mobilise male involvement in PMTCT programmes

v. Strengthened systems to manage client follow up through the breastfeeding period

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

Table 18: PMTCT outcome results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2013/14</td>
</tr>
<tr>
<td>OC18     HIV Positive pregnant women who received ARV to reduce the risk of mother to child transmission has increased from 71% in 2009, to 80% in 2013/14 and to 95% by 2015/16</td>
<td>71%</td>
<td>80%</td>
</tr>
<tr>
<td>OC19     Infants born to HIV positive mothers who are also HIV positive has reduced from 10% in 2010, to 5% by 2013/14 to less than 2% by 2015/16</td>
<td>10%</td>
<td>5%</td>
</tr>
<tr>
<td>OC20     Improved health status for HIV infected mothers their children and families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC21     Reduction of unintended pregnancies in women with HIV</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.1.4 Prevention of blood borne transmission of HIV

4.1.4.1 Prevention HIV transmission through Blood Transfusion (Maintaining Blood Safety)

Contaminated blood and blood products are the most effective means of HIV transmission if appropriate measures are not taken to screen them. It is for this reason that blood safety is considered a universal pre-requisite for all national HIV and AIDS responses. Lesotho has embraced this principle and screens 100% of all blood for HIV or other transfusion-transmissible infections (TTI) such as Hepatitis B, Hepatitis C, and syphilis.

In order to minimise and reduce the number of blood units that are infected, blood collection strategies have become more rigorous and focus on population groups that exhibit low risk behaviours such as young people in schools or in the community. In Lesotho young people are being encouraged to donate blood by being offered different non-monetary incentives in line with the global guidance of collecting blood from non-remunerated donors. Blood donation is also being encouraged as a reinforcement strategy for regular blood donors to stay negative.

In 2009, the total number of blood units collected and screened was 3319. Of these 3148 units were found suitable for use while 3% of the units were found to be infected with HIV. The infection rate was higher than the WHO recommended level of 1%. Currently only the central laboratory at Queen II screens blood.

To prevent infection through blood transfusion, laboratory capacity for blood screening will be strengthened through technological improvements, training more technologists and maintaining rigorous recruitment procedures for blood donors. The coordination and management capacity of the Lesotho Blood Transfusion Service (LBTS will be strengthened to scale up blood collection in an attempt to meet national demand for safe blood. In 2009, the total blood units collected was 3000 against a national target of 9000 units.

The National Blood Transfusion Policy (2006) will be reviewed to ensure its continued relevance in managing blood safety in the country. The policy will in particular pay special attention to strategic issues such as clinical use of blood, quality assurance standards and processes, monitoring of blood data collection, human resources management and effective strategies for disposal of contaminated blood and blood products.

Gaps Challenges:

i. Staff shortages at Lesotho Blood Transfusion Services (LBTS)
ii. Inadequate vehicles to support blood collection and distribution of screen blood to health facilities
iii. Inability to meet national demand for safe blood by hospitals.

Key strategies [blood transfusion]

The following strategies will be implemented to address the above identified gaps and challenges.

i. Ensure that the screening of all blood donated for transfusion meets WHO standards
ii. Decentralise blood screening and transfusion services to three additional districts
iii. Increase the number of voluntary, non-remunerated donors, especially among youth, to increase blood donations
4.1.4.2 Prevention of blood borne HIV transmission in the workplace (including health facilities)

Blood borne infections at the workplace are often accidental. Most infections occur in health care settings and work environments where use of machineries and other equipment is intensive. Additional infections associated with the work place occur during the process of providing services. This is particularly the case of police officers attending road accidents or firemen in rescue missions. Accidental HIV exposure also occurs in community settings in different circumstances including during home deliveries, traditional circumcision where concerned parties don’t know their HIV status or that of the other party. World Health Organization (WHO) estimates that approximately 5% of new infections in developing countries including Lesotho are attributed to unsafe health care infections.

Lesotho will develop a strategy to reduce blood-borne HIV transmission in the workplace. The capacity of health facilities will be strengthened to managing blood borne infections, maintaining quality assurance, undertake infection control, manage waste and apply universal precautions. Provision of post exposure prophylaxis (PEP) will be expand and integrated with other health care services and in particular those providing ART, PMTCT and HTC among others. Appropriate supplies and equipment including safety syringes and needles, gloves, PEP kits, and safety boxes will be procured and distributed to health facilities. The referral system will be reviewed and improved to ensure that people in need of PEP receive PEP within the prescribed 72 hour period.

Communities will be mobilized and sensitized on how infections are likely to occur and how they can provide initial services before the situation is attended by a health professional. Awareness of PEP will be intensified. At the health facilities PEP will be initiated to reduce the risk of HIV infection within the recommended period of 72 hours of suspected exposure. PEP administration will include first aid care, counselling and risk assessment, HTC, and short-term ARV prophylaxis.

Gaps and Challenges:

1. Blood borne infections continue to occur in the workplace and in the community settings.
2. Most people are not well informed or lack sufficient experience in dealing with blood borne accidental exposure to HIV.
3. Monitoring of blood borne infections in non health work environments and in the community is weak.
4. Inadequate awareness of PEP

Key strategies:

To achieve the desired results the following strategies will be used for

1. Develop and implement a national strategy for the provision of PEP in occupational and other settings.
2. Strengthen the capacity of health and non-health care workers who have the potential to be exposed accidentally to HIV to implement infection prevention measures;
3. Provide protective materials
4. Provide HTC to all persons exposed to blood borne infections
5. Provide PEP to all in need.
The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results.

**Table 19: Outcome level results for Prevention of blood borne transmission of HIV**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC22</td>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Blood units donated in the last 12 months that have been screened in accordance to national guidelines is maintained at 100% during the period of NSP</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>OC23</td>
<td></td>
<td>87%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>Health workers in need of PEP receiving PEP has increased from 87% in 2009, to 95% by 2013/14 and to 100% by 2015/16</td>
<td>87%</td>
<td>95%</td>
</tr>
<tr>
<td>OC24</td>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>People reporting to be in need of PEP in the last 12 months and who have received PEP services as per national guidelines has increased and maintained at 100% throughout the period of NSP</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
4.2  Treatment Care and Support

4.2.1  Overview

Provision of comprehensive treatment, care and support has significantly improved the quality of life of PLWHA. The programme has adopted an integrated approach that includes, HIV counselling and testing, management of opportunistic infections including TB and STIs referral services, nutrition and home based care. Services will be scaled up taking cognisance of the need to maintain quality, ensure universal access and equitable implementation. Health systems will be strengthened to support this strategy and ensure sustained provision of services. Communities will be mobilised to generate demand for HIV counselling and testing and the subsequent need for treatment.

The treatment protocols are based on international standards and best practice. Facilities are assessed and accredited and Service providers trained and certified to ensure quality standards. Lesotho has embraced and is implementing the “treatment 2.0” concept. The concept attempts to make use of a combination effort to help bring down treatment costs, make treatment regimens simpler and smarter. The approach is also intended to reduce the burden on health systems. In 2008, Lesotho reviewed the eligibility criteria from CD4 200 to CD4 350 for adults and children aged five years and above. The MOHSW has established (2008) a quality assurance unit that has already assessed and accredited 16 hospitals and 147 health facilities to provide ART.

During the implementation of the NSP the ART M&E system will be reviewed and strengthened to ensure a robust system that will include early warning system indicators to detect drug resistant strains of the virus, adverse drug effects and drug-to-drug interactions. According to MOHSW some of the PLWHA has failed the first line of ART and have been enrolled on the second line. The current guidelines have made provision for third line ART.

While early access and enrolment of PLWHA on ART is considered an effective strategy to improving the quality of life, Lesotho will review, strengthen and consolidate on-going initiatives on pre-ART care and support. The institutionalisation of pre-ART is intended to retain people living with HIV on pre-ART much long before being enrolled on ART.

4.2.2  pre-Antiretroviral Therapy

The change in the eligibility criteria makes it possible for more PLWHA to access ART much earlier. However, providing quality services that delay initiation of ART is not only essential but critical in the management of AIDS, and hence the need to consolidate and institutionalise the pre-ART programme. It is anticipated that pre-ART will minimise the pressure on health facilities and contribute to the reduction of HIV related morbidity and mortality in the longer term.

During the period of the NSP implementation, pre-ART services will be standardised and service providers trained on pre-ART services provision. The core pre-ART services will include screening of opportunistic infections (OI), provision of cotrimoxazole prophylaxis, TB-IPT, monitoring of viral loads, nutritional support, treatment literacy (in preparation for ART enrolment), HTC, condom use, and psycho-social support, amongst others.

Pre-ART services will be integrated in existing ART sites or filter clinics. Alternatively pre-ART could be mainstreamed in community home based care. This option will require that CHBC service providers be
adequately trained to provide some of the basic services, while tasks shifting could be considered for more qualified health workers.

Gaps and challenges:

i. Pre-ART services are not yet standardised and provided at all levels.
ii. Inadequate human, financial and infrastructure resources to support an efficient pre-ART model
iii. Lack of a defined minimum package for PLWHA not yet on enrolled on ART. This has implications on what services can be provided as part of CHBC.

Key Strategies

i. Define a minimum pre-ART package
ii. Train service providers on pre-ART with particular attention to screening of opportunistic infections (including STIs etc), and monitoring of viral load, nutrition etc
iii. Develop and implement a comprehensive patient monitoring system, with clearly identified early warning indicators on changes in quality of life.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

Table 20: Pre-ART outcome level results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC25</td>
<td>More PLHIV have improved quality of care: PLWHA enrolled on pre-ART are retained until they are enrolled on ART has increased</td>
<td>*</td>
</tr>
</tbody>
</table>

4.2.3 Anti-Retroviral Therapy (ART)

By 2010, 80% (101,000 of 126,251 in need) PLHWA were enrolled on ART. By 2008, 148 health facilities were providing ART. The total number of people enrolled on pre-ART in 2009 was 49,642 of whom 7% were children under the age of 14 years. By the end of 2009, 62,190 adults and children had been enrolled on ART. In a cohort study conducted in 2009, 39,247 (80.07%) of the PLHWA were found to be alive twelve months after the initiation of ART. Lesotho also changed the eligibility criteria from CD4 200 to CD4 350 for adults and children five (5) years and above.

The demand for ART has increased as more people access treatment, including HIV+ women referred from PMTCT, PEP, TB patients who are HIV positive and the inclusion of people with HIV/Hepatitis B co-infection on ART. The increased demand for ART will also trigger an increased demand for other services and in particular for adherence counselling, clinical and laboratory patient monitoring. Unless health systems are adequately strengthened to cope with the demand, the waiting time and rushed-doctor consultations will be inevitable. Strengthening of pre-ART clinics will contribute to lessening the burden on main ART clinics.

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60 NAC, Annual Report National Response to HIV and AIDS – January to December 2009
ART will be complemented by the provision of a comprehensive package that will include counselling, nutritional and psychosocial support, treatment literacy, home based and palliative care, and support for vulnerable children living with sick parents or guardians.

**Gaps and challenges:**
- i. 20% of people in need of ART are not getting ART
- ii. The uptake for paediatric ART is still low
- iii. ART is not rolled out to all potential (that are likely to meet the accreditation criteria) health facilities
- iv. Inadequate capacity to provide ART and monitor adherence.
- v. Inadequate integration of ART services with other health care services and settings.

**Key Strategies**
- i. Develop a clear ART scale up strategy.
- ii. Roll out ART services to all health facilities that are potentially ART sites. These sites will require to be assessed and accredited.
- iii. Strengthen health systems (human resources, infrastructure, technological resources, procurement and supply chain management, referral system, M&E etc) to cope with the demand for ART.
- iv. Periodically review national ART technical guidelines to bring them to current WHO standards. The current guidelines were reviewed in 2010.
- v. Strengthen capacity for paediatric ART services. Technical assistance has been received from Baylor to strengthen paediatric ART.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

**Table 21: Antiretroviral Therapy (ART) outcome results**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2013/14</td>
</tr>
<tr>
<td>OC26 Adults and children who are eligible and are receiving ART has increased from 59% (65510 of 111,000) in 2009 to 70% by 2013/14 and 90% by 2015/16</td>
<td>59%</td>
<td>70%</td>
</tr>
<tr>
<td>OC27 Children (0-14 yrs) who are eligible and receiving ART has increased from X% in 2010, to Y% in 2013/14 and Y% by 2015/16</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

**4.2.4 Management of TB/HIV Co-Infection**

By the end of 2009, 12,201 cases of all forms of TB were reported. Tuberculosis (TB) poses greater challenges in managing the HIV epidemic as it remains the single most serious opportunistic infection for PLHWA. World Health Organisation (WHO) notes that TB is a major cause of mortality among PLHWA.

By 2008 TB case detection rate had reached 80%, with a treatment success rate of 74%. In 2009, seventy eight percent (78%) of individuals with TB were tested for HIV and 76.5% were found to be HIV positive. Ninety five percent (95%) were put on cotrimoxazole prophylaxis while 27.6% being enrolled on ART. Eighty-seven (87) cases of multi-drug resistant (MDR) and two cases of extensively drug resistant (XDR) 61

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61 WHO Three "I"s meeting, Intensified Case Finding, Isoniazid Preventative Therapy and TB Infection Control for people living with HIV, April 2008
TB were detected in 2007. MDR-TB/HIV co-infection rate was estimated at 65%. Eight (8) MDR-TB related deaths were recorded in 2007.

Timely detection and treatment of TB is therefore critical to the effectiveness of ART. A combination of ART and TB treatments has the potential to reduce mortality rate among patients with TB/HIV co-infection with 50%. Stakeholders will intensify implementation and coverage of effective strategies such as the WHO’s “Three I’s” strategy that entails Intensified Case Finding (ICF), provision of Isoniazid Preventative Therapy (IPT) and TB Infection Control (IC). HIV surveillance amongst TB patients and TB among HIV patients will be intensified. IPT will be provided as appropriate. Monitoring of MDR-TB and XDR-TB will also be strengthened. Lesotho will continue to enrol all TB patients who test HIV positive on ART regardless of their CD4 count.

**Gaps and Challenges**

i. Inadequate integration and roll out of TB/HIV services to all health facilities

ii. Slow pace in scaling up TB/HIV co-infection collaborative actions

iii. Lack of comprehensive data on the extent of MDR and XDR-TB in the country.

iv. Lesotho has not attained the treatment success rate (85%) recommended by WHO

v. Insufficient community awareness of TB/HIV interactions

**Key Strategies**

The following priority strategies will be implemented

i. Develop and disseminate TB/HIV collaborative activities guidelines. This will also require training of service providers on the application of the guidelines.

ii. Accelerate HIV testing in TB patients and their enrolment on ART.

iii. Roll out TB/HIV services in all health facilities.

iv. Strengthen the capacity of health facilities to provide TB/HIV services including diagnosis, testing, counselling, and referral services.

v. Conduct community mobilisation to create awareness of the interactions between TB and HIV.

vi. Build community capacity to support community home-based TB and HIV interventions and in particular adherence to treatment.

vii. Establish treatment adherence programme for TB/HIV patients to safeguard against early development of drug resistance.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results.

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63 In 2008 the NTCP reported that 66.9% of TB patients had been tested for HIV
Table 22: Outcome level results – Management of TB/HIV co-infection

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC28 People diagnosed with TB who were tested for HIV has increased from 78% in 2009, to 95% in 2013/14 and sustained above that level by 2015/16</td>
<td>78%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>OC29 HIV+ people who do not have active TB are initiated on IPT prophylaxis has increased</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC30 TB patients who were tested for HIV enrolled on ART has increased from 41% in 2010 to 80% in 2013/14 and to 90% by 2015/16</td>
<td>41%</td>
<td>80%</td>
<td>90%</td>
</tr>
</tbody>
</table>

4.2.5 Community Home Based Care (CHBC)

Home based care is an important component of the national HIV and AIDS response. Providing quality and comprehensive home based care has eased congestion in health facilities. CHBC is particularly support strategy for pre-ART services. By the end of 2009, the number of people on home based care had increased to 43,513 of whom 24,315 were women and 19,198 were men.

Until recently home based care has focused on providing services to individuals rather than the family. During the implementation of the NSP considerations will be made to provide services to vulnerable households based on the “family care model”. The model provides opportunities for integration and harmonisation of services and rationalisation of resources given that one or more person receiving HBC live in the same household. Among the core CHBC services includes HIV prevention, adherence and treatment literacy, palliative care, basic nursing and clinical care, counselling, nutrition, and psycho-social support.

Strategic partnerships will be established with civil society organisations to scale up CHBC services. This will be necessary given the scaling up of pre-ART, ART, and TB/HIV services. Their capacity will be strengthened as part of the broader strategy for community systems strengthening.

Gaps and Challenges

i. Inadequate and fragmented coordination of home based care services.
ii. Many service providers are not adequately trained in CBC services and waste management.
iii. High attrition of trained volunteers
iv. CHBC and the Essential Services Package (ESP) are not adequately aligned and harmonised.
v. Quality of services is often compromised by poor adherence to set services standards.
vi. The referral system remains the weakest link in CHBC.
vii. Limited access to HBC materials and supplies.

Key Strategies

The following strategic actions will be implemented.

i. Train home based care givers in basic skills.
ii. Standardise and harmonise the ESP and CHBC minimum packages
iii. Define quality standards for HBC services and conduct orientation for service providers
iv. Review and strengthen the referral system.
v. Develop and disseminate guidelines for waste management.
vi. Procure and distribute home based kits to all CHBC service providers
vii. Strengthen supervision of CHBC service providers as part of quality assurance.
viii. Strengthened M&E and reporting of community and home based care services

Outcome Level Results

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

Table 23: Community Home Based Care outcome results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All people in need of home based care are receiving comprehensive care and support by 2015/16.</td>
<td>35,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home based carers who have been trained to provide home and palliative care services according to national guidelines has increased by 2015/16</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.3 HIV Impact Mitigation

4.3.1 Overview

Lesotho has identified OVC, PLHWA, women and girls, people with disability and herd boys as vulnerable groups requiring interventions to mitigate the socio-economic impacts of the epidemic. Many of them live in vulnerable households that are unable to meet their basic needs, invest and or save resources for other essential services including education for their children. Approximately 62,555 households are considered to be vulnerable. Growing food insecurity, the narrowing of livelihood opportunities for vulnerable groups, deepening household poverty, loss of skills necessary to sustain livelihoods and weakened service delivery systems are among some of the indicators of communities whose capacity to cope has been compromised.

It is evident that the relationship between vulnerability and HIV infection is reciprocal as the factors that contribute to either vulnerability or HIV infection also increases the susceptibility to the other. Poverty, violence and ignorance, for example increases a persons’ susceptibility to HIV infection and hence becomes a driver of the epidemic. Being HIV positive re-enforces vulnerability that enables the epidemic to thrive and worsens the quality of life.

In the context of impact mitigation, stakeholders will implement interventions that will contribute to two strategic results. First, interventions that strengthens households to cope with the socioeconomic impacts of HIV and AIDS, poverty and support them to move towards self-reliance over time. Second, stakeholders will strengthen community and household strategies that will empower vulnerable households to choose, adopt and adhere to key prevention strategies.

Interventions will be delivered within the context of the broader Social Protection Framework. The framework is designed to contextualise interventions in such as way that they facilitate the reduction of social and economic risks and vulnerability, alleviate extreme poverty, deprivation through transformative strategies that change social policies and attitudes; promote strategies that enhance earning capacity; preventive strategies, that help avert deprivation. These strategies are potentially overlapping and enable social transformative.

4.3.2 Support for Orphans and Vulnerable Children

Orphans and Vulnerable children (OVC) are the most visible social impact of HIV and AIDS epidemic. In Lesotho, the number of OVC is estimated at 180,000 of whom 122,000 are due to AIDS. Some of them are living with HIV and AIDS. In 2009 7,850 were in need of ART and 31,000 were in need of cotrimoxazole prophylaxis. 94.3% of infants in need of ART received ARV.

OVC are more vulnerable to risk of early sexual debut than non-OVC partly due to lack of parental guidance. OVC experience trauma, emotional distress as they continue to live with parents who are very sick, and they are often stigmatised and discriminated at home, in the community or at school.

More often OVC, especially in the girls, assumed the roles of caregivers and heads of households. This has compromised their rights to attend school and even make them more vulnerable to abuse, neglect and rejection. Property left behind by parents is often grabbed by relatives under the pretence of traditional

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In the absence of adequate and effectively enforced legislation and policies, the rights of OVC to a decent life are violated by the very duty bearers supposed to defend them.

Stakeholders will focus on interventions that provide quality and comprehensive care for OVC - from having a caregiver, provision of food, shelter, space for socialisation, to ensuring that OVC have access to protection, education and health care.

**Gaps and Challenges**

i. Delays in the development of the National Action Plan for OVC  
ii. Delays in the finalisation of the Child Welfare and Protection Bill  
iii. Lack of domestication of the provision of the Convention on The Rights of the Child (CRC).  
iv. Weak coordination and management of OVC support services.  
v. Lack of reliable data on OVC. Data from different sources is currently conflicting and not harmonised. Lesotho does not have a central database for OVC.  
vi. Not all OVC receive food basket and external support.

**Priority Strategies**

The following strategic actions will be implemented

i. Advocate for the enactment and adoption of the Child Protection Welfare Bill  
ii. Advocate for the domestication of the Convention on the Rights of the Child  
iii. Advocate for the finalisation and implementation of the National OVC Action Plan  
iv. Develop guidelines for a minimum package for OVC support. The package will incorporate psychosocial support, socialisation of OVC, protection and care among others.  
v. Provide basic support to OVC households.  
vi. Develop an integrated and functional national OVC data management system  
vii. Develop programmes that keep OVC and in particular members of child-headed households in schools

**Outcome Level Results**

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

**Table 24: Care and Support of OVC outcome results**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC3 OVC aged 0-17 whose households received support in caring for OVC has increased from X% in 2010 to 50% in 2013/14 and to 75% by 2015/16</td>
<td>To be determined</td>
<td>50% 75%</td>
</tr>
</tbody>
</table>
4.3.3 Support for Vulnerable Households and Vulnerable Households

Vulnerable Households

Over the years, the response to vulnerable households and in particular those affected by HIV and AIDS has been a welfare approach. Support has primarily targeted PLWHA and OVC rather than the vulnerable households they live in. Evidence shows that one vulnerable household may have more than one vulnerable adult or child and hence focusing on individuals does not make social or economic sense.

As the epidemic unfolds, more people have succumbed to AIDS and in most cases they have lost their ability to earn a decent living. HIV and AIDS have largely contributed to the deterioration of human development and human capital. Fifty six (56%) percent of the population live below the national poverty datum.68

The strategy for the NSP impact mitigation is to focus on vulnerable households for a number of reasons. First most of the vulnerable people live in vulnerable households. Addressing the needs of individuals does not necessarily alleviate vulnerability at household level, neither change household vulnerability. A household approach has also proved to be a good strategy of removing labels that are seen to be discriminatory and stigmatising. This is particularly the case for OVC and PLWHA. There is a need to strategically re-orient impact mitigation strategies.

During the implementation of the NSP, stakeholders will advocate for a household approach and a shift in service delivery from welfare support to self-reliance. For instance most income generating activities are established for OVC or PLWHA at an individual level could benefit an entire vulnerable household if they were scaled up to the appropriate level. Such projects have the potential to strengthen household safety nets and to a large extent ensure sustainability. Empowering vulnerable households to be self-reliant is also a national priority for poverty reduction.

The NSP has also considered the impacts of gender inequality and patriarchy that in particular creates major disadvantages for female-headed households that include gender-based violence, women’s lack of access to social and economic resources, and poverty. The NSP strategies suggest that all impact mitigation service and interventions consider gender and human rights dimensions with appropriate indicators to measure the impacts of gender and human rights mainstreaming in related projects.

Moving beyond welfare, stakeholders will promote activities that have greater potential for socioeconomic transformation of vulnerable households and sustainability. Such activities include community revolving micro credit schemes, backyard and community gardening, small livestock and poultry initiatives. These activities are necessary as they have the potential to improve house income in addition to improving household food security. Food security has become the single most important element in addressing vulnerability. It is estimated that 15% of the population is malnourished and 30% are food insecure. According to the DHS (2009), 39% of children under five are stunted, 4% are wasted and 13% are underweight. This illustrates the urgency to improve household food security.

Impact mitigation activities cannot succeed unless complementary but essential services such as improved community and household sanitation, access to clean and safe water, access to education and health care

for children and adults, legal and social protection and community systems strengthening are an integral components.

Vulnerable Groups and Individuals

The Government of Lesotho has identified OVC, PLWHA, women and girls, prisoners (inmates), sex workers, migrant workers, people with disabilities (PWD) and herd boys as those among the vulnerable groups. The nature and degree of vulnerability vary from one group to another. In most cases vulnerability has been influenced by socioeconomic or biological status with the most vulnerable groups being those at the lowest quintile.

Women and girls are disproportionately vulnerable to the socio-economic impacts of HIV and AIDS. Their vulnerability stems from the fact that their legal status as equals with men has been undermined over the years through cultural and other social practices. Prior to the enactment of the Legal Capacity of Married Persons Act (2006) married women had no decision making power on their sexuality, or economic well being. While laws may exist, there is a gap in the implementation and interpretation of the laws.

The success of any multi-sectoral response to HIV and AIDS is dependent on meaningful participation and involvement of PLHWA. Over the years stakeholders have attempted to address critical issues that create barriers for PLHWA participation in the national response. In most cases, the environment in which PLHWA are expected to meaningfully participate in, is characterised by denial, fear, stigmatisation and discrimination. On the other hand, even where the political, social and legal environment is conducive, the participation of PLHWA is rarely reflected in the formulation of policies and programmes. In most cases they are seen as merely beneficiaries of services and not as key stakeholders.

While some of the groups have access to prevention, treatment, care and support interventions others have very limited access to such services given the nature of their occupation or health i.e. physically disabled. In the absence of reliable data planning for interventions targeting them has become increasingly challenging.

Stakeholders will develop and implement effective strategies that will ensure meaningful involvement and participation of vulnerable groups in the national HIV and AIDS response. Existing organisations of vulnerable groups will be capacitated to support scaling up of appropriate interventions. Technical assistance will be provided to develop specific policies and action plans that support and inform implementation.

Gaps and Challenges

The following are the key gaps and challenges associated with vulnerable households.

i. Lesotho does not have national strategy to inform impact mitigation interventions associated with HIV and AIDS,

ii. Data on household and or community vulnerability is largely lacking. This has compromised the development of strategic and targeted interventions.

iii. Most interventions have not adequately addressed the gender or human rights dimensions of vulnerability.

iv. Implementation of impact mitigation interventions has not been accorded the priority it deserves. Consequently implementation has lagged behind.

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v. Vulnerable households lack the capacity and skills necessary to implement and sustain impact mitigation interventions.

**Key Strategies**

i. Conduct Quality of Impact Mitigation survey to determine extent of vulnerability, the number of vulnerable households, and key challenges they encounter.

ii. Develop a comprehensive data management system for vulnerable households.

iii. Provide support to vulnerable households to start alternative sustainable livelihoods—such as back yard farming, poultry, keeping small livestock etc

iv. Implement and enforce policies and legal instruments that empower vulnerable groups.

v. Conduct workshops that promote self-esteem for women and girls.

vi. Support the development and implementation policies and action plans for the various vulnerable groups.

vii. Improve universal access to HIV prevention, treatment, care and support by vulnerable groups

**Outcome Level Results**

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

**Table 25: Support for vulnerable groups and households outcome results**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2013/14</td>
</tr>
<tr>
<td>OC33</td>
<td>Vulnerable households with one or more vulnerable persons have reduced from 62,555 in 2010 to 56,300 (10% of 62555) in 2013/14 and to 47,855 (15% of 56,300) in 2015/16</td>
<td>62,555</td>
</tr>
</tbody>
</table>
4.4 **Response Coordination and Management**

The effectiveness of the national response to the HIV epidemic requires sound management and coordination mechanisms, effective systems and structures. Lesotho has adopted a multi-sector and decentralised coordination approach based on the three ones principle. A National Coordination Framework has been developed that articulate the roles and responsibilities of the various stakeholders. The existing structure has improved stakeholder coordination resource tracking and to some degree harmonisation and alignment of stakeholders’ programmes with national priorities.

4.4.1 **Advocacy, Public Policy and Legislation**

The existence of an enabling policy and legal environment is a pre-requisite for the success of the national multisectoral response. The creation of an enabling environment is largely dependent on the degree and extent of advocacy at all levels of the response. Such advocacy is intended to place and maintain HIV and AIDS issues on the national socioeconomic development and political agenda. Within the context of the NSP advocacy work will target community, religious and political leaders, who will in turn influence policy formulation and resource allocation, and maintaining HIV and AIDS issues on the social, political and development agenda. At the community level advocacy will focus on social mobilisation and community engagement. A key area of advocacy will be a focus on epidemic drivers and other structural factors influencing the spread of HIV.

In the context of policy and legislation, stakeholders will support the review and strengthening of existing policies and legislation to ensure that they adequately address issues of HIV and AIDS, gender and human rights. Where there is demand stakeholders will advocate for development of new policies and legislation. The implementation and enforcement of existing policies and legislation will be core activities at all levels of the national response.

**Gaps and Challenges**

The following policy and legislation gaps will be addressed during the implementation of the NSP at various levels.

i. Inadequate implementation and monitoring of existing policies and legislation

ii. Lack of awareness among stakeholders of existing policies and legislation and the implication on their work.

iii. Inadequate meaningful involvement of political, community and religious leaders\textsuperscript{71} in influencing decision and policies around HIV and AIDS. The involvement of the Cabinet and parliament in IV and AIDS programmes has been ad hoc. This may change with the development of the Parliamentary HIV and AIDS Strategic Plan for HIV and AIDS.

iv. The legal mandate of the National AIDS Commission has not been adequately accepted by many stakeholders. This has created confusion on the roles and responsibilities for the coordination and management between NAC and other coordinating structures.

v. Stigma and discrimination associated with HIV and AIDS is still prevalence despite all the efforts to address stigma in the society and work place

\textsuperscript{71} Leadership includes leaders in all sectors
Key Strategies

The following strategic actions will be carried out.

i. Intensify advocacy work with leaders to have a more meaningful and sustained involvement and participation in HIV and AIDS response especially in policy and legal instruments formulation, increased funding and law enforcement.

ii. Intensify and expand coverage of advocacy work among leaders to support strategic interventions, especially around multiple and concurrent partnerships, inter-generational sex, alcohol and drug abuse.

iii. Enhance capacity of Legislators and policy makers to review policies and legislation based on available evidence.

iv. Review the National HIV and AIDS Policy and align it with emerging issues and best practices.

v. Disseminate existing (relevant to HIV and AIDS response) policies and legal instruments to all stakeholders.

vi. Carry out advocacy with stakeholders for compliance (reporting, use of national indicators etc) with requirements for the National Monitoring and Evaluation System.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results.

Table 26: Policy, legislation and Advocacy outcome results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC35</td>
<td>A policy, cultural and legal enabling environment created and enabling the effective implementation of HIV and AIDS interventions country wide by 2013/14 and sustained to 2015/16</td>
<td>Baseline to be determined</td>
</tr>
</tbody>
</table>

4.4.2 Coordination and Management of the National Multisectoral Response

The effective and efficient coordination and management of the national response is a key determining factor for the successful implementation of the response. Coordination and management depend on the existence of a policy and legal enabling environment coupled with strong political leadership, effective institutions, policies and legislation and more importantly on the clarity of roles and responsibilities of partner organisations at all levels of the response.

Coordinating structures of the national response at national, district and community levels have been established and in most cases many of them are functional. The establishment of these structures is premised on the three-one principles and guided by the National Coordination Framework.

At national level coordination is increasingly more complex and dynamic given the diversity of coordinating structures. Coordination at this level revolves around issues of policy making, joint planning and programming, resource mobilisation, policy development, technical assistance, monitoring and evaluation, harmonisation and alignment of development partner programmes with national policy frameworks and programmes. The complexity in coordination arises from the different stakeholders’ mandates, roles and responsibilities, and accountability channels.
The National AIDS Commission is mandated by the Act to coordinate the national multisectoral response. The Ministry of Health and Social Welfare is responsible for coordinating the health sector response. Civil society organisations and private sector are coordinated through self-regulating umbrella organisations. Development partners are coordinating through Specific forums including the Partnership Forum. Ministry of Local Government and Chieftainship plays an important role in facilitating coordination of the decentralised response through the District AIDS Committees (DAC) and Community Councils AIDS Committees (CCAC).

These structures will be strengthened, and their roles and responsibilities clarified. The capacity of NAC will be strengthened to provide effective and efficient multisectoral management and coordination of the response. Capacity development will focus on human resources, systems strengthening, provision of financial resource to support coordination, implementation and enforcement of policies legislation that articulate mandates, roles and responsibilities of the structures. The structure of NAC will be reviewed and harmonised with emerging needs for coordinating a multisectoral and decentralised national response.

Gaps and Challenges

The following challenges will be addressed

- The capacity of existing national coordinating structures at different levels remains weak and in some cases the infrastructure is underdeveloped.
- Civil society coordination is fragmented and largely un-coordinated between the umbrella organisations
- The coordination of the private sector institutions is inadequate. However this may be associated with the fact that the umbrella coalition is in its infancy stage.
- The stakeholders have not adequately adhered to the provision of the National Coordination Framework or the National HIV and AIDS
- Coordination of resource mobilisation is fragmented and ad hoc. Tracking HIV resources is problematic given that reporting is not consistent.
- Coordination of HIV and AIDS mainstreaming remains a challenge, given that not all non-sectors demonstrate strong commitment to the process.
- The pace of implementation of the decentralised policy and decentralised response has been slow.

Key Strategies

The following actions will be taken to strengthen coordination and management of the national response.

i. Review and update the National Coordination Framework. The framework should be published and disseminated to all coordinating structures in the country. There is also need to translate the framework into Sesotho.

ii. Organise a national forum to review and articulate mandates, roles and responsibilities of the various coordinating structures.

iii. Streamline coordination between NAC and MOHSW. These will require strong political leadership.

iv. Strengthen the capacity for coordination structures at all levels with a focus on leadership and governance, human resources, infrastructure (appropriate offices), finances and operational systems.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results.
Table 27: Coordination and Management outcome results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC36 - The capacity for national and decentralised coordination and management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>structures is streamlined, roles and responsibilities clarified and communicated by 2015/16</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 4.4.3 Resource Mobilisation and Management

The implementation of the NSP will require sustained resource mobilisation, effective and efficient resource tracking and management systems. The National AIDS Spending Assessment show that domestic funding primarily from the Government of Lesotho has increased significantly. However majority of the national response funding comes from external resources. Most of the external funding comes from Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Presidents Emergency Plan for AIDS Relief (PEPFAR). Additional funding comes from other bilateral, multilateral and private donors.

The private sector tends to mobilise its own resources to support HIV and AIDS workplace programmes. In 2008, Global Fund to Fight AIDS, TB and Malaria (GAFTM) provided funding to private sector through Round 8 proposal. A minimal but critical contribution comes from communities both in cash and in-kind. Community contributions are directed to support community based interventions and are often not captured in national reports.

It is evident that Lesotho will require to develop effective strategies for resource mobilisation to meet demand for “an accelerated evidence and results based” national response in addition to developing a long term financial sustainability strategy.

**Gaps and challenges:**

i. Inadequate capacity for resources mobilisation especially among sectors outside government (civil society and private sector)

ii. Lack of a national financial sustainability plan

iii. Inadequate funding for civil society and private sector

iv. Private public partnership arrangements are under-developed

v. Resource tracking from both the supply and demand ends has been inadequate compromising national level accountability.

**Key Strategies**

i. Develop and operationalise a resource mobilisation strategy

ii. Develop a capacity for resource mobilisation that would also include donor diversification

iii. Develop and implement a resource tracking system

iv. Develop a financial sustainability plan for the national response.

v. Strengthen donor coordination mechanisms
The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

Table 28: Resource Mobilisation and Management outcome results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td>OC37</td>
<td>100% of the national response financial resource needs as costed in the NSP have been mobilised and efficiently managed by 2015/16</td>
<td>To be established&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

4.4.4 Capacity Development

Successful implementation of the NSP will depend on the availability of adequate, skilled and competent human resources. Developing human resource capacity should be seen as a long term and continuous strategy that take cognisance of the current and future requirements. The strategy should focus on improving the skills of existing human resources while developing new human resources through strategic recruitment.

Stakeholders’ capacity for NSP implementation will be strengthened based on health and community systems strengthening. Emphasis will be on human resources (skills, competencies and retention), operational systems, infrastructure, strategic information management, monitoring and evaluation and HIV research. Additional capacity will be developed for evidence and results based planning, gender and human rights mainstreaming.

Capacity development is a pre-requisite for the implementation of the NSP and its accompanying National Operational Plan (NOP). Lesotho will undertake a comprehensive national capacity assessment in the non-health sectors (public and private sectors, civil society). Advocacy will be conducted to support timely implementation of the health sector (MOHSW) Human Resources Strategic Plan 2005-2025.

Gaps and challenges

i. Inadequate human resources capacity (adequacy, skills and competencies)
ii. Lack of a retention strategy especially outside of the public sector and in particular among civil society organisations
iii. Although operational systems are in place most of them are under resourced, implementation is weak and lack synergy with other systems.
iv. Community systems are under developed
v. Health systems are overburden and coping capacity is diminishing.

Key Strategies

i. Undertake a comprehensive capacity assessment with a focus on capacity required for the implementation of the national response during and beyond the current NSP time frame
ii. Develop a human resource capacity development strategy for the non-health sector institutions.

<sup>2</sup> this will done during the financial gap analysis of the NSP and the costing process
iii. Advocate for the implementation of the Health sector Human Resources Strategic Plan 2005 -2025.
iv. Develop a human resource retention strategy and in particular for civil society organisations
v. Strengthen the capacity of community and health systems to support the implementation of the national response.
v. Strengthen the capacity of community based HIV and AIDS coordinating structures in particular the CCAC’s
vii. Strengthen leadership and governance of the national response at all levels.

The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results

Table 29: Capacity Development outcome results

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets 2013/14</th>
<th>Targets 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community systems Strengthening</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC38</td>
<td>Community Councils are implementing and reporting on the ESP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CO39</td>
<td>Community based interventions effectively monitored, implemented and well coordinated</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health systems Strengthening</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC40</td>
<td>Health systems are strengthened to provide comprehensive support for health and HIV and AIDS, services by type of support (human resources, infrastructure, funding, technology, services integration)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC41</td>
<td>Health care workers who successfully completed an in-service training program in key services delivery areas (HTC, Male circumcision, TB/HIV co-infection, ART, paediatric (ART) has increased</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HIV, Gender and Human Rights Mainstreaming</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OC42</td>
<td>Public and Private sectors, and civil society organisations who have costed, and funded and are implementing annual HIV and AIDS workplace programme</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Section 5: Monitoring, Evaluation and HIV research

5.1 Strengthening National HIV Monitoring, Evaluation and HIV Research

The adoption of evidence and results based approaches in the planning and implementation of the NSP demand that the country be in a position to generate empirical evidence. This will require a comprehensive and robust national monitoring and evaluation system. Lesotho has developed the “Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) that is designed to manage the sourcing, collection, collation, analysis, reporting and use of routine input and output monitoring data about HIV services.

The M&E system will measure the performance results (output, outcome and impact) of the multisectoral HIV and AIDS response within the context of the NSP. In doing so, the system will guides the process of data collection, processing, presenting and using the relevant information for decision making and planning, and hence promote “evidence and results based management” decision making.

The monitoring and evaluation of health sector based HIV and AIDS response is coordinated and managed by MOHSW. The Ministry collaborates with the private sector institutions that provide health sector related services. Data is reported through the Health Information Services (HMIS). Currently there are systematic linkages between the M&E system at NAC and the HMIS.

It is evident from recent reviews that monitoring of the national response has been compromised by inadequate and competent human resources and an under developed M&E multi-sectoral operational system. Stakeholders are yet to align their M&E systems with the national M&E framework – LOMSHA.

Many of the targets and baselines for the NSP 2006 -2011/12 could not be established as this information was not collected, or was collected and not reported, or the analysis of the raw data was not done. Consequently the NSP III (2011/12-2015/16) has prioritised strengthening the M&E system around the twelve M&E components. UNAIDS is supporting the institutionalisation of Country Response Information Systems (CRIS) and the World Bank is providing technical assistance to operationalise LOMSHA. A operational manual for LOMSHA is currently being developed.

The focus of the M&E systems strengthening will (a) creation of an enabling M&E environment where systems are harmonised and aligned to the national M&E system and capacity is developed to operationalise them, (b) support routine HIV data collection, analysis and reporting and finally (c) promote the use of M&E and HIV research information for decision making and planning. It is anticipated that an effective M&E system will contribute to improved HIV and AIDS knowledge management.

5.2 Creating an enabling M&E environment

Efforts will be made to strengthen an enabling policy environment for M&E that will be characterised by a clearly defined M&E road map and operational system. Stakeholders will agree on a common set of results, targets and indicators that will be used to measure progress. At the operational level stakeholders will align and harmonise their results, targets and indicators with the national ones. Support will be provided to ensure existing M&E structures at national, district and sector levels are functional.

Advocacy work will be carried out to promote a national culture of monitoring and evaluation of HIV and AIDS response, sharing of information, experiences and providing feedback to collaborating partners particularly those involved in primary data collection and activities implementation.
5.3 Generating gender disaggregated data

Stakeholders will be capacitated to generate reliable, accurate and comprehensive data that is also gender disaggregated and human rights sensitive. User friendly data collection tools will be developed and reporting tools harmonised. Reporting mechanisms will be reviewed and streamlined to lessen the burden associated with multiple reporting lines. Reporting channels will also be consolidated. M&E policy and technical guidelines will be developed and disseminated to all stakeholders that will require stakeholders to monitor and report on their progress without necessarily violating their institutional rights and data confidentiality. A results index and indicator description guide will be developed and distributed to all stakeholders.

5.4 HIV research

During the implementation of the NSP periodical surveys and surveillance, behavioural and bio-medical studies will be conducted to generate new data for evidence necessary for the response management. Surveys will be conducted to determine coverage, access and quality of services and emerging challenges.

Priority will be given to behavioural and biological surveys, Quality of Impact Mitigation Services (QUIMS) survey, Services Availability Mapping (SAM), Stigma measurement (based on HASI), National AIDS Spending Assessment (NASA), AIDS Indicator Survey (AIS), and Demographic and Health survey (DHS), micro-biological surveillance for sexually transmitted infections and the Sentinel HIV/Syphilis Surveillance among others.

Capacity for HIV and AIDS research will be strengthened alongside the capacity of the HIV Research and Ethical Committee to coordinate research initiatives. A central repository of HIV and AIDS related research will be established.

5.5 Generating demand for M&E and HIV research data use in decision making and HIV and AIDS planning

Although Lesotho has adopted evidence and results based management approaches, there is limited evidence on how stakeholders are using M&E and HIV research data in decision making and strategic planning for HIV and AIDS. This is partly attributed to inadequate capacity in evidence and results based management (RBM), and also the lack of reliable data. Given the diverse stakeholders operating in Lesotho data management at operational levels has been confusing as the quality of data has been compromised by differing data values.

During the period of the NSP capacity will be developed to use qualitative and quantitative data in decision making and planning. Innovative mechanisms for data dissemination will be developed and operationalised to ensure that data is readily available. The National M&E technical working Group and the District M&E Technical working groups will also be strengthened to spearhead data collection and management at their respective levels.

A national HIV and AIDS data base will be developed and linked to other data bases including the Bureau of Statistics, Health Management Information System (HMIS), the National Orphans and Vulnerable Children (OVC) database (currently being developed) and Educations Information Management system among others.
5.6 Harmonisation and Alignment of existing M&E systems in Lesotho

In Lesotho there are many and diverse stakeholders, with different operational mandates. All stakeholders agree that they should work within the context of three ones. However, institutional and operationalising the concept especially the “one national M&E framework” has been challenge. Consequently there are as many M&E systems as there are implementing partners. These systems in most cases do not talk to each other. For example, although the National AIDS Commission has facilitated the development of the national multisectoral HIV and AIDS strategic plan 2006-2011, few stakeholders harmonised their strategic results, indicators and or targets with national ones.

This has contributed to the challenges of effectively monitoring the implementation of the national response. The Partnership Forums tend to fill the gap when stakeholders submit reports for inclusion in the quarterly or annual reports. While this has served its purpose it has not solved the problem of harmonisation and alignment and hence the fragmentation of data. One of the key priority actions in the NSP is to strengthen the national M&E systems to ensure efficiency and effectiveness in strategic information management and use of data to inform policy and planning.

Linkages between various databases are equally very weak or non-existent. Existing databases and M&E systems lack synergy and complementarity. Consequently, a large amount of data available in the country is not adequately processed or accessible. This is evidenced by the lack of baselines for many of the results as evidenced in the NSP (II) 2006-2011.

Attempts will be made to consolidate and strengthen the national M&E system creating linkages with other databases and systems. Coordination of the M&E system will be strengthened and expanded to include decentralised structures. National AIDS Commission is already engaged in an M&E improvement programme with technical support from a number of development partners.

Gaps and Challenges

i. Weak M&E system – this is evidenced by the inability to collect data to establish strategic baselines during the implementation of the out-going NSP 2006-2011.

ii. Diversity and un-coordinated M&E systems that in most cases operate in vertical lines. Effective linkages between various M&E systems are lacking

iii. Inadequate M&E capacity at all levels. Capacity development has been ad and not adequately focused on key capacity gaps.

iv. Insufficient culture and commitment for monitoring and reporting,

v. Data quality – currently data quality is compromised various factors including the different data collection tools in use, lack of supervision and skills in data analysis

Key Strategies

i. Review and strengthen the M&E system consolidating linkages, with other stakeholders systems.

ii. Harmonise and align national indicators, result and targets.

iii. Strengthen the capacity of M&E personnel at all levels with appropriate M&E skills

iv. Develop and implement systems for data quality assurance

v. Review and update the HIV research agenda based on the emerging needs

vi. Develop a national HIV and AIDS database under LOMSHA

vii. Develop capacity of operational HIV research.

viii. Lack of baseline data in most results to inform evidence and results based planning for HIV and AIDS.
The above strategies will inform the choice of development of specific activities that will contribute to the output results (contained in the national operational plan) that in turn will contribute to the achievement of the following outcome level results.

**Table 30: Monitoring and Evaluation outcome results**

<table>
<thead>
<tr>
<th>Outcome Level Result</th>
<th>Baseline</th>
<th>Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2013/14</td>
</tr>
<tr>
<td>OC43  The capacity of national M&amp;E system is strengthened and provides 100% indicator values of the NSP impact, outcome and output results by 2015/16</td>
<td>Baseline to be established</td>
<td>100%</td>
</tr>
<tr>
<td>OC44  The National HIV research agenda is fully implemented</td>
<td>Baseline to be determined</td>
<td>50%</td>
</tr>
</tbody>
</table>
Section 6: Sustainability of the National Response

Moving From Dependence to Sustainability of the National Response

As the HIV and AIDS epidemic unfolds more resources will be needed to accelerate universal access to prevention, treatment, care and support. While the demand for additional financial resources is on the rise the global pool of HIV and AIDS resources is shrinking, coupled with the effects of the global economic crisis and declining national productivity.

In the case for Lesotho, demand for additional resources will be generated mainly from two fronts. First, additional resources will be required to implement a more comprehensive and robust HIV prevention strategy. Lesotho has prioritised prevention with the hope of stopping new infections. Second, with the adoption of the CD4 350 criteria more people in need of ART will now become eligible for ART. There is also evidence some PLWHA failed line one of ART treatment and have moved to second line where the cost of antiretroviral (ARV) drugs is higher. It is worth noting that Lesotho has adopted the UNAIDS Treatment 2.0 concept with the aim of lowering those ARV costs and making ART regimens smarter.

Based on this premise, sustainability of the national HIV and AIDS response is a major concern for the Government of Lesotho and hence the need to develop innovative strategies to address issues of financial and service sustainability.

At the moment, the national response is to a large extent dependent on a few donors i.e. the Government of Lesotho, GFATM and PEPFAR. However, several other bilateral and multilateral development partners contribute to the national response. Dependence on donor funding poses potential risks in the event donor policies or priorities changed, or the global economic crisis impacts negatively on the ability of donors to continue supporting the response.

This calls for a review of the current funding mechanisms to ensure a gradual movement from dependence to sustainable financing of the national response. Lesotho is aware of this need, and sustainability strategies of the response were considered in the legal Act that established the NAC. However, this has not yet been operationalised. The strategies will be further developed during the implementation of the NSP.

The Lesotho concept of sustainability goes beyond financial sustainability to ensuring sustainable organisations especially with civil society organisations, leadership and governance, and community ownership and hence the need to develop comprehensive sustainability strategy. In developing sustainability strategies, Lesotho will consider issues of efficiency and effectiveness of interventions, reduction of duplication of efforts in service delivery, promotion of public private partnerships with the private sector, development of a HIV and AIDS Fund, improvements on health insurance and advocacy for increased domestic funding. The choice of the appropriate strategies will depend on available evidence of their efficacy. Lesotho will commission an independent study to inform the development of a sustainability strategy.
Section 7: The Implementation Arrangement of the NSP 2011/12 to 2015/16

Introduction

The implementation of the NSP will be multisectoral and decentralised in nature. Stakeholders will participate in the implementation process based on their institutional mandate, comparative advantage, technical capacity and availability of resources. The implementation will take place at national, district and community levels. Organisations will undertake different roles and responsibilities ranging from planning and programme development, direct implementation, monitoring and evaluation, advocacy, funding, provision of technical assistance, information and knowledge management.

National Operational Plan

A costed National Operational Plan (NOP) will guide and inform the operationalisation of the NSP. NOP will focus on output results and will articulate main and sub activities, with specific timeframes for implementation. Each of the output results will be specific, measurable and timed. Although some activities will be measured on annual basis their implementation will be multi-year. The NOP will provide annual targets for annual progress monitoring. Implementation will be monitored to ensure that there is no laxity among implementing partners on the premise that they can roll over activities into the following year. The NOP will identify both lead agencies and collaborating partners responsible for the implementation of the specific activities. The NOP will be disseminated extensively.

In addition to the NOP, specific components of the NSP will be operationalised through complementary strategies, plans and policies, for example the National Prevention Strategy, 2011-15, Health Sector Policy on Comprehensive HIV Prevention, the National Action Plan for OVC, and a variety of sectoral plans that are aligned to the NSP and the NOP.

Individual implementing partners will be encouraged and supported to harmonise their strategic plans or operational plans with NSP /NOP as much as possible. Capacity will be developed on appropriate skills for harmonisation and alignment processes.

Coordination and management of the decentralised HIV prevention response is strengthened

Lesotho has adopted a multisectoral approach in the coordination and implementation of the national response, which is premised on the “Three-ones” principle and the National Coordination Framework. NAC has the overall responsibility for coordinating the national response and is responsible for the development and coordination of national policies, strategies and programmes for combating HIV and AIDS.

The MOHSW is responsible for coordinating the health sector HIV and AIDS response. At the operational level, the coordination of the response to HIV and AIDS has been decentralised to districts, umbrella organisations, and key government ministries such as the Ministry of Local Government and Chieftainship (MOLGC) and the Ministry of Gender, Youth, Sport and Recreation.

Development partners will be coordinated through the Partnership Forum while the UN agencies
coordination will be facilitated through the Joint Team on HIV and AIDS. A Country Coordinating Mechanism (CCM) has been established to provide oversight coordination of the GFATM funded initiatives in Lesotho.

The National Coordination Framework articulates a vision for HIV and AIDS programme coordination at the district level via the Gateway Approach, which is the government’s decentralization plan for all development activities, including HIV and AIDS. Local Authorities serve as “gateways” for development activities, using existing district government coordination mechanisms under the auspices of the MOLGC. With respect to HIV and AIDS, the Gateway Approach is operationalised via a strategy known as the Essential HIV and AIDS Services Package (ESP) that was launched in 2007. The District AIDS Committees (DAC) and the Community Councils AIDS Committees (CCAC) play an important role in the decentralised response coordination and in particular the implementation of ESP.

Monitoring Evaluation and HIV Research

The monitoring of the national response will be based on the LOMSHA, the HMIS and the OVC M&E system. An M&E framework will be developed that will outline national results, indicators and targets for the national response. Monitoring and reporting tools will be developed, disseminated and people trained in their use. Stakeholders’ indicators and targets will be harmonised and aligned to national ones. The Stakeholders Data Users manual will also be finalised and disseminated.

HIV research will be guided by the national HIV Research Agenda, and coordinated by the National HIV Research and Ethical Committee. Guidelines for developing a HIV research protocol for submission to the HIV Research and Ethical Committee will be developed.

A midterm review of the NSP and NOP will be conducted in 2013/13 while the end evaluation will be conducted in 2015/16. Prior to the midterm and or end term a number of other studies and surveys will be conducted.

Joint Annual Programme Review

A joint annual stakeholders’ review of the NOP will be conducted towards the end of the fiscal year. This will be harmonised with the government planning cycles.
Section 8: Costing of the NSP / Financial implications

Note: This section will be completed once the costing of the NSP has been completed. It will include information related to:
- Methods used for costing the NSP and estimating resource needs
- NSP resource needs estimates
- Resource mapping – mapping of available/committed resources
- Resource gaps analysis
- Resource allocation – by thematic areas and by key results

Annexes

Annex 1: The Results Framework
Annex 2: Financial Gap Analysis
Annex 3: Programme and Service Delivery Gaps