LESOTHO

Global AIDS Response Country Progress Report

Towards Zero new infections, Zero AIDS related deaths and zero discrimination.

January 2010-December 2011

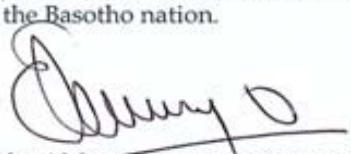
STATUS OF THE NATIONAL RESPONSE TO THE 2011 POLITICAL DECLARATION ON

(March 26, 2012)

MINISTRY OF HEALTH & SOCIAL WELFARE, LESOTHO

ACKNOWLEDGEMENTS

The development of the Lesotho's 2011 Global AIDS Response Country Progress Report was led by the Ministry of Health and Social Welfare with technical support from partners. A Technical Working Group, comprised of key governmental and non-governmental stakeholders in the multi-sectoral response to HIV and AIDS guided the collection and interpretation of data and the writing of the narrative. Representatives from civil society organizations, Development Partners and line ministries gave of their time and experience to ensure that all perspectives on the country's achievements in addressing HIV and AIDS since 2009 were completely and accurately profiled. This was equally true for the country's ongoing challenges in rolling back the many negative consequences of its ongoing HIV epidemic. Lesotho's Country Progress Report has once again been enriched by the voices of key groups within the population who continue to have difficulty having their needs for HIV prevention, treatment and care both recognized and addressed. To all organizations and individuals that have contributed to the development of this report, and that continue to join hands in the country's effort to contain and reverse the HIV epidemic, we give our sincere thanks on behalf the Basotho nation.



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LIST OF ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ANC	Antenatal care
ART	Antiretroviral treatment
ARV	Antiretroviral
BCC	Behaviour change communication
BIPAI	Baylor Paediatric AIDS Initiative
CARE	Co-operative for African Relief Everywhere, Inc.
CCM	Country Coordination Mechanism
CD4	T-helper cells (part of the immune system that is destroyed by HIV infection)
CDC	Center for Disease Control and Prevention
CGP	Lesotho Child Grants Programme
CGPU	Child and Gender Protection Unit
CHAI	Clinton HIV and AIDS Initiative
CPT	Cotrimoxazole prophylaxis
CSO	Civil society organization
CRIS	Country Response Information System
DFID	Department for International Development (UK)
DHS	Lesotho Demographic and Health Survey
DNA	Deoxyribonucleic acid
DSW	Department of Social Welfare
EDF	European Development Fund
EGPAF	Elizabeth Glazer Paediatric AIDS Foundation
EU	European Union
GFATM	Global Fund to Fight AIDS, TB and Malaria
GFCU	Global Fund Coordination Unit
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) (German Technical Corporation)
GOL	Government of Lesotho
HIV	Human immune-deficiency virus
HTC	HIV testing and counselling
IA	Irish Aid
JICA	Japanese International Cooperation Agency
LBLC	Lesotho Business and Labour Coalition on HIV and AIDS
LCN	Lesotho Council of NGOs
LCS	Lesotho Correctional Services
LDF	Lesotho Defence Force
LENASO	Lesotho Network of AIDS Service Organizations
LENEPWHA	Lesotho Network of People Living with HIV and AIDS
LIRAC	Lesotho Inter-Religious AIDS Consortium
LMPS	Lesotho Mounted Police Services
LSL	Lesotho loti
M&E	Monitoring & evaluation
MCA	Millennium Challenge Account
MCC	Millennium Challenge Corporation

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

LESOTHO GLOBAL AIDS RESPONSE COUNTRY PROGRESS REPORT
STATUS OF THE NATIONAL HIV AND AIDS RESPONSE
2011

Overview

The 2011 United Nations High Level Meeting on AIDS (HLM) took place from 8 to 10 June 2011 at the general Assembly in New York. A new declaration, entitled *Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV and AIDS* was unanimously adopted by member states on 10 June. The Declaration set new targets and called on Member States to redouble efforts to achieve, by 2015, universal access, with a view to attaining Millennium Development Goal 6. The Declaration also recognized key populations at higher risk of HIV infection—men who have sex with men, people who inject drugs and sex workers.

In the new declaration, entitled *Political Declaration on HIV and AIDS, the following targets were reaffirmed:*

- *Reduce sexual transmission of HIV by 50 per cent by 2015;*
- *Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015;*
- *Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths;*
- *Have 15 million people living with HIV on antiretroviral by 2015;*
- *Reduce tuberculosis deaths in people living with HIV by 50 percent by 2015;*
- *Reach a significant level of annual global expenditure in low and middle income countries;*
- *Critical enablers and synergies with development sectors.*

Following the Global political declaration, Lesotho has set the following targets to affirm its commitment:

- *Reduce the rate of new infections by 50% by 2015/16;*
- *Eliminate mother to child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths;*
- *Have 90% of adults and children with advanced HIV infection receive antiretroviral therapy by 2015;*
- *Reduce tuberculosis deaths in people living with HIV by 50% by 2015*;
- *Government ministries allocate 2% of their budget to HIV and AIDS;*
- *Strengthened systems and partnerships for effective HIV response.*

Table 1: Progress on Universal Access (UA) Targets and Indicators that support measurement of High level political commitment in Lesotho

The status of Lesotho's national multi sectoral HIV and AIDS response in relation to the key country level targets for 2011 Political Declaration on HIV and AIDS is shown in Table1 below. Details on these achievements are explained in the summary that follows.

Universal Access Commitments	Indicators		Progress 2005	Progress 2007	Progress 2009	Progress 2011	NSP/Universal Access Target 2015	Baseline Source/Year
1. Reduce sexual transmission of HIV by 50% by 2015.	1.1	Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV	Male: 18% Female: 26%	Male: 18% Female: 26%	Data pending from 2009 DHS.	Male: 29% Female: 39%	Male: 85% Female: 85%	DHS 2009
	1.2	Percentage of young women and men who have had sexual intercourse before the age of 15.	Male: 27% Female: 15%	Male: 27% Female: 15%	Data pending from 2009 DHS.	Male: 22.1% Female: 7.8%	NA	DHS 2009
	1.3	Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	Male: 21.1% Female: 7.2%	Male: 21.1% Female: 7.2%	Data pending from 2009 DHS.	Male: 45% Female: 25.9%	Male: 22.4% Female: 12.9%	DHS 2009
	1.4	Percentage of adults aged 15-49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse.	Male: 48% Female: 50%	Male: 48.6% Female: 41.9%	Data pending from 2009 DHS.	Male: 50.5% Female: 37.5%	Male: 80% Female: 70%	DHS 2009

Universal Access Commitments	Indicators		Progress 2005	Progress 2007	Progress 2009	Progress 2011	NSP/Universal Access Target 2015	Baseline Source/Year
	1.5	Percentage of young women and men aged 15-24 who are HIV infected.	Both male and female: 10% Male: 6% Female: 14%	Both male and female: 18.7.	Data pending from 2009 DHS.	Both male and female: 9.3% Male: 4.2% Female: 18.3%	NA	DHS 2009 DHS 2004
2. Reduce transmission of HIV among key populations and vulnerable groups by 50%	2.1a	Percentage of most-at-risk populations reached with HIV prevention programmes.	No available data.	No available data.	73%[1]	Inmates: 100% Others, insufficient data.	60%	LCS epidemiological and behavioural study 2011
	2.1b	Percentage of most-at-risk population for whom HIV interventions are ongoing.	No available data.	No available data.	No available data.	100%[2]	100%	NAC and MOHSW 2011
	2.2	Percentage of female and male sex workers reporting the use of a condom with their most recent client.	No available data.	No available data.	No available data.	Insufficient data.	60%	No current source.

[1] There were 11 key populations (most-at-risk and vulnerable groups) identified in the revised NSP 2006-2011. In 2009, interventions were underway for 8 of the 11 groups.

Universal Access Commitments	Indicators		Progress 2005	Progress 2007	Progress 2009	Progress 2011	NSP/Universal Access Target 2015	Baseline Source/Year
by 2015.	2.3	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	No available data	No available data	48.2%[3]	*Inmates: 53%[4] **MSM: 48.2%[5]	60%	*LCS epidemiological and behavioural study 2011 **Cross-sectional Assessment of Sexual Minorities in Lesotho 2010
	2.4	Percentage of most-at-risk population that have received an HIV test in the last 12 months and who know the results	No available data.	No available data.	No available data.	*Inmates: 63.2% **MSM: 54.5%	80%	*LCS epidemiological and behavioural study 2011 **Cross-sectional Assessment of Sexual Minorities in Lesotho 2010

[2] The NSP 2011/12-2015/16 defines four key populations: sex workers, men-having-sex-with-men, migrant labourers and inmates. It also defines six vulnerable groups: people with disabilities, OVC, herd boys, women and girls, PLHIV, and mobile populations. In 2011, prevention interventions were underway for all ten of the identified groups.
[3] UNDP/NAC 2010, op. cit. note 9, p17. 95/194 of MSM respondents used condoms every time with a male partner.
[4] Of the 17 respondents indicating sexual contact in the past three months, 9 reported using a condom.
[5] 95/194 of MSM respondents used condoms every time with a male partner.

Universal Access Commitments	Indicators		Progress 2005	Progress 2007	Progress 2009	Progress 2011	NSP/Universal Access Target 2015	Baseline Source/Year
	2.5	Percentage of most-at-risk populations who are HIV infected.	No available data.	No available data	Inmates: 17%[6] MSM: 11.6%[7] WSW: 7.1%	Inmates: 31.4% Others, no data.		LCS epidemiological and behavioural study 2011.
3. Eliminate new infections among children by 2015 and substantially reduce AIDS-related maternal deaths.	3.1	Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission.	5.9%	31%	71%	2010: 81% 2011:	100%	Family Health Division, MOHSW
	3.2	Percentage of infants born to HIV-positive mothers receiving a virological test for HIV within 2 months of birth.				Data pending.[8]	100%	Family Health Division, MOHSW
	3.3	Percentage of infants born to HIV-positive mothers who are also HIV-positive.	Both male and female: 10% Male: 6% Female: 14%	Both male and female: 18.7.	Data pending from 2009 DHS.	2010: 8.2%[9] 2011: 10 %	<2%	Family Health Division MOHSW

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

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

[8] A study is ongoing to determine the proportion of infants born to known HIV-positive mothers who undergo DNA PCR testing within 8 weeks of birth. As an indication of testing coverage, volume of DNA PCR tests processed has increased from 3,600 in 2007 to 10,907 in 2010 See MOHSW. 2011. Annual Joint Review Report FY 2010/11. Maseru, LS: MOHSW.

[9] A proxy is used for this indicator which is the percentage of DNA PCR results that are HIV-positive when processed at Central Laboratories. Not all tests requested are for new born infants.

Universal Access Commitments	Indicators		Progress 2005	Progress 2007	Progress 2009	Progress 2011	NSP/Universal Access Target 2015	Baseline Source/Year
4. Reach 90% of people living with HIV who are in need of ARVs with lifesaving antiretroviral treatment by 2015.	4.1	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.	16%	31% (CD4<350) 42% (CD4<200)	51% (CD4<350)	2010: 58% 2011: 61%	90%	STI/HIV and AIDS Programme, MOHSW
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	82%	74.4%	80%[10]	2010: 74% 2011: 77%(Botha Bothe data not included due to late submission)	90%	STI/HIV and AIDS Programme MOHSW

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

Universal Access Commitments	Indicators		Progress 2005	Progress 2007	Progress 2009	Progress 2011	NSP/Universal Access Target 2015	Baseline Source/Year
5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015.	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for HIV and TB.				2010: 27% 2011: 39.8%	90%	National TB Programme, MOHSW

Universal Access Commitments	Indicators		Progress 2005	Progress 2007	Progress 2009	Progress 2011	NSP/Universal Access Target 2015	Baseline Source/Year
6. Close the Global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries.	6.1	Domestic and international AIDS spending by categories and financing sources.	NA	Public Expenditure: 2005-06: M 58,921,026 2006-07: M 55,779,134 External Expenditure: 2005-06: M 83,298,401 2006-07: M 122,627,478	Public Expenditure: 2007-08: M 150,053,982 2008-2009: M 355,066,269 External Expenditure: 2007-08: M 252,970,071 2008-2009: M 268,617,087	Public 2009/10: USD53,536,625 External 2009/10: USD58,876,028 Total: USD108,412,653 [11]	Total required: USD322,744,996*	National AIDS Spending Assessment (NASA) 2008/9-2009/10, NAC *NSP 2011/12-2015/16
7. Critical enablers and	7.1	National Commitments and Policy Instruments	See Attachments B & C.	See Attachments B & C.	See Attachments B & C.	See Attachments B & C.	NA	NCPI Questionnaire results

[11] USD1=LSL7.5; Public: LSL401,524,690; External: LSL411,570,208; Total: LSL813,094,898

Universal Access Commitments	Indicators		Progress 2005	Progress 2007	Progress 2009	Progress 2011	NSP/Universal Access Target 2015	Baseline Source/Year
synergies with development sectors.	7.2	Proportion of ever-married or partnered women (15-49) who experienced physical or sexual violence from a male intimate partner in the past 12 months.	No current data.	No current data.	No current data.	No current data.	NA[12]	No current source.
	7.3	Current school attendance among orphans and among non-orphans age 10-14.	1:1	1:1	Data pending from 2009 DHS.	Male: 0.94:1 Female: 1.01:1	1:1	DHS 2009
	7.4	Proportion of the poorest households who received external economic support in the last 3 months.	No available data.	No available data.	No available data.	Insufficient data.[13]	NA	No current source.

[12] This is a new indicator within the country's National HIV and AIDS Strategic Plan results framework. A target has not yet been estimated.
[13] The country is rolling out the Lesotho Child Grants Programme, a quarterly cash transfer targeting destitute households caring for children. At the end of the pilot phase, in December 2010, 9,915 households supporting 27,707 children received their quarterly payment.

1.1 PROFILE OF THE HIV AND AIDS EPIDEMIC IN LESOTHO

In 2011, Lesotho's HIV prevalence rate for adults (15 to 49 years) remained at 23% signalling a continuing stabilization of the epidemic.[14] However, gender disparities in HIV prevalence remain: 26.7% of all adult women are HIV-positive as compared to 18% of all adult men. Approximately 60% of all HIV-positive adults and children are female.

Between 2008 and 2011, the incidence of new HIV infections declined by 16% from approximately 21,000 to 17,500. Over the same time period, the number of AIDS-related deaths declined by 16% from an approximately 12,000 in 2008 to 8,500 in 2011. In the same year, there were an estimated 252,669 HIV-positive adults (15 to 49 years) and 37,172 HIV-positive children (0 to 14 years) living in Lesotho.

Lesotho's HIV epidemic continues to be fuelled by inter-relationships between both behavioural and structural drivers.

The primary *behavioural drivers* include:

- Multiple and concurrent sexual partnerships;
- Inadequate levels of HIV-testing and personal knowledge of HIV status;
- Inadequate frequency of condom use across all sexually active population groups;
- Slow progress for adolescents and youth to change patterns of sexual behaviour;
- High rates of alcohol use; and,
- Low demand for voluntary, health-facility-based male circumcision.

The primary *structural drivers* include:

- Social and cultural factors affecting women and girls;
- Poverty & food insecurity; and,
- Barriers to access to health care services.

Since the last reporting period, comprehensive, strategic information has become available to enable all partners in the multi-sectoral response to HIV and AIDS to truly

[14] MOHSW. 2012. National HIV and AIDS Estimates for Lesotho. Maseru, LS: MOHSW.

'know the epidemic' and to improve the reach and intensity of their HIV and AIDS interventions. This has guided the country's continued achievements in addressing the HIV epidemic over the 2009 to 2011 timeframe.

1.2 SUMMARY OF PROGRESS IN RESPONDING TO HIV AND AIDS IN LESOTHO

Although it is clear that the social, economic and cultural context for responding to HIV and AIDS in Lesotho remains challenging, between 2009 and 2011, Lesotho maintained a strong momentum in building and strengthening the national response to the HIV and AIDS epidemic. The country continued to make tangible progress in managing and containing the epidemic during this current reporting period.

1.2.1 Release of the National HIV and AIDS Strategic Plan 2011/12-2015/16

The country's national, multi-sectoral HIV and AIDS response is now guided by new targets that relate directly to the HLM commitments of 2011. The new National HIV and AIDS Strategic Plan 2011/12-2015/16 (NSP) was launched on December 1, 2011 by His Majesty, King Letsie III.

While consolidating the gains in progress made under the previous NSP, and taking into account lessons learned and ongoing challenges, the priorities going forward for the multi-sectoral response to the HIV epidemic over the next five-year period are:

- To accelerate and intensify HIV prevention in order to reduce new annual HIV infections by 50%;
- To scale up universal access to comprehensive and quality-assured care, treatment and support;
- To strengthen coping mechanisms for vulnerable individuals, groups and households; and,
- To improve the efficiency and effectiveness of coordination of the national multi-sectoral HIV and AIDS response.

The new NSP incorporates Lesotho's Universal Access commitments under the 2011 Political Declaration on HIV/AIDS as well as its Millennium Development Goals.

1.2.2. National and District Symposiums on HIV/AIDS Prevention and Launch of the Statement of Commitment by National High Level Leadership.

Following on Lesotho's participation in the UN's High Level Meeting in June 2011, the Government of Lesotho and its partners in the response to HIV and AIDS convened the

country's own high level meeting called the National Symposium on HIV and AIDS. Over 300 delegates attended representing all sectors and all stakeholder groups in Lesotho.

Over the course of the three-day event, participants reviewed the state of the HIV and AIDS epidemic, reflected on their contribution to the multi-sectoral effort to contain the epidemic, and prepared commitment to action statements in order to strengthen and increase the impact of their contribution. At the close of the symposium a Statement of Commitment was launched (see Section 9.2). His Majesty King Letsie III of the Kingdom of Lesotho led the country in signing his name to the Statement and launching a pledge of commitment in the Ledger book to be signed by all Basotho.

District symposiums were also held at the district level before the national symposiums with the same objectives and processes as in the national symposiums. So far 50% of the districts have held their district HIV prevention symposiums where they have identified their priorities and commitments to achieve in reducing HIV transmissions within their districts.

As a prelude to each district HIV prevention symposium, youth HIV prevention symposiums were also held. So far all the 10 districts have held their youth HIV prevention symposiums with priorities and commitments identified.

1.2.3. Achievements in HIV and AIDS Prevention

Reducing sexual transmission of HIV by 50% by 2015.

- In addition to progress made as depicted in table 1, that indicates progress so far in reducing sexual transmission of HIV as measured by impact and outcome indicators, the outputs below are available to be utilized in the efforts of meeting this commitment;
- A comprehensive National Multi-sectoral HIV and AIDS response strategy was developed with wide stakeholder consultation and launched by His Majesty King Letsie III of the Kingdom of Lesotho during 2011 Worlds AIDS day;
- A National HIV Prevention Strategy for a Multi-Sectoral Response to the HIV Epidemic in Lesotho 2011/12-2015/16 was completed in 2010. The overall goal of the strategy is to reduce new incidence of HIV infection by 50% by 2015/16 and launched by His Majesty King Letsie III of the Kingdom of Lesotho during 2011 Worlds AIDS day;
- HIV Prevention Revitalization Operational Plan 2011-213, which will Operationalise key priorities with the National HIV Prevention Strategy. Implementation of the plan began in 2011 with consultations and interventions at the community level to strengthen the effectiveness of the local traditional and

political leadership in HIV interventions, to engage more men in HIV prevention activities.

Behaviour Change Communication (BCC)

- Starting in 2010, once the National BCC Strategy was approved and disseminated to all stakeholders, implementation of BCC activities began. New multi-media materials were released targeting adolescents and youth, addressing multiple and concurrent partnerships, promoting PMTCT, encouraging HTC and access to treatment, and encouraging more male involvement in HIV prevention.

Male Circumcision

- In 2011, Lesotho began the scale-up of safe, facility-based medical circumcision. A new national policy recognizes the cultural significance of circumcision in Lesotho, as well as its important public health implications as an HIV prevention intervention. The policy builds consensus across both traditional and public health stakeholders. The policy regarding how facility-based medical circumcision should be promoted and how traditional initiation practices regarding circumcision can contribute to national prevention targets. By the end of 2011, training of health professionals was underway, and equipment and other commodities had been procured. Two health centres in the Maseru area began offering the procedure. There is a steady demand by men for circumcision at these facilities.

Condom Promotion and Distribution

- As noted above, one of the drivers of the HIV epidemic in Lesotho continues to be inconsistent use of condom by sexually active men and women. One of contributors to this is the challenge of making readily condoms available in communities across the country. To address this, at the close of 2011, a new Condom Strategy was in the final stages of review by the multi-sectoral partners. In order to strengthen distribution networks and to improve the availability of condoms in communities across the country, non-governmental partners in condom promotion and distribution have been engaged to expand networks and to significantly increase the reliability of condom supplies at every distribution point.

Interventions for Adolescents and Youth

- The voices of adolescents and youth (15 to 24 years) were very prominent at the National HIV Prevention Symposium on HIV preventions. As one spokesperson

said to the rest of the assembly, "We are ready to prevent HIV to secure our nation. Are you?" Youth continue to face challenges with regards to preventing HIV infection and improving sexual and reproductive health. In 2009, 38.6% of females and 28.7% of males were considered to have comprehensive knowledge about HIV and AIDS. While this is an improvement from 25.8% and 18.4%, respectively, from 2004, the country still considers this level of knowledge to be unacceptable. Also in 2009, 72.4% of young women and 76.9% of young men indicated that they knew a source from which to obtain condoms and of these youth reporting sexual contact in the past 12 months, 65% of both females and males reported the use of a condom (an increase from 50% and 47%, respectively in 2004). The multi-sectoral partners continue target adolescents and youth, both in and out of school, with innovative and youth-driven HIV prevention interventions.

Diagnosis and treatment of sexually transmitted infections (STI)

- According to the latest data (2009 DHS), 15% of all sexually active women and 13% of all sexually active men reported experiencing symptoms of an STI in the previous 12 months. For women, 43% of those reporting symptoms were also HIV-positive; 33% of men reporting symptoms were HIV-positive. STI case management in Lesotho is based on the WHO-recommended Syndromic Management approach. Seeking treatment for symptoms of STIs remain amongst the top ten reasons for visiting hospital Out-Patient Departments. The intensification of HIV prevention interventions that is currently underway in the country includes STI prevention. Lesotho expects to see significant declines in rates of STIs over the next reporting period.

HIV testing and counselling (HTC)

- The percentage of Basotho who have taken an HIV test and have received their results has greatly increased since the country started to rapidly expand the availability of HIV testing and counselling services, and to intensify demand creation strategies at community level. The proportion of Basotho testing has increased significantly between 2004 and 2009, from 15% to 68.8% for females, and from 11% to 39.3% for males. The country considers these rates to still be too low and is making a major effort to address this. As the implementation of the HIV Prevention Revitalisation Operational Plan 2011-213 moves forward, the country is intensifying its efforts to encourage every Basotho 12 years and over to know his or her HIV status and to monitor it on a routine basis. The country has also been intensifying provider initiated testing and counselling (PITC) to ensure that wherever an individual encounters the health care system, he or she takes the opportunity to know their status. The recently completed building

interpersonal communication skills, and to offer opportunities for HIV testing and counselling, and subsequent referral, at the household level.

Reduce transmission of HIV among key populations and vulnerable Groups by 50% by 2015.

- In addition to progress made as depicted in table 1, that indicates progress so far in reducing transmission of HIV as measured by impact and outcome indicators, the outputs below are available to be utilized in the efforts of meeting this commitment;

- Within the general population of Lesotho, there are specific sub-groups which are at greater risk of HIV transmission. The massive effort the GOL has made to address the general population, the group within which most HIV transmission occurs, has not yet fully included the needs of these key populations. This situation is changing. During the reporting period, Lesotho moved forward with HIV and AIDS interventions addressing prisoners, police officers, military staff, sexual minorities, herd boys, people with disabilities, sex workers, migrant labourers, and HIV-positive children and adolescents (see Section 4.4).

Eliminating new infections among children by 2015 and substantially reduce AIDS-related maternal deaths

- The achievements in terms of coverage and transmission rates have been articulated in table 1.
- Lesotho continues to expand the provision of PMTCT interventions to reach all pregnant women in every household and community in the country. PMTCT coverage reached 80% during the reporting period. In 2011, the Mother-Baby Pack was launched at health centres across the country (see Section 9.1). In addition, the Strategic Plan for Elimination of Mother-to-Child Transmission of HIV and for Paediatric HIV Care and Treatment (2011-2016) was launched with the full commitment of all stakeholders to reach zero vertical transmission of HIV by 2015.

Reach 90% of people living with HIV who are in need of ARVs with lifesaving antiretroviral treatment by 2015.

Provision of antiretroviral treatment (ART) to adults and children

For 2011, it was estimated that of the 289,841 adults and children living with HIV and AIDS, 123,187 or 42% were in immediate need of ART, of which 23,369 or 19% were children under the age of 15 (11,182 or 48% are children under the age of 5. Guided by the country's ART guidelines, which require individuals to collect their ARVs on a monthly basis, at December 2010, 80,695 ART patients collected medicines while in December 2011, approximately 83,624 patients collected their ARVs. Overall ART coverage at that time was 58%. For adults it was 66% (75,793 adults), and for children under the age of 15 it was 21% (4,902 children), the current coverage is 61% with coverage of adults being 63% and that of children being 43%. The country continues to strengthen the decentralized provision of ART at health centre level using teams of mentors in each district to support health care providers. In addition, with technical support from Development Partners, the provision of infant diagnosis and ART for children has been significantly strengthened and expanded.

Community and home-based care

Lesotho's primary health care system is undergoing a process of comprehensive renewal. This includes the provision of new and refurbished infrastructure as well as revised roles and responsibilities for health care providers, particularly at community level. Community-based provision of primary health care services, including home-based care and support to chronically ill PLWHAs, is part of the renewal strategy. In addition, many non-governmental partners continue to provide home-based support services to PLWHAs and other chronically ill individuals in communities across the country.

Reduce tuberculosis deaths in people living with HIV by 50% by 2015

Management of TB/HIV co-infection

The identification and management of TB and HIV co-infected individuals have improved significantly since 2009. Although the incidence of co-infection remained stable at 76% (with approximately 80% of new TB patients being tested for HIV) the proportion of those co-infected being enrolled on ART has increased substantially, from 26.9% in 2009 to 39.8% in 2011. This has occurred as a result of significant improvements in the diagnosis and management of co-infected patients. Revised national ART guidelines, which now recommend that all HIV-positive individuals with

active TB infection be started on ART regardless of CD+ lymphocyte count, have also contributed to this improvement.

Close the Global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries.

- Between fiscal years 2008/09 and 2009/10, the country's investment in the national HIV and AIDS response increased by LSL186, 488,903 (USD24, 865,187) or 30% to reach LSL813, 443,068 (USD108, 412,653). Increases in 2010 for prevention, for example, reflected the availability of additional resources from the GOL and from Development partners. Multi-sectoral investment in ART remained strong led by the GOL which, despite a national revenue crisis, sustained its contribution to the overall cost at approximately 70%. Increases in expenditure on the provision of material support for OVC, matched the expansion of country capacity to reach more adults and children with these national programmes.

- Lesotho's national response to HIV and AIDS receives significant support from its development partners. These include the UN Joint Country Team, Global Fund, PEPFAR, and other USG Partners, Millennium Challenge Account, Clinton Health Access Initiative, World Bank, European Union, Irish Aid, GIZ, DFID, Baylor International Paediatric AIDS Initiative, Boston University, the Kellogg Foundation and JICA, among others.

Critical enablers and synergies with development sectors.

Leadership

The political support for the national HIV and AIDS response continues to be strong in Lesotho. As noted previously, His Majesty King Letsie III launched the new NSP, national prevention strategy and national eMTCT plan in December 2011 and was the first to sign the Statement of Commitment in the Ledger in the book. The Prime Minister was at the King's side for both of these events and signed his name to the Statement of Commitment as well. He has undergone HIV testing repeatedly to show by example his personal commitment to the national response. The Minister of Health and Social Welfare, Dr. Ramatlapeng is equally as outspoken and active on HIV and AIDS. Religious and community leaders, traditional leaders and the multi-party political leaders all routinely speak out on the importance for the country of addressing and resolving the HIV and AIDS epidemic.

Advocacy, policy & legislation

In 2010 and 2011 important legislation was enacted to alleviate some of the vulnerabilities of children and adolescents to HIV and AIDS. In 2010, the promulgation

of the Education Act entrenched in Lesotho law free and compulsory basic education. The degree of educational attainment has a direct affect on reducing the chances of children and adolescents becoming HIV-positive. In addition, in 2011, the promulgation of the Children's Welfare and Protection Act fully domesticated within the laws of Lesotho the rights and entitlement of children to health and well-being. Finally, the Anti-Trafficking in Persons Act 2010 has heightened awareness of this global criminal scourge and has already led to investigation and incarceration of those caught or suspected to be involved in the trafficking of women and children.

Coordination & management of the multi-sectoral response

The period 2009 to 2011 saw important changes within the coordination and management of the national response to HIV and AIDS. In 2010, a review process aimed at restructuring the National AIDS Secretariat (NAS) began. After a period of expert analysis and broad consultation, a decision was made to rebuild the NAS to make it more effective and efficient in its role to coordinate and manage multi-sectoral engagement on HIV and AIDS. In addition to the role played by NAC in terms of multi-sectoral coordination, other non-governmental entities worked to improved networking and collaboration at the local, district and national levels.

National M&E Systems

At the close of the last UNGASS reporting period, country capacity to provide this information had reached important milestones. In particular, by the end of 2009, a new data collection and analysis framework called the Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) had been developed and training of stakeholders in advance of full implementation of the system was underway.

During 2010, these efforts continued to move forward but full deployment of LOMSHA was put on hold when the NAS restructuring process began in 2011. Nevertheless, the multi-sectoral partners within the national HIV and AIDS response continued to assess and strengthen their capacity for monitoring and evaluation and for building evidence to guide their HIV-related interventions.

Reduced stigma, discrimination and violence related to HIV

As the number of PLWHAs starting ART has increased throughout the country awareness and acceptance of individuals and households affected by HIV and AIDS has grown. In 2009, over 80% of the population stated that they would be willing to care of HIV-infected members of their families, would accept HIV-positive teachers in the classroom, or would buy fresh fruits or vegetables from a vendor known to be HIV-positive. This is a significant change compared to 50% to 55% in 2006. As the country's multi-sectoral partners have continued to build awareness of the rights and

entitlements of PLWHAs at community level, instances of stigma and discrimination against HIV-infected or affected individuals and households have continued to decline.

Support to Orphans & Vulnerable Children (OVC)

Results from the 2011 national estimates show that for 68% of all OVC, HIV and AIDS is the major factor causing orphanhood and vulnerability. The magnitude of this challenge has caused many of the traditional systems of care and support for orphaned children to disintegrate. In many families, the 'middle generation' has succumbed to the HIV epidemic and children are left in the care of grandparents or on their own in child-headed households. To respond to the challenge of the large and growing number of OVC, the GOL, under the leadership of the DSW, continues to work with multi-sectoral partners to expand programmes and services for vulnerable children in order to alleviate the impact of negative socio-environmental conditions on children.

Addressing the needs of women and girls

Between 2009 and 2011, the GOL and its partners continued to implement strategies to address the disproportionate effect of the HIV epidemic on women and girls. The country continued to struggle to fully alleviate social, cultural and economic imbalances that place girls and women in positions of moderate to extreme vulnerability to HIV infection. A revised National Action Plan for Women, Girls and HIV and AIDS 2012-2016 has been launched. New statutes protecting children from abuse, and protecting women and girls from human trafficking have been enacted. All of the multi-sectoral partners within the national HIV and AIDS response continue to intensify their efforts at community level to address and resolve gender imbalances and the vulnerability of women and girls.

1.0. BACKGROUND

1.1. INTRODUCTION

In 2011, Lesotho joined its global partners at the United Nations General Assembly High Level Meeting on AIDS. The participants at the meeting reflected on a decade's worth of development in the global effort to address the HIV and AIDS pandemic since the Declaration of Commitment on HIV/AIDS, made in 2001 at the United Nationals General Assembly Special Session (UNGASS), and the Political Declaration on HIV/AIDS, made in 2006. At the end of the session, a new Political Declaration on HIV and AIDS was issued along with aggressive global targets for managing and, ultimately, ending the global pandemic.[15] These targets include reducing the sexual transmission of HIV by 50% by 2015, eliminating mother-to-child transmission of HIV by 2015, and increasing global access to HIV treatment for adults and children to 15 million by 2015, towards the vision of "*zero new infections, zero AIDS related deaths and zero discrimination".*

2011 Political Declaration on HIV/AIDS: Targets and Elimination Commitments

1. Reduce sexual transmission of HIV by 50% by 2015;
2. Reduce transmission of HIV among people who inject drugs by 50% by 2015;
3. Eliminate new infections among children by 2015 and substantially reduce AIDS-related maternal deaths;

Lesotho's 2011 Global AIDS Response Country Progress Report details the progress made in addressing a population-wide, hyper-epidemic of HIV since its last UNGASS report submitted at the end of 2009. It takes into account the revised country targets set out in Lesotho's National HIV and AIDS Strategic Plan 2011/12-2015/16. The country targets incorporate Lesotho commitment under the Universal Access initiative and the Millennium Develop Goals regarding HIV and AIDS. Finally, it provides a baseline from which to measure the county's ongoing achievement in relation to the new 2015 global targets.

This report reflects the views of a wide range of stakeholders with regard to their assessment of the countries achievements and its ongoing challenges. It serves as a high-resolution portrait of Lesotho's efforts at the end of 2011 to address its HIV epidemic and to preserve and protect the health and well-being of its people.

1.2. DEVELOPMENT OF THE 2011 GLOBAL AIDS PROGRESS COUNTRY REPORT

The development of Lesotho's 2011 Global AIDS Progress Country Report was led by the Ministry of Health and Social Welfare (MOHSW) with technical support from the UNAIDS country office team. Representatives from government, civil society, the

[15] The text of the Political Declaration is available at http://www.unaids.org/en/media/unaids/contentassets/documents/document/2011/06/20110610_UN_A-RES-65-277_en.pdf

private sector and Development Partners participated in the development process. Data was primarily sourced from the MOHSW, other line ministries, NAC and civil society organizations (CSO). Data collection procedures included document review, key informant interviews, survey, and stakeholder panels. In addition, focus groups were convened with representatives from key populations. Data analysis procedures included variance analysis, trend analysis (including curve fitting), frequency analysis, and other standard qualitative analysis procedures, in particular thematic analysis using coding.

The preparation of the report's contents was guided by a Technical Working Group (TWG) comprised of the country's main stakeholders within the national multi-sectoral response to HIV and AIDS. A stakeholder validation workshop was held near the end of the process to ensure equal representation of all viewpoints and to validate the findings and conclusions of the report. Finally, the report was presented to His Majesty's Cabinet by the Minister of Health and Social Welfare for review and approval before submission to UNAIDS.

The report is subject to standard limitations. Data from key informant interviews and focus groups was taken at face value with no independent tests for accuracy or validity. Not all representatives from important stakeholders were available to fully participate in the report preparation process. Consequently, some aspects of the report may represent only partial views from these different entities. Focus groups were conducted mainly in Sesotho. Summaries were prepared and then translated into English and, for that reason, some of the specificity and nuance of the focus group data may have been lost.

1.3. NATIONAL COMPOSITE POLICY INDEX QUESTIONNAIRE

The National Composite Policy Index (NCPI) questionnaires gather the views of the governmental, non-governmental and development partner stakeholders with respect to all of the key components of an effective national response to HIV and AIDS. For the 2011 report, the questionnaires were administered by an external consultant. Respondents were then invited to panel discussions to explore the results, to provide additional observations on the state of the national HIV and AIDS response, and to reach consensus on the overall ratings of the country's progress since 2009. These final ratings are included under the different components of the country's response as they are discussed in the relevant sections throughout the report. Comparisons are made with NCPI findings in previous years where data was available.

2.0. HIV AND AIDS IN LESOTHO AT 2011

2.1. LESOTHO COUNTRY PROFILE

The Kingdom of Lesotho, located in the eastern part of Southern Africa, is a land-locked country completely surrounded by the Republic of South Africa (RSA). The Kingdom covers an area of 30,350 km^2 and has a population of 1,876,633 million. Lesotho has been an independent, democratic nation since 1966. The country is governed by a constitutional monarch, His Majesty King Letsie III. A multi-party National Assembly provides the day-to-day leadership for the country according to the provisions of the Constitution of Lesotho. Over the past decade, Lesotho, with assistance from Development Partners, has been implementing a decentralized local governance structure through 74 local community councils. 51% of the population is female; 23% of the population lives in urban areas clustered along the northern borders with RSA.[16] 77% of the population lives in rural and remote mountainous areas. 58% of the population is under the age of 19. The life expectancy for the Basotho is currently 41 years. The population growth rate declined between 1996 and 2006, from 1.5% to 0.08%. Lesotho currently has the lowest growth rate in the southern African region. The impact of the HIV epidemic is a major factor in the decline in population growth.

Lesotho's economic health is dependent on inflows of workers' remittances and receipts from the Southern African Customs Union (SACU). Approximately 60% of the Government of Lesotho's (GOL) annual budget is funded through these receipts.[17] After reaching historic highs in 2009, SACU revenues declined by over 50% between 2010 and 2012. This prompted the GOL to introduce national austerity budgets starting in 2010 and continuing into 2012. It has also led to the need for an agreement with the International Monetary Fund for a three-year Extended Credit Facility worth USD61.4 million.

The country's official unemployment rate is 19.2%.[18] The definition of what constitutes employment is expansive. It includes, "all persons who work for pay or profit, or had a job but were not currently at work for various reasons, or were unpaid family workers who assist in the operation of either a farm or family business usually run by the household head for at least a third of normal working hours." Overall, only 17.7% of men and 11.7% of women ages 15 to 64 have salaried employment. For women, this ranges from 10% in rural areas to 24%in urban areas. For men the range is 16% to 26%.

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[16] GOL. 2009. Lesotho 2006 Population and Housing Census. Maseru, LS: MOFDP/BOS.
[17] GOL. 2012. Background to the 2012/13 Budget. Maseru, LS: MOFDP.
[18] GOL. 2009. Lesotho 2006 Population and Housing Census Analytical Report. Volume IIIB: Socio Economics Characteristics. Maseru, LS: BOS.

Approximately 31% of all women 'work' as homemakers or housewives. 43.2% of the population lives on less than USD1.25 per day; 68% lives on less than USD2 per day.[19]

The impact of the HIV epidemic is linked to broader health and development challenges for Lesotho. A number of key indicators regarding infant and child survival have been deteriorating since the year 2000. In 2009, for example, the country's under-five mortality rate was 117 per 1,000 live births, far above Lesotho's goal of reducing this to less than 37 per 1,000 by 2015.[20] Reflecting a similar trend, the maternal mortality rate has continued to increase to reach an estimated 1,155 deaths per 100,000 live births in 2009 (the rate was 416 deaths per 100,000 in 2004).[21] Along with Malawi, Lesotho has the highest maternal mortality rate in the SADC region.[22]

Approximately, 77% of households in Lesotho depend on subsistence agricultural production as their main source of food. Changes in climactic conditions in recent years have had catastrophic effects on food security. Food security trends are monitored on a continuous basis by the Lesotho Vulnerability Assessment Committee (LVAC). Between December 2010 and February 2011, for example, unusually heavy rains had negative impacts on crop yields. The rainfall for the period was the highest on record since 1933. It was projected at the time that maize production would decline by 60% and sorghum by 80% due to crop damage. The LVAC estimated that by June 2011, 582,000 households would face high levels of food insecurity with many of these households requiring emergency food assistance.[23]

The impacts of changes in climactic conditions are magnified by unsustainable practices in livestock management and farming which contribute to soil erosion and low vegetation quality. The widespread use of wood as cooking fuel has contributed to high rates of deforestation, particularly in the rural and remote regions of the country. Sixty percent of rural households and 44% of all households use wood as their primary cooking fuel. In 2009, 56% of households in urban areas and 94% of households in rural areas were without electricity. Only 16% of the population used electricity in the home (a significant increase, nevertheless, from 7% in 2004).

These aspects of the country context for Lesotho constitute important background conditions affecting the nation's effort to effectively address and reverse the lasting negative impacts of the HIV epidemic.

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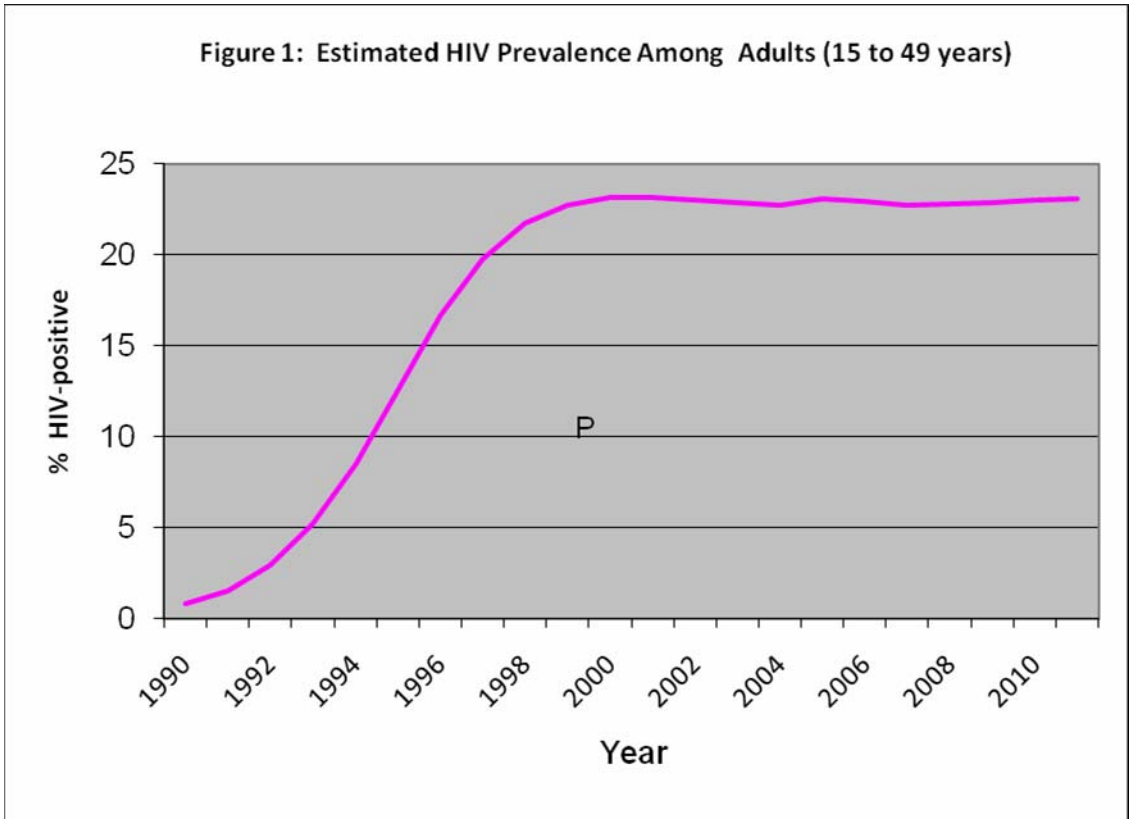
[19] GOL 2012, *op. cit.* note 13.
[20] UNDP. 2010. Lesotho Millennium Development Goals Report 2010. Maseru, LS: UNDP
[21] MOHSW and IFC Macro. 2010. 2009 Lesotho Demographic and Health Survey. Maseru, LS: MOHSW.
[22] MOHSW. 2010. Annual Joint Review Report 2009/10 FY. Maseru, LS: MOHSW/HPSU.
[23] Lesotho Vulnerability Assessment Committee (LVAC). 2010. Annual Report 2011. Maseru, LS: LVAC.

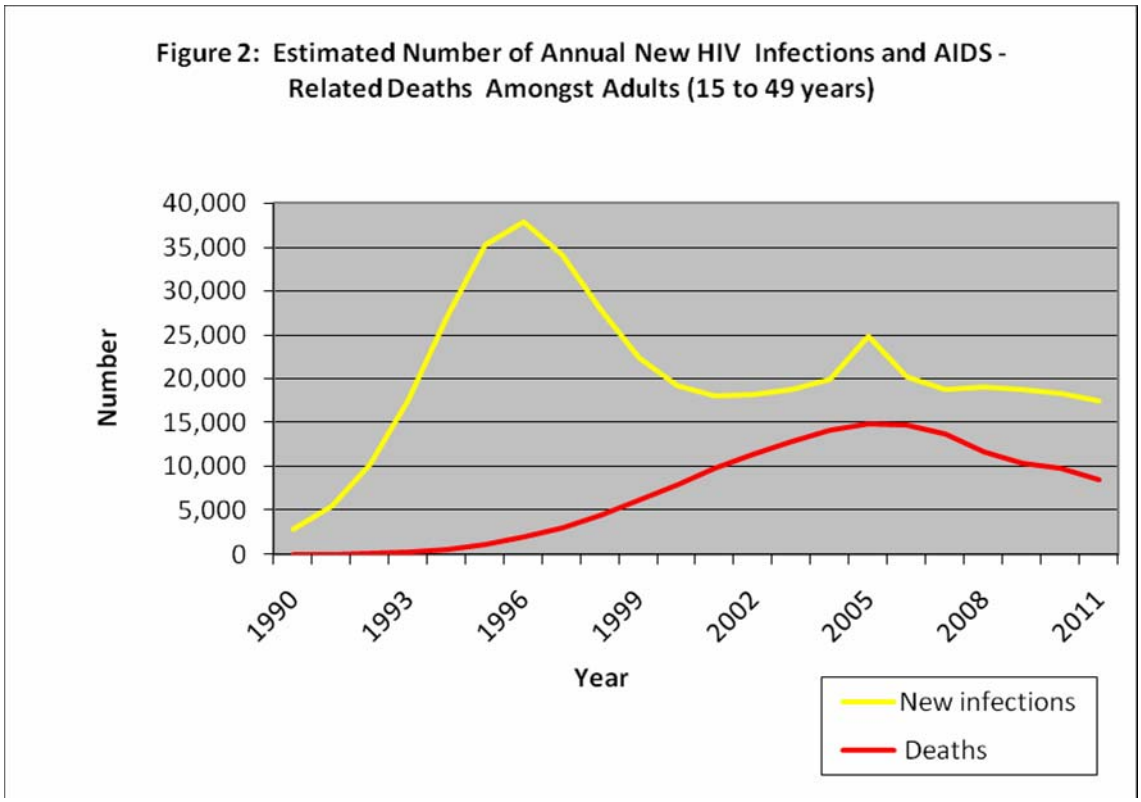
2.2. STATUS OF HIV AND AIDS IN LESOTHO

In 2011, Lesotho's HIV prevalence rate for adults (15 to 49 years) remained at 23% signalling a continuing stabilization of the epidemic as shown in Figure 1 below.[24]



A decrease in new HIV infections and in AIDS-related deaths, as shown in Figure 2 below, contributes to this stabilization.

[24] MOHSW 2012, op. cit. note 10.

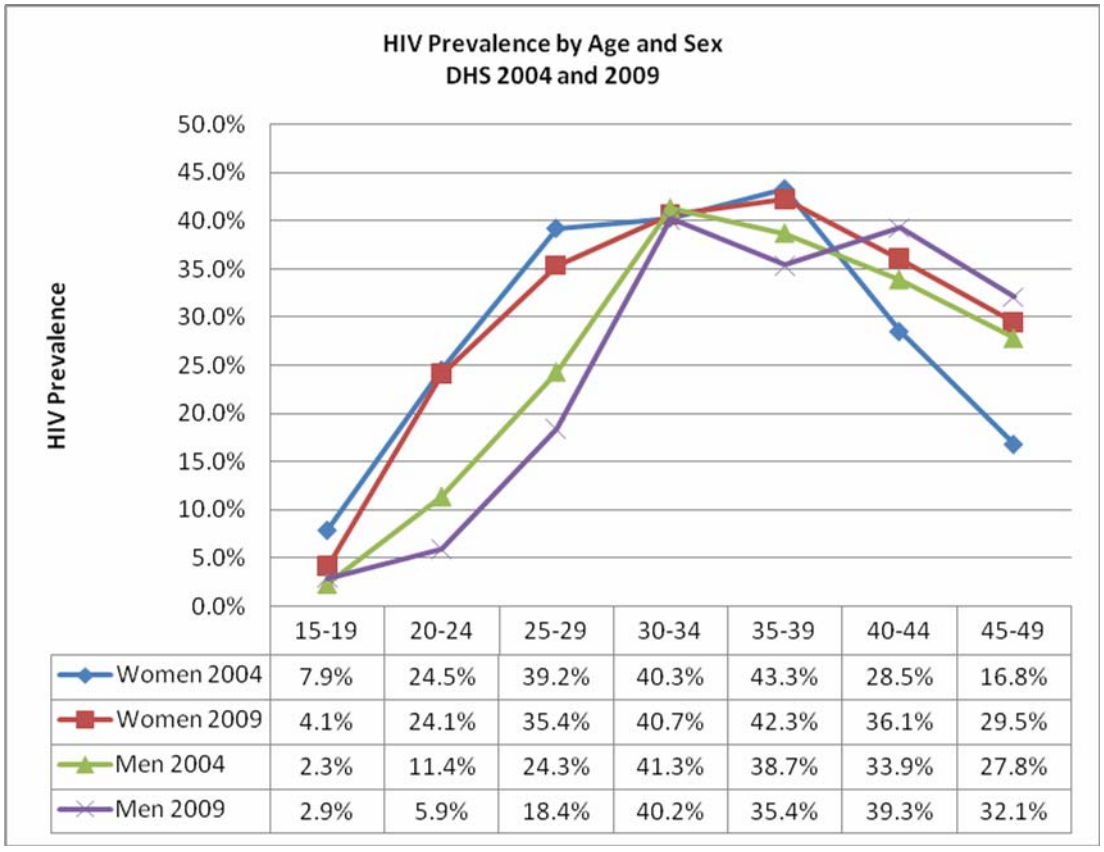


Between 2008 and 2011, the incidence of new HIV infections declined by 16% from approximately 21,000 to 17,500. Over the same time period, the number of AIDS-related deaths declined by 16% from an approximately 12,000 in 2008 to 8,500 in 2011. In the same year, there were an estimated 252,669 HIV-positive adults (15 to 49 years) and 37,172 HIV-positive children (0 to 14 years) living in Lesotho.

Results from the 2009 Lesotho Demographic and Health Survey (DHS) showed the distribution of HIV prevalence across the population. Figure 3 below compares this more recent data against the results from the 2004 DHS.[25]

[25] MOHSW and IFC Macro 2010, op cit. note 17.

Figure 3: HIV Prevalence by Age and Sex: DHS 2004 and 2009 Comparison



	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Women 2004	7.9%	24.5%	39.2%	40.3%	43.3%	28.5%	16.8%
Women 2009	4.1%	24.1%	35.4%	40.7%	42.3%	36.1%	29.5%
Men 2004	2.3%	11.4%	24.3%	41.3%	38.7%	33.9%	27.8%
Men 2009	2.9%	5.9%	18.4%	40.2%	35.4%	39.3%	32.1%

Although there is approximate gender parity across Basotho society (51% female, 49% male), there are substantial differences in prevalence rates and HIV risk factors that arise from issues of gender.[26] Nationally, in 2009, 26.7% of all adult women were HIV positive compared to 18% of all adult men. Between 2004 and 2009, this situation did not change significantly. Particularly in the 20 to 30 year age group, rates of prevalence are substantially higher for females than for males. For females 20 to 24 years, the prevalence is 24% compared to between 6% and 11% for their male counterparts. At 25 to 29 years, particularly for 2009, the difference is substantial with 35.4% HIV prevalence for females and 18.4% for males. In the age groups 15 to 24 years, and 25 to 29 years, over 70% of HIV-positive individuals are female. However, HIV prevalence converges at 40% for both female and males by the time individuals in these groups reach the age of 30.

[26] GOL 2009, op. cit. note 12.

2.3. EPIDEMIC DRIVERS

Results from the 2009 DHS have allowed Lesotho to up-date its knowledge about the drivers of the country's HIV epidemic.[27] The determinants of the trends in the HIV prevalence pattern have been difficult to identify and explain. What follows is an extended analysis based on this new evidence. It shows the depth at which the country is currently able to know its HIV epidemic and to respond with appropriately targeted interventions.

3.3.1 Behavioural Drivers:

a) Multiple and concurrent sexual partnerships:

From Lesotho's modes of transmission analysis, conducted in 2009, it was found that there was a high frequency of multiple and concurrent sexual partnerships (MCP) amongst the country's sexually active population.[28] Further exploration revealed that a number of cultural, social and economic factors contribute to a high frequency of MCP.[29] For men, having different concurrent partners was a measure of masculinity and sexual virility. For women, having different partners provided them with a way of gaining assistance with important social or economic needs.

In 2009, 45% of all sexually active adult males reported sexual contacts with more than two partners in the past twelve months. Among the ages of 20 and 30 reported multiple sexual partnership lie between 40% and 60%. During the same year, for sexually active adult women, 25.9% reported multiple sexual partners. Between the ages of 20 and 30, the proportion ranged from 20% to 36%. Of the group of men reporting multiple partners, 80.1% were married. For women, 93.8% were married. It is notable that 87% of men and women, regardless of social status, identified that limiting sexual contacts to one uninfected partner reduced the risk of acquiring HIV.

For 64.5% of married or cohabiting couples both partners were HIV-negative. As for the remainder, in 18.9% of relationships both partners were positive; in 16.6% one or the other partner was HIV-positive (in 9.2% discordant couples it was the female and in 7.4% it was the male). Married men and women show higher prevalence rates than their non-married counterparts; for married men, 30.7% are HIV-positive; for married women, 26.4% are HIV-positive. Divorced and widowed men and women have the

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[27] MOHSW and IFC Macro 2010, op cit. note 17. All prevalence and behavioural data in this section is taken from this source unless otherwise indicated.
[28] GOL. 2009. Lesotho HIV Prevention and Modes of Transmission Analysis. Maseru, LS: UNAIDS/NAC/MOHSW.
[29] NAC. 2009. Gender and Multiple Concurrent Sexual Partnerships in Lesotho. Maseru, LS: NAC. See also SADC. 2006. Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa Report. Gabarone, BW: SADC Secretariat.

highest prevalence. It is 30.8% for divorced men and 62.0% for widowed men. For divorced or widowed women, 59% of both groups were HIV-positive.
HIV-prevalence increases for both men and women in tandem with the number of lifetime sexual partners. Overall, women have an average 2 lifetime sexual partners and men have an average 8. The increase is most dramatic for women going from 18% for those with only 1 lifetime partner, to 32% for those with 2, to 41% for those with 3 or 4, to as high as 66% for those with 5 or more lifetime partners. For men, the increase in prevalence over this same range is from 13% to 33%.

b) Inadequate levels of HIV-testing and personal knowledge of HIV status;

The percentage of Basotho who have undergoing HTC has greatly increased since the country started to rapidly expanded the availability of HIV testing and counselling services, starting in 2004, and intensifying demand creation strategies at community level. The proportion of Basotho testing increased significantly between 2004 and 2009, from 15% to 68.8% for females, and from 11% to 39.3% for males. In 2009, 92.6% of adult females and 80.6% of adult men indicate knowledge of where to obtain HIV testing. For adolescents and youth (ages 15 to 24), 89% of young women and 73.7% of young men knew where to obtain HTC. At the same time, 59.8% of females and 26.9% of males have ever sought HIV testing. Moreover, only 50% of sexually active young females and 20% of sexually active young males underwent HTC and received their results in the past twelve months. It was estimated that, in 2009, 30.8% of the HIV-positive adult population had never been tested (25.7% of HIV-positive females and 41% of HIV-positive men).

c) Inadequate frequency of condom use across all sexually active population groups

From a range of sources, it has been shown that social meanings around condom use limit the effectiveness of this intervention.[30] For example, insisting on condoms in sexual relationships could be interpreted as signifying sexual infidelity or lack of trust. In 2009, 86.9% of adult women and 79.8% adult men knew that using condoms could prevent the transmission of HIV from one sexual partner to another. However, for those reporting multiple sexual contacts in the past 12 months, only 37.5% of females and 50.5% of males reported the use of a condom.

Rates of sexually transmitted infections (STIs) are a marker for both multiple sexual partners and frequency of condom use. Of the proportion of the population reporting symptoms of an STI in the previous 12 months, overall, 38.9% were also HIV-positive. When differentiated by gender, 42.9% of women and 33.3% of men reporting symptoms of STIs were also HIV-positive.

[30] GOL 2009, op. cit. note 24.

d) Challenges for adolescents and youth to change patterns of sexual behaviour

In 2009, 38.6% of young females (ages 15 to 24) and 28.7% of young males were considered to have comprehensive knowledge about HIV and AIDS (compared to 25.8% and 18.4%, respectively, in 2004). Forty-seven percent of young women and 62.7% of young men report that they were sexually active before the age of 18 years. Seven-point-eight percent of young women and 22.1% of young men had their first sexual experiences before the age of 15. Within the 15 to 19 year age group, 7.2% of young women and 0.3% of young men report sexual contact with a partner older than 10 years. At the same time, 72.4% of young women and 76.9% of young men indicated that they knew a source from which to obtain condom and of these youth reporting sexual contact in the past 12 months, 65% of both females and males reported the use of a condom (increasing from (an increase from 50% and 47%, respectively in 2004). For young adults with 2 or more sexual partners in the past 12 months (3.8% of females, 20.5% of males), 60% of males used condoms and 44% of females did the same.

e) High rates of alcohol use

In the country's 2009 modes of transmission analysis, it was found that alcohol consumption often precedes sexual activity in many different types of relationships.[31] There is no indication that this has changed in Lesotho.. Preliminary information on the relation of alcohol use to HIV-prevalence was obtained through the 2009 DHS. HIV-prevalence for men consuming alcohol was slightly higher at 23% than those who reported never taking alcohol at 16%. Insufficient responses for females prevented a similar analysis. Investigating this link remains a top priority for the country.

f) Low demand for voluntary, health-facility-based male circumcision

Overall in Lesotho, 51.6% of males aged 15 to 49 are circumcised (after age 20, 60% of males is circumcised). For 66.1% of circumcised males, circumcision occurred between the ages of 13 and 19. Males living in rural areas are more likely to be circumcised than their urban counterparts (33.8% and 58.6%, respectively). This suggests that most men are circumcised during initiation rituals which have a more entrenched practice in the rural and mountainous regions of the country. HIV-prevalence rates differed only marginally by method of circumcision. Twenty percent of males reporting ritual circumcision were HIV-positive compared to 17.7% of those that reported being circumcised in a health facility with a health care provider. Whether an individual was circumcised or not before their first sexual contact showed limited effect on HIV-prevalence. Of men that engaged in sexual contact before circumcision, 19.9% were HIV-positive compared to 21.8% that were circumcised after they first became sexually active.

[31]Ibid.

3.3.2 Structural Drivers:

a) Social and cultural factors affecting women and girls:

Although recognition of the rights and entitlements of women and girls has changed significantly within the legal system in Lesotho, these changes have not yet influenced ongoing social and cultural practices regarding female roles in marriage and sexual relationships. Lesotho continues to have troubling trends in discriminatory attitudes towards women and girls which fuel gender-based violence. For women themselves, in 2009, 37.1% agreed that there could be at least one reason for a husband to legitimately beat his wife. In the lowest wealth quintile, this rose to 55%. Amongst men, 47.9% agreed that there could be at least one reason to beat their wives. This view was shared by 59% of men in the lowest wealth quintile. If a woman refused to have sex with her husband, 62.5% of men felt it was acceptable to get angry and to threaten their spouse; 26.3% felt it was acceptable to deny financial support; 16.5% felt it was acceptable to force sex on their spouse; and, 28.7% felt it was acceptable to have sex with another woman. For women, 14.6% stated that a woman was never justified in refusing to have sex with her husband; for men it was 16%. For a wife to refuse sexual contact with her husband when she knows he has other partners was supported by 52% of women and 53% of men.

b) Poverty and Inequality

There are large inequities in socio-economic status across Basotho society. Amongst the 70% of the population that lives in rural areas, 50% or more are within the lowest wealth quintile. Of the remaining portion of the population living in urban areas, only 4.4% are at the same socio-economic level. In a recently completed study on child poverty in Lesotho, it was estimated that the richest 10% of the population held 40% of the country's wealth, while the poorest 10% held only 1%.[32] As noted previously in this report, 43.2% of the population lives on less than USD1.25 per day; 68% lives on less than USD2 per day.[33] These distributional inequalities fuel social inequalities for families and children in the poorer strata of the population.

Wealth inequalities have important effects on school attendance. While there are only small differences with regard to primary school attendance were (in 2009, 97.4% of children in the highest wealth quintile attended primary high across the country against 90.5% in the lowest), beyond primary, the differences are substantial. Overall, for secondary school, in 2009, only 34.3% of all eligible children (13 to 17 years) attended school. More girls (40.1%) than boys (28.3%) attended secondary school. There were large differences between wealth quintiles. In the lowest quintile, 6.7% of boys and 14.8% of girls attended secondary school. This was compared to 59.9% of boys and

[32] UNICEF. 2010. Lesotho Child Poverty Study. Maseru, LS: UNICEF.
[33] GOL 2012, op. cit. note 13.

61.8% of girls in the highest wealth quintile. In rural areas, 27.6% of children attended secondary school versus 57.2% in urban areas.

With respect to educational attainment, the patterns are similar. In 2009, across the population, 11% of all men aged 15-49 years had no education compared to 1.7% for women. At the level of basic education, 23.7% of women and 36.4% of men attended primary school but did not complete. Only 52.2% of women and 40.1% of men have completed secondary education. The differences in educational attainment were most pronounced across socio-economic status. In the lowest wealth quintile, only 0.9% of women had completed secondary school compare to 15.5% in the higher wealth quintiles. For men, the difference was just as dramatic with only 0.3% in lowest wealth quintile having completed secondary school versus 16.0% in highest.

Finally, for Lesotho's primarily rural based population, chronic food insecurity continues to prevail. The quarterly analysis of food security trends issued by the LVAC continues to identify hundreds of thousands of households facing food insecurity. Because of unusual weather patterns and crop damage due to flooding, in 2011 LVAC estimated that more than 500,000 households would face food shortages with a portion requiring emergency food assistance to sustain them.[34]

c) Access to health care services

Differences in the accessibility of health care services, by socio-economic status and by gender, occur across Lesotho but are intensified in rural areas and within the poorest portion of the population. Of all women, in 2009, 72.9% experienced at least one barrier in access to health care services at the community level. The frequency of problems described, in descending order, were concern that no drugs would be available, the facility was too far away, or there were no funds for transport. Women in the lowest wealthy quintile were 20% more likely to have encountered at least one barrier to accessing health services than their wealthier peers. Also in 2009, it was shown that 58.7% of all births took place in either public or private health facility. The remaining portion took place in the home attended by community health workers, relatives or immediate family members. In the lowest wealth quintile, 66.4% of all births took place at home compared to 10.5% in the highest wealth quintile.

Although it is clear that the social, economic and cultural context for responding to HIV and AIDS in Lesotho remains complex, the country continued to make progress in managing and containing the epidemic between 2009 and 2011.

[34] LVAC 2010, op. cit. note 19.

3.0. PROGRESS IN RESPONDING TO HIV AND AIDS 2010-2011

3.1. OVERALL ACHIEVEMENTS SINCE 2009

The most significant achievements during this reporting period towards achievement HLM targets are as follows:

3.2. Reduce sexual transmission of HIV by 50% by 2015.

- The completion and launch of the National HIV Prevention Strategy 2012-2016, and the HIV Prevention Revitalization Action Plan 2011-213;
- The completion and launch of the National Strategic Plan on HIV and AIDS 2011/12-2015/16 and its national M&E framework;
- The release of new HIV prevention tools and materials targeting youth;
- The convening of a National Symposium on HIV Prevention and the subsequent launch of a Commitment Statement to end HIV transmission to be signed by all Basotho;
- The integration HIV and AIDS prevention, treatment and care within a Primary Health Care Revitalization Strategy; and,

3.3. Reduce transmission of HIV among key populations and vulnerable Groups by 50% by 2015.

- The completion and launch of the National HIV Prevention Strategy 2012-2016, and the HIV Prevention Revitalization Action Plan 2011-213;
- The completion and launch of the National Strategic Plan on HIV and AIDS 2011/12-2015/16;
- The release of new HIV prevention tools and materials targeting youth;
- The convening of a National Symposium on HIV Prevention and the subsequent launch of a Commitment Statement to end HIV transmission to be signed by all Basotho;
- The integration HIV and AIDS prevention, treatment and care within a Primary Health Care Revitalization Strategy; and,
- The registration of networks of MSM and Sex Workers by the registrar of societies and associations.

3.4. Eliminating new infections among children by 2015 and substantially reduce AIDS-related maternal deaths

- Reaching 81% coverage of PMTCT in districts and communities across Lesotho;
- The release of the revised PMTCT guidelines and the launch of the Mother-Baby Pack in all districts;
- The launch of the Strategic Plan for Eliminating of Mother-to-Child Transmission of HIV, and for Paediatric HIV Care and Treatment by His Majesty King Letsie III the King of the Kingdom of Lesotho.

3.5. Reach 90% of people living with HIV who are in need of ARVs with lifesaving antiretroviral treatment by 2015.

- Expanding coverage of ART to reach 67.4 % of those in need;
- The decentralization of paediatric HIV treatment and care to all districts and health centres;
- The release of up-dated HIV treatment guidelines;
- The implementation of the Health Human Resources Retention Strategy;

3.6. Reduce tuberculosis deaths in people living with HIV by 50% by 2015

- The release of up-dated HIV treatment guidelines;
- The full implementation of the decentralization of a basic package of primary health care services to reach all Basotho.
- The implementation of the Health Human Resources Retention Strategy;

3.7. Close the Global AIDS resource gap by 2015 and reach annual global investment of US$22-24 billion in low- and middle-income countries.

- The expansion of the coverage of the Lesotho Child Grants Programme;

3.8. Critical enablers and synergies with development sectors.

- The enactment of the Children's Welfare and Protection Act;

- The release of the full results of the 2009 Lesotho Demographic and Health Survey;
-

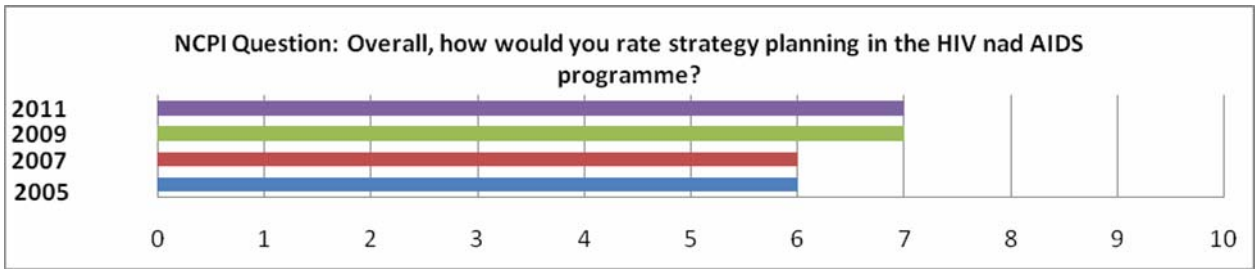
3.9. *Reduced stigma, discrimination and violence related to HIV*

- The enactment of the Children's Welfare and Protection Act;

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

NATIONAL HIV AND AIDS STRATEGIC PLAN 2011/12-2015/16

Lesotho's National HIV and AIDS Strategic Plan (NSP) 2011/12-2015/16 was completed and released on December 1, 2011 by His Majesty King Letsie III.[35]



This is the country's third NSP since the current scaled-up response to HIV and AIDS began in 2004. While consolidating the gains in progress made under the previous NSP, and taking into account lessons learned and ongoing challenges, the priorities going forward for the multi-sectoral response to the HIV epidemic are as follows:

- To accelerate and intensify HIV prevention in order to reduce new annual HIV infections by 50%;
- To scale up universal access to comprehensive and quality-assured care, treatment and support;
- To strengthen coping mechanisms for vulnerable individuals, groups and households; and,
- To improve the efficiency and effectiveness of coordination of the national multi-sectoral HIV and AIDS response.

The performance targets, addressing the biomedical, behavioural and structural drivers of the epidemic that are aligned to these priorities are:

- To improve Lesotho's Human Development Index score from 0.427 in 2010 to 0.55 in 2016;
- To reduce new annual infections by 50% from 21,000 in 2010 to 10,500 in 2016;
- To increase the number of adults and children know to be on ART 12 months after the initiation of treatment from 80% in 2009 to 98% in 2016; and,
- To reduce by 25% the number of vulnerable households requiring external assistance from 62,555 in 2010 to 47,859 in 2016.

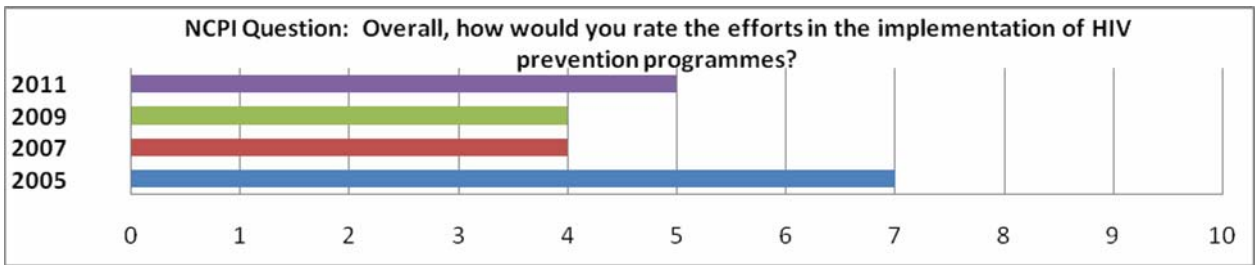
The implementation of the NSP further intends to improve management and coordination of the HIV and AIDS response such that it, "prevents infection, mitigates

[35]NAC. 2011. National HIV and AIDS Strategic Plan 2011/12-2015/16. Maseru, LS: NAC.

the impact of the epidemic, and enhances the care and support of Basotho." In addition, the strategy intends to address all remaining strategic information gaps through scaling-up epidemiological, behavioural, operational and other research.

3.10. PREVENTION

Since 2009, Lesotho has sought to substantially increase its emphasis on scaling-up and rolling out evidence-based prevention strategies to address the complex relationships between the different drivers of the epidemic.



3.10.1. National Symposium on HIV/AIDS Prevention and the Launch of the Statement of Commitment by Basotho

Following on Lesotho's participation in the UN's High Level Meeting in June 2011, the Government of Lesotho and its partners in the response to HIV and AIDS convened for the country's own high level meeting called the National Symposium on HIV and AIDS. District and youth symposiums were also held before the national symposiums. Over 300 delegates attended representing all sectors and all stakeholder groups.

Over the course of the three-day event, participants reviewed the state of the HIV and AIDS epidemic, reflected on their contribution to the multi-sectoral effort to contain the epidemic, and prepared commitment to action statements in order to strengthen and increase the impact of their contribution. At the close of the symposium a Statement of Commitment was launched (see Section 9.2). His Majesty King Letsie III led the country in signing his name to the Statement and launching a pledge of commitment to be signed by all Basotho.

His Majesty the King Letsie III signing the ledger of commitment to preventing HIV transmission

3.10.2. National HIV Prevention Strategy for a Multi-Sectoral Response to the HIV Epidemic in Lesotho 2011-2016

To complement the NSP, a National HIV Prevention Strategy for a Multi-Sectoral Response to the HIV Epidemic in Lesotho 2012-2016 was completed in 2010. The overall goal of the strategy is to reduce new incidence of HIV infection by 50% by 2016.

The strategy has four main objectives:

- To reduce the sexual transmission of HIV;
- To Eliminate mother-to-child transmission of HIV;
- To prevent blood borne transmission of HIV; and,
- To strengthen the systems necessary for an effective national HIV prevention response.

There are two tiers of priorities and results for the strategy according to the concentration of HIV prevalence across different groups in the population:

First Tier Priority Results

- Reduction of the number of youth and adults reporting multiple partners, with a focus on reducing levels of concurrency, and inter-generational sex;
- Increased numbers of adults and youth using condoms correctly and consistently with a focus on higher risk partners;
- Increased numbers of adults and youth who get tested and know their HIV status;
- Reduction of HIV transmission between HIV discordant partners;
- Reduction of HIV transmission resulting from sexual and gender-based violence;
- Increased prevalence of male circumcision;
- Reduction of mother-to-child transmission of HIV;
- Coordination and management of the HIV prevention response is strengthened; and,
- The effectiveness of HIV prevention responses is strengthened through the use of strategic information.

Second Tier Priority Results

- Reduction of the impact of alcohol and drug use on HIV transmission;
- Reduction of risky sexual practices among at-risk populations;
- HIV infection through blood transfusion eliminated;
- Blood-borne HIV transmission in and out of clinical settings is reduced; and
- Improved human resources, infrastructure and capacity to implement the national HIV prevention response.

The recently completed HIV Prevention Revitalisation Operational Plan 2011-213, which will operationalise key priorities with the National HIV Prevention Strategy. The plan has a focus on community and household level interventions, including building interpersonal communication skills. By offering opportunities for HIV testing and counselling, and subsequent referral, at the household level, the plan will provide a way for those who are HIV-positive to begin to lead healthy lives, to prevent further spread of HIV, and to seek treatment and care early and pro-actively in the course of their HIV disease.

3.10.3. Behaviour Change Communication (BCC)

Starting in 2010, once the National BCC Strategy was approved and disseminated to all stakeholders, implementation of BCC activities began. In addition to those of the GOL, funds from Development Partners have enabled the country to significantly scale up and accelerate its BCC activities.

Within the MOHSW, the BCC unit was strengthened through the engagement of two technical advisors. Additionally, the Health Promotion IEC Material Clearing House team was revived and a multi-sectoral HIV and AIDS technical implementation team was established. One of the achievements of the team during the reporting period was the development and implementation of health promotion monitoring and evaluation tools to be used by all BCC implementers country-wide.

3.10.4. Prevention Interventions for Adolescents and Youth

As part of the preparation for the National HIV Prevention Symposium, held in November 2011, district level discussions were convened with support from UNICEF. From this discussion, young people were identified to represent their peers and to participate in the symposium. Youth delegates delivered a statement during the event to bring the voice of all youth into the discussion. As the youth who delivered the statement began:

> *In my voice dwells an illiterate herd boy, a religious and non-religious young person, a young person living with HIV and AIDS, a young person whose family members are HIV positive, a young person living in prison, a young teenager, a young person living with a disability, a young person who has left school, a student, a young person living in an urban or rural area, and all other factors that mark young people in this county.*

Within the statement, the country's youth committed themselves to overcoming their challenges and to take leadership in the national effort to combat HIV and AIDS. They also spoke strongly against the attitudes of parents and elders that prevent young people from getting the information they need to prevent HIV-infection. In the words of the statement,

We commit to discussing the many faces of HIV with our peers, to help others develop higher self-esteem and confidence, to encourage young people to take part in youth-driven clubs and organizations, and to organize youth against HIV through football, music, and through Facebook and Mixit.

The statement concluded with a challenge: *We are ready to prevent HIV and to secure our nation. Are you?*

Within the national BCC strategy, a specific youth component was launched during 2010. This included training manuals and mass media communication materials (print and audio-visual) to be utilised in reaching adolescents and young people with HIV risk reduction and avoidance skills and knowledge. The national roll-out of these communication materials began in 2009 and continued to the end of 2011. Also during this time, the MOGYSR, in collaboration with non-governmental and Development Partners, created the Minimum Package Guide on HIV Prevention Programmes with and for Young People. The purpose of the minimum package was to standardize the content and the quality of HIV prevention interventions targeted towards this high priority population group.

With support from the GOL and Development Partners, CSOs such as Kick-4-Life, Lesotho Planned Parenthood Association, Sentebale and World Vision Lesotho managed to reach over 70,000 adolescents and youth with a variety of youth-oriented prevention interventions. In 2011, Kick-4-Life alone engaged over 100,000 young people in an HIV-related activity using messages sent via SMS. The Lesotho, Lesotho Youth Federation engaged 40 youth as peer educators called Youth Ambassadors. These individuals in-turn reached more than 25,000 of their peers in every district of the country. Other CSOs implementing youth focussed interventions included Apparel Alliance to Fight AIDS (ALAFA) and the Anti Drug Abuse Association of Lesotho (ADAAL).

3.10.5. Condom Promotion and Distribution

As noted above, one of the drivers of the HIV epidemic in Lesotho continues to be inconsistent use of condom by sexually active men and women. One of contributors to this is the challenge of making readily condoms available in communities across the country. Urban and rural condom coverage is estimated at 69% and 33%, respectively.[36] To address this, at the close of 2011, a new Condom Strategy supported by the multi-sectoral partners was in the final stages of approval. In order to strengthen distribution networks and to improve the availability of condoms in communities across the country, non-governmental partners in condom promotion and distribution have been

[36] PSI Lesotho. 2010. PSI Research and Metrics. HIV/AIDS TRaC Study Among Men and Women Aged 15-35 in Lesotho. Third Round. Maseru, LS: PSI.

engaged to expand networks and to significantly increase the reliability of condom supplies at every distribution point.

3.10.6. Male Circumcision

In 2011, Lesotho began the scale-up of safe, facility-based medical circumcision. A new national policy recognizes the cultural significance of circumcision in Lesotho, as well as its important public health implications as an HIV prevention intervention. The policy builds consensus across both traditional and public health stakeholders. The policy regarding how facility-based medical circumcision should be promoted and how traditional initiation practices regarding circumcision can contribute to national prevention targets. By the end of 2011, training of health professionals was underway, and equipment and other commodities had been procured. Two health centres in the Maseru area began offering the procedure. There is a steady demand by men for circumcision at these facilities. The country has also adopted the WHO/UNAIDS approach to introducing neo-natal circumcision.

3.10.7. Prevention of Mother-to-Child Transmission of HIV

Lesotho continues to expand the provision of PMTCT interventions to reach all pregnant women in every household and community in the country. Knowledge about the importance of PMTCT has been improving steadily since 2004. The 2009 DHS revealed that 71% of adult women and 50% of adult men knew that HIV could be transmitted from an HIV-positive mother to her infant during delivery and through breast feeding. This same proportion of adults knew that HIV transmission could be prevented through the use of ARVs prior, during and after childbirth. The comparable 2004 DHS results were 42% for women and 32% for men.

Table 2: Annual PMTCT Statistics 2007-2011

	2007	2008	2009	2010	2011
# of facilities providing PMTCT	136	183	186	191	188 (provided PMTCT reports)
# of clients pre-test counselled	26 293	28033	29300	30190	37418
# of clients tested	23 965 (91%)	26203 (89%)	27389 (93%)	28035 (93%)	25695
# of clients post-test	23 196	25050	25322	27983	25332

counselled					
# of clients HIV positive	5 539 (24%)	6402 (26%)	9798	5510 (20%)	10696
# of clients who received ARV prophylaxis	2799	2235	4625	3834	7131
# of clients who received HAART	1167	1 324	4221	1242	2984
# of clients who received ARV Prophylaxis and HAART	3966 (71.6%)	3559 (86.7%)	8846 (90.3%)	5076 (92%)	10115
# of deliveries	17 656	20761	19323	24433	22862
# of HIV positive mothers delivering live births	3 584	4685	4613	5846	5372
# of babies who received ARV prophylaxis	2 767	3470	4240	5589	5000
HIV test uptake	91%	89%	93%	81%	69%
% of HIV infected pregnant women who received ARVs to reduce the risk of MTCT	31%	56%	71%	81%	78%

In 2010, revised national guidelines for PMTCT were released. These revised guidelines incorporated changes in the WHO recommendations for effective PMTCT interventions. The more significant changes included offering all HIV-positive pregnant women AZT prophylaxis starting as early as week 14 in their pregnancy. In addition, infants born to HIV-positive mothers will receive Nevirapine (NVP) prophylaxis starting at birth until one week after weaning from breast-feeding. The guidelines also maintain the recommendation for exclusive breast feeding for 6 months. After 6 months, the guidelines recommend the introduction of complementary feeding with continued breast feeding up to 12 months while the infant continues to receive daily doses of NVP prophylaxis.

In relation to these challenges, the strategy aims to eliminate new HIV infections amongst new-borns by 2015. Additionally, the plan aims to provide treatment for all HIV infected children and to keep their mothers alive through enhanced treatment, care and support.

There are eight strategic focus areas:

- Prevention of HIV infections among HIV uninfected women and men of reproductive age;
- Prevention of unintended pregnancies in women infected with HIV;
- Prevention of transmission of HIV from women infected with HIV to their children;
- Increase access to quality treatment, care and support for HIV infected women, their Male partners and their families;
- Promote access to quality paediatric HIV treatment, care and support for all HIV infected infants, children and adolescents;
- Achieve full integration between HIV, MNCH and related services;
- Health system strengthening; and,
- Coordination and collaboration between government and all relevant stakeholders.

In order to scale-up the provision of PMTCT to the level of universal access for all pregnant women, the MOHSW has created a Mother-Baby Pack.[37] Realizing that 90% of all pregnant women attend anti-natal care (ANC) services at least once, this strategy is meant to capture all women who attend ANC on their first visit whether or not they are HIV-positive. The women receive one of three types of packs according to their HIV-status and whether or not they are already initiated on ART.

Training was conducted across the country on the new PMTCT guidelines and the Mother-Baby Pack starting in November 2010. Distribution of the Mother-Baby Pack started in January 2011. By the end of 2011, all GOL, CHAL and Lesotho Red Cross health facilities providing PMTCT services distributed of the Mother-Baby Pack. The MOHSW is working to register all health facilities, including private clinics and health centres, to ensure that PMTCT services are offered in compliance with the new guidelines.

The total number of women attending their first ANC visit has been steadily increasing from 24,651 in 2007 to 36,500 in 2010 and 37418 for 2011. HIV testing coverage among pregnant women has reached 69% in 2011. In order to improve the accuracy of PMTCT data, a new data form has been implemented. District Health Management Teams

[37] The Mother-Baby Pack intervention is described in more detail in Section 9 of this report.

(DHMTs) have also been instructed to intensify their supervisory activities to ensure complete and accurate reporting from all health facilities.

In 2011, in an effort to further increase coverage of PMTCT and to strengthen momentum and commitment from the central to the community levels, the MOHSW and its partners developed the Strategic Plan for Elimination of Mother-to-Child Transmission of HIV by 2015, and for Paediatric HIV Care and Treatment. During the development process, a number of ongoing challenges to full coverage and effectiveness of PMTCT were identified and solutions proposed. They included:

a) *Improving primary prevention of HIV infection in men and women of reproductive age*;

Primary prevention efforts that were found to need strengthening were improving the effectiveness of BCC interventions on safer sexual behaviour in communities; promoting HTC so that all individuals are aware of their status; and, promoting and improving access to biomedical interventions for HIV prevention (such as consistent and correct condom use, and male circumcision).

b) *Preventing unintended pregnancies in women with HIV infection;*

It was identified that women of reproductive age need to have access to and be educated about contraceptive methods. This must be done within an enabling community environment that promotes and protects women's reproductive rights.

c) *Preventing transmission from HIV-infected women to their infants;*

Despite progress in access to and coverage of PMTCT services across the country, a number of challenges continued to limit the effectiveness of this intervention. It was found that there was a need to strengthen the general knowledge of the community on the importance of regular and early ANC attendance; the importance of delivery by a skilled birth attendant; and, the necessity of accessing PMTCT interventions as early as possible during pregnancy and throughout breastfeeding. At health facilities, more needed to be done to ensure that all HIV-infected pregnant women and their infants received the full complement of interventions, such as ART for their own health or NVP prophylaxis, ongoing monitoring and follow-up, post-natal care, and appropriate counselling on infant feeding.

d) *Providing comprehensive care and treatment to HIV-infected women and their families;*

The PMTCT programme needed to improve linkages with programmes for ART, psychosocial support, nutritional support, and other family-health-related interventions. More emphasis needed to be placed on PMTCT as an entry point for the entire family in relation to HIV and family health in general. Health service delivery

needed to urgently adapt to be able to offer a full complement of family health interventions at the same time as a woman begins to participate in PMTCT.

e) Providing all HIV-infected infants, children and adolescents with comprehensive care, treatment and support services;

It was noted that efforts were urgently needed to scale-up provider-initiated testing and counselling and for early infant diagnosis with prompt initiation of ART where appropriate. There was also a need to substantially improve the capacity of the health system, particularly at health centre level, to offer paediatric diagnosis, treatment, care and support for HIV-positive infants, children and adolescents.

f) Integrating HIV services into MNCH and SRH services;

It was necessary to strengthen coordinated service delivery to allow women, children and families to receive the full range of health interventions wherever they initiate contact with the health system. Areas in need of strengthening included screening for cervical cancer, postnatal service provision, and diagnosis and management of STIs.

g) Strengthening health systems; and,

There were still challenges across the health system related to the sufficiency of trained and motivated health human resources; procurement and supply management of medicines and other essential health products; comprehensive and responsive laboratory and other diagnostic services; linkages between services at all levels; and, monitoring and evaluation.

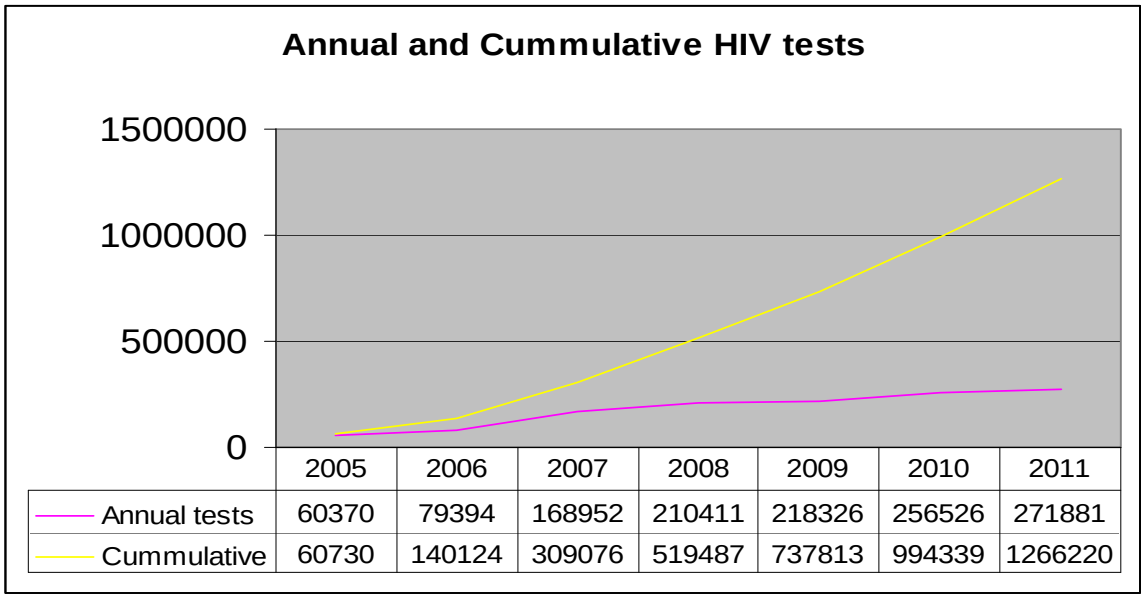
h) Coordination and collaboration between MOHSW and other stakeholders.

As there were many multi-sectoral partners supporting the MOHSW to lead the national HIV and AIDS response, there was need to improve communication and to facilitate forums for ongoing planning and implementation in order to strengthen collaboration, to maximize synergies and to avoid duplication.

The MOHSW and its multi-sectoral partners are currently collaborating to move forward on identified priorities and to raise sufficient resources to implement the plan at the scale and scope that is necessary to end mother-to-child transmission of HIV. What has also become evident is that success in this domain entails broader health system strengthening and more comprehensive social change.

3.10.8. HIV testing and counselling

The percentage of Basotho who have taken an HIV test and have received their results has greatly increased since the country has expanded the availability of HIV testing and counselling services, supported by intensive education and demand creation strategies at community level. The proportion of Basotho testing has increased significantly between 2004 and 2009, from 15% to 68.8% for females, and from 11% to 39.3% for males. In 2010 170,197 tests were done on females while 78,769 on males. In 2011 stands at 182,111 for females and 89,770 males respectively. These rates are considered low by the country.



	2005	2006	2007	2008	2009	2010	2011
Annual tests	60370	79394	168952	210411	218326	256526	271881
Cummulative	60730	140124	309076	519487	737813	994339	1266220

Through the HIV Prevention Revitalisation Operational Plan 2011-213, Lesotho will be intensifying its efforts to encourage adolescents 12 years and over, and all sexually active adults, to know their HIV status and to monitor it on a routine basis. The plan has an overall goal of all people above the age of 12 years living in Lesotho to know their HIV status. The plan advocates for HIV testing and counselling on a door-to-door basis at the household level. There is a large component of community mobilization that will be required in order to build the necessary acceptance at local levels..

The plan builds on the gains made during the previous country-wide Know Your Status campaign. Many of the local community and lay counsellors trained under the previous campaign will be re-engaged, re-trained and then deployed in their respective communities. The plan aims to offer a package of HIV prevention, care, treatment and support services through stronger referral systems between households, communities and service points, and through partnerships with other organizations and entities

addressing HIV prevention at the community level. In order to support high quality HTC services, the GOL's Laboratory Services Unit has been expanding and strengthening its quality assurance programme. This has included training senior HTC counsellors in all districts on HIV rapid test quality assurance procedures.

As part of the country's strategy to identify and treat HIV-positive infants and young children, the implementation of DNA-PCR testing has been continuously expanding. The capacity to process these tests has been available in-country since 2010. As a result of the ongoing scale up of decentralized treatment and care services for HIV-positive infants and children, the annual volume of DNA-PCR tests has been increasing. The number of tests performed has gone from 3,600 in 2007 to 10,907 in 2010 and 11,437 in 2011. The data for 2011 includes tests done at both health facility level and community level. Over this period, the proportion of tests giving HIV-positive results has declined from 9.2% to 8.2% and 9.4% in 2011.

3.10.9. Blood Safety

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

3.10.10. Post-exposure Prophylaxis

The provision of Post-exposure Prophylaxis (PEP) for occupational exposure to HIV has been integrated within the national Infection Control Policy and programme. PEP kits and registers have been distributed across the country. In 2010, all uniformed services were trained on provision of PEP. Chiefs were also trained on the administration of PEP within the context of community care. In 2010, 54 adults and 7 children were administered PEP while 2011 PEP figures are 485 adults and 62 for children.

3.10.11. Diagnosis and treatment of sexually transmitted infections (STI)

According to the latest data (2009 DHS), 15% of all sexually active women and 13% of all sexually active men reported experiencing symptoms of an STI in the previous 12 months. As noted above, for women, 43% of those reporting symptoms were also HIV-positive; 33% of men reporting symptoms were HIV-positive. The overall prevalence of STIs has not changed since 2007. STI case management in Lesotho is based on the WHO-recommended Syndromic Management approach. Seeking treatment for symptoms of STIs remain amongst the top ten reasons for visiting hospital Out-Patient Departments.

3.10.12. ADDRESSING Key Populations[38]

Within the general population of Lesotho, there are specific sub-groups that have been recognised globally to be at a greater risk of HIV infections and transmission. GOL has made great efforts to include addressing these populations in HIV and AIDS service provision a priority in policies and service provision as described below

4.4.1 Uniformed services: Lesotho Correctional Service

Amongst uniformed services in Lesotho, which include Lesotho Correctional Service (LCS) Lesotho Mounted Police Services (LMPS), Lesotho Defence Force (LDF), health care workers and emergency response personnel, the progress of LCS in addressing HIV risk within its institutions is profiled in this report.

In 2011, the first epidemiological and behavioural study of HIV within the prison system in Lesotho was released.[39] The study included both inmates and staff. Staff and inmate perceptions of the occurrence of high risk activities within correctional facilities were relatively consistent with few exceptions. Sexual activity, use of drugs, and physical violence were uniformly perceived to be occurring within facilities on a constant basis. Within this environment, it was not surprising that many inmates (76.7% of male and 61.6% of female respondents) and staff (80.8% of male and 71.5% of female respondents) perceived some level of personal risk of contracting HIV within the prison environment.

Voices: Police Officers

"Yes we know that condoms can prevent HIV infection but most people don't use them or don't know how to use them properly."

"In special service departments, things like gloves to handle emergencies are not always there. In

Amongst LCS inmates and staff, most (>80%) had undergone HTC. 62.3% of males and 75% of females had under gone HTC within the previous year. For staff, the corresponding rates were 56.7% and 82.1%, respectively. Within the inmate population, 78.8% of male inmates but only 33.3% of female inmate respondents had received their last HIV test at LCS. Moreover, 93.7% of male inmates and 75% of female inmates stated that their most recent HIV test was voluntary.

The observed HIV prevalence rate of 31.4% for male inmates was considered a reliable estimate for the male inmate population. The HIV prevalence findings for male and

[38]Included in this section are excerpts from focus group discussions convened during the development of the report. In general, groups had 10-20 participants; accidental sampling was used as the participant recruitment method. The statements contained in the excerpts may not fully represent the views of the overall key population. The interpretation of the statements should be kept within this context.
[39]LCS. 2011. Lesotho Correctional Service HIV Sero-prevalence and Behavioural study: Findings Report. Maseru, LS: LCS.

female staff respondents were not significantly different from those found generally amongst adults across Lesotho. The female inmate sample was too small for findings to any level of significance. When the HIV prevalence was set against time spent in prison, there was an increase in prevalence for male inmates staying in prison for 1 year and longer. What may have been suggested by these findings for the 80% of male inmates imprisoned for between 1 and 10 years is that at least some HIV transmission is occurring within the prison and that it is happening relatively early in an individual's sentence.

Half (56.3%) of the HIV-positive and three quarters (73.3%) of the HIV-negative male inmate respondents had been tested within the past 12 months. Most male staff respondents (>80%) as a group had undergone HTC at least once. Of the HIV-positive male staff respondents, 6 individuals (16.5%) indicated that they had never had an HIV test. 95% of HIV-positive and 79.4% of HIV-negative female respondents had undergone HTC within the past 12 months.

Almost all male inmate respondents indicated that they were sexually active with a partner of the opposite sex before incarceration. Most (89.9%) indicated that they were not sexually active after incarceration, including within the past three months. Of the 512 male inmate respondents, only 9% or 41 disclosed that they had had sexual contact within the past three months while in prison. 36 respondents (or 8% of the male inmate sample) disclosed that their sexual contact had been with another male. Of these male inmates, almost all (35) stated that they had done so willingly. However, less than half (15) had used a condom during this encounter. Almost half (17) of male inmate respondents reporting recent sexual contact with another man indicated that some form of benefit was exchanged. This included money, cigarettes, food, toiletries and, in one instance, protection from gangs. A condom was used in just over half (9) of these encounters. Prior to being in prison, all female inmate respondents were sexually active with a partner of the opposite sex. After incarceration, all respondents stated that they were not sexually active.

In the past three months, more than two-thirds of male staff respondents (66.5%) and female staff respondents (72.0%) had had sexual contact with a regular partner, most often their spouse. Just under one third of male and female staff respondents (27.5% and 28.0%, respectively) had had sexual contact with a non-regular partner. For male staff respondents, 14.6% reported sexual contact with two partners, almost all with a regular and a non-regular partner. Just over half of male (55.4%) and female staff (55.3%) respondents reported using a condom during their last sexual encounter. When related to HIV status, only 50.0% (n=36) of HIV-positive and 56.6% (n=136) of HIV-negative male staff respondents reported using a condom during the last sexual encounter. For females, 83.3% (n=24) of HIV-positive respondents reported using a condom while only 47.4% (n=63) of HIV-negative respondents did the same.

Of the male staff respondents who reported not using a condom during their last sexual encounter (n=78), 52.6% said it was because they were already HIV-positive; 20.5% said it was because condoms were not available at the time. Of the female staff respondents who reported not using a condom during their last sexual encounter (n=35), 38.2% said it was because condoms were not available at the time, 11.8 % said their sexual partner objected, and 11.8% said that they were already HIV-positive.

Prior to the study, LCS had drafted a comprehensive HIV and AIDS strategic plan and a corresponding HIV and AIDS policy. Currently, it is reviewing these two strategic documents in light of the findings of its first HIV-related epidemiological and behavioral survey. It is notable that during this time, LCS has maintained its practice of providing condoms in all of its correctional facilities and improving comprehensive HIV and AIDS services for inmates and staff.

4.4.2 People with disabilities

Voices: People with Disabilities

"Mentally handicapped people understand sex only so far as they have developed. By puberty, they can become very pre-occupied with sex. This makes them vulnerable to people who take advantage of this interest in sex."

According to the 2006 population census, 3.7% of the population in Lesotho is considered to have a disability of one form or another.[40] Amputations of digits or limbs, congenital paralysis or lameness, blindness, deafness, mental illness and mental retardation are the most frequent types of disability found in the population. Approximately 1.5% of the population aged 0 to 19 years is disabled. The more frequent types of disability found in this group are deafness and blindness, lame or paralysed limbs occurring at birth, speech difficulties and mental retardation.

In 2010, the Lesotho National Federation of Organizations for the Disabled (LNFOD) carried out a national situational analysis of people living with disabilities and the impact of HIV on their lives.[41] The assessment was carried out at household level using a questionnaire that captured data on people with disabilities along with comparative data from the non-disabled. The assessment found that people with disabilities generally had much lower comprehensive knowledge regarding HIV and AIDS, particularly with respect to ways of preventing HIV infection. However, people with disabilities were equally likely to be sexually active. In the study, 61.6% of people with disabilities reported sexual contact within the past 12 months, 28.6% with more than one sexual partner. For the non-disabled sample, the results were 57.6% and 30.2%, respectively. Similarly, within the sample of people with disabilities, 20.6% reporting

[40] GOL. 2009, op. cit. note 14.
[41] LNFOD. 2011. Situational Assessment Study of HIV and AIDS on Persons with Disabilities in Lesotho: Report of the Study Findings (DRAFT). Maseru, LS: LNFOD.

using a condom during their last sexual contact compared to 28.3% of the non-disabled sample.

The full results from the assessment are still under discussion. However, even at this preliminary stage, it is clear that people with disabilities are just as vulnerable if not more so to the negative impacts of HIV and AIDS, particularly HIV infection. LNFOD will soon finalize the results of the assessment and release them broadly. The organization is currently working with its partner organizations to design interventions, including advocacy strategies, to address the multiple needs of people with disabilities in terms of HIV prevention and general health promotion.

4.4.3 Sexual minorities

At the time of the 2009 country progress report, a cross-sectional study on sexual minorities in Lesotho had just been completed. The results of the study were used to advocate for recognition of sexual minority rights in Lesotho as well as used to develop HIV and AIDS interventions to respond to the needs of sexual minorities

As part of advocacy, Matrix hosted an evening of public discussion in May 2011 to mark the International Day against Homophobia and was attended by senior public officials from the Ministry of Justice, Human Rights and Correctional Service who elaborated on the promise of the Constitution of Lesotho to protect citizens from discrimination of any kind. It is still acknowledged that acceptance of sexual minorities by Basotho society is still a challenge a journey had began to address these perceptions.

Voices: Gays and Lesbians

"Because we participate in the Matrix Support Group, we have the advantage. We are able to receive information and education about our situation and the risk of HIV and AIDS."

"The things we need to protective ourselves from HIV and AIDS are never where we can find them if we need them."

"The laws about sodomy have not been changed so that sex between gay people is still very much a secret. Sometimes, it is difficult to go to the doctor because he won't understand how we have contracted an STI."

"There are many concurrent sexual partnerships practiced because of the secrecy that needs to surround our lives."

"Some of us experience forced sex from other men. Such things are never talked about but there are men who force themselves on younger ones whom they think are different. They take advantage of us at a time when we are still feeling bad about our situation and have not yet accepted it as a natural status. There is no place where the younger ones can go to get help."

"Because our status cannot be recognized when we are with someone, it makes it very hard to be faithful to one partner. Always finding new partners is considered to be more normal than just staying with one."

The particular needs of sexual minorities with respect to HIV and AIDS have been more effectively included in the new NSP and the national prevention strategy. With support from Development Partners, the Matrix Support Group is continuing to strengthen its role moving forward with activities to both improve social awareness and to protect and promote the health of its members.

4.4.4 Herd boys

Herd boys are male individuals whose spend most of their time out in the mountains herding cattle and either for family, relatives or for payments in kind. It is estimated that there are about 30,000 herd board spread all over the country. Their age ranges from 7 years and 50 years.

A comprehensive assessment of the situation of herd boys with respect to the HIV and AIDS epidemic was completed in 2010.[42] The findings of the assessment included the following:

Voices: Herd Boys

"We know about having many girlfriends. There is one who is known by our parents and families as the girlfriend. Then there are the others who are not known. It is our brothers and friends who tell us to do this. It says that a boy is a man if he has many girlfriends."

"Condoms are not used so much. I think, 'How can I get HIV if I don't use a condom just this one time?'"

"Knowing someone who is HIV-positive is like a whisper when no one is listening. We only know their status behind their backs."

"We know about 'khomo-ea-maoma.' Sometimes we use 'khoma fatse' which makes us highly sexed. Then we find aother herder that is smaller than us and relieve ourselves."

- There was no baseline data on HIV prevalence amongst herd boys nor was there adequate data on what makes this group vulnerable to HIV infection.
- There was no baseline data on the number of children and adolescents engaged as herders nor the different social characteristics that such individuals share or do not share;
- The reality that herd boys worked under adverse conditions and that their role was not covered by the same labour-related laws and regulations as other categories of employment contributed to their vulnerability;
- The assessment reconfirmed what was found in a study done over a decade ago, that almost one third (29%) of the respondents had received no formal education (never attended school).[43] This is continuing to create barriers with regard to written information about health and social needs and, more importantly, limiting

[42] Ibid, NAC 2010a.
[43] Makhosi *et al.* 1999. The Situation and Needs Analysis Survey of Herd Boys in Lesotho. Roma, LS: NUL.

individuals' understanding of health-related threats for herd boys, and ways of managing and mitigating these risks;

- Herd boys commonly worked during the day when livestock was taken out to pasture. This made schools and health and social services inaccessible to them as such entities only operated during daytime hours;

- Organisation of herd boys was ill organised at both constituencies and national level. The Lesotho Herd Boys Association (Monna-Ka-Khomo) (had only limited capacity to address this gap. Consequently there was widespread silence on the health and social needs of this group and a corresponding urgency to develop health-related and social protection interventions to improve the environments in which herd boys lived and worked;

- Most community-oriented HIV support and impact mitigation initiatives did not specifically involve herd boys. Members of this population were rarely invited to participate in support groups. The nature of their work made them largely absent in communities when traditional and political structures were engaged to identify their local challenges and to proposed appropriate solutions;

- Where basic education programmes were available, there was a distinct absence of content and materials targeting the specific needs of herd boys. This was particularly true with respect to vocational training, and income generating schemes, among others, to both prepare herd boys for alternate employment, and to provide them with opportunities to alleviate the poverty which compels them to remain as herders;

- Basic materials and commodities to prevent HIV transmission, to maintain health, and to avoid risks to well-being, were only intermittently, if at all, available and accessible to herd boys;

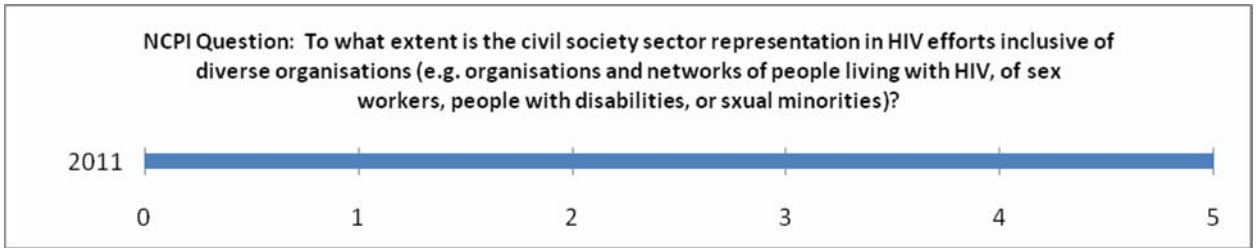
- Because herders spent large of amounts of time in isolated locations away from communities, they did not benefit from routine socialization and this caused problems with these individuals when they returned to communities. This was particularly true with respect to engagement in sexual activities. Knowledge and sensitivity with respect gender, and knowledge attitudes, beliefs and practices regarding sexually transmission infections, including HIV, were two aspects of socialization and engagement with communities where the gap was the greatest; and,

- Cattle posts, where herd boys resided when livestock was taken out to pasture for extended periods (particularly during the winter or dry season months), provided inadequate protection against weather and had little or no access to potable water or

a consistent supply of adequate food. These conditions resulted in HIV and AIDS being a very low priority for this population. They were also at risk of injury and death from wild fires that spontaneously occurred during the winter or dry season.

Finally, herd boys were vulnerable to the impacts of environmental degradation and mismanagement as they relied on plants and other natural resources around them for sustenance. The recognition of these factors has resulted in herd boys being considered as having specific needs regarding HIV interventions due to poverty, education levels and geographical inaccessibility, among others.

Based on the findings of the situational assessment, an HIV and AIDS Strategic Plan For the Herd Boys Community 2010-2012 was developed with facilitation by NAC. In 2011, a National Action Plan was prepared. The main priorities across these two documents include improving access to basic education particularly for younger herders; developing minimum conditions for employment that reduce occupational risks and the risk of exploitation; tailoring service provision regarding basic education and HIV and AIDS intervention to make them more accessible and available to this key population; and, finally, providing opportunities for herders to improve their livelihoods with different types of income generation activities.



4.4.5 Commercial sex workers

Strategic information on commercial sex workers and the impacts of HIV and AIDS in their lives remains as a gap in the country's national response. One organization, CARE Lesotho/South Africa, has implemented a peer support programme. The programme supports sex workers trained as peer educators to work within their networks in Maseru and Maputsoe. These individuals are able to provide condoms and other sexual health commodities. They also serve as referral points for HTC, ART and other sexual and reproductive health needs. Finally, the peer educators assist women who desire it to find the means to transition out of sex work as the main livelihood for themselves and their families.

Voices: Sex Workers

"The life of a sex worker is characterized by secrecy and violence."

"We lead a double life. During the day we can be with our families and then we go out at night."

"We cannot say where we are going or where we are from at any given time. Lying is second nature."

Some information on the nature and frequency of sexual activity in exchange for money, and its HIV-related risks, were

revealed through the 2009 DHS. Amongst sexually active men, 7.1% reported ever having paid for sexual activity, 2.6% within the past 12 months. Of this last group, 61% reported the use of a condom. Although the overall frequency of paid sexual encounters appears to be low (and may be under-reported given the level of social stigma attached to such encounters), 40% of such contacts currently occur without the use of a condom. Sex workers themselves report initially insisting on condom use during the negotiation of the sexual encounter. However, for different reasons, some of which are unknown, in 4 of 10 cases, there is no agreement on condom use.

In 2012, CARE Lesotho/South Africa will undertake a comprehensive situational assessment of HIV-related risks amongst commercial sex workers. Given the relationships this organization has established with this key population, the assessment is likely to provide important information about their needs in order to reduce HIV-related risks in their lives.

4.4.6 Migrant workers

Within the population of Lesotho, there are different categories of migrant workers. Aside from the public sector, the two largest sources of employment for the country's population are the mining industry in neighbouring RSA, and the textile industry. In the former case, the predominantly male employees spend extended periods of time away from their families and communities in Lesotho. As for the textile sector, many women travel from their homes to maintain one of these precious few opportunities for salaried employment.

ALAFA, the main non-governmental provider of HIV-related interventions, including HTC and ART in the textile sector, is currently conducting a new HIV prevalence and behavioural survey. Previously, data had shown elevated levels of prevalence amongst the predominantly female workforce. Changes in risk-related behavioural patterns were also emerging. With respect to miners, no comprehensive or specific epidemiological or behavioural data is currently available.

Within the results of the 2009 DHS, there were only small variations in HIV prevalence, between 1% and 3%, for men and women who had spent significant time away from their homes in the past twelve months compared to those that had not. Lesotho continues to be part of a 14-country HIV cross-border initiative aiming to harmonizing and coordinate approaches to HIV and AIDS, other STIs and TB within the SADC region.[44] One of the aims of the initiative is to ensure that wherever migrant labourers seek out HIV-related services, a basic package of interventions is always available.

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

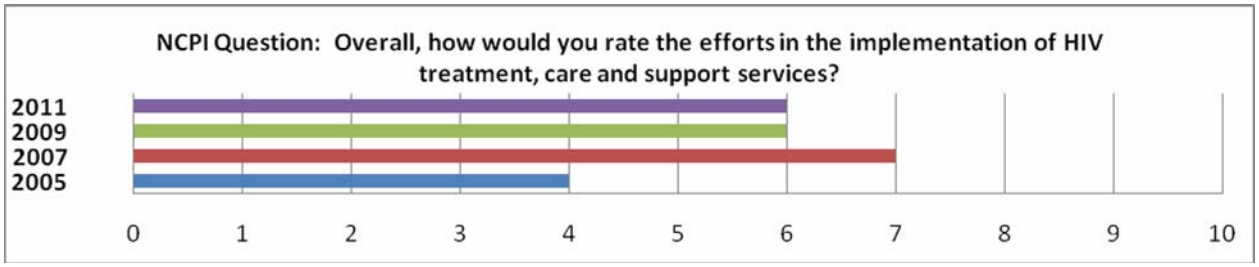
4.4.7 Children and Adolescents Living with HIV and AIDS

Of the estimated 289,841 adults and children living with HIV in Lesotho in 2011, 50,642 *or 17% were children and adolescents below the age of 19 years*. 55% of this group was female. The burden of HIV and AIDS on Lesotho's children is one of enormous magnitude. Lesotho continues to experience high rates of infant and early childhood mortality despite the scaled-up efforts of the GOL and its partners to reverse this trend. HIV prevalence is considered to be one of the driving factors of this tragic situation.

Successes in the scale-up of PMTCT across the country have meant fewer new infections for infants at birth as well as earlier identification of HIV-exposed children. Through the commitment of the GOL and the assistance of its partners, including the Elizabeth Glazer Paediatric AIDS Foundation, the Clinton Health Access Initiative, Sentebale, Touch Roots Africa, and the Baylor International Paediatric AIDS Initiative, the standard of care for HIV-positive children and adolescents has greatly improved. Health care providers have become more competent and more confident in caring for this special population. Family members, care givers, teachers, pastors and many other individuals at community level that interact with these children have been sensitized on how to identify and provide for their psycho-support needs. Finally, largely through efforts of Sentebale, camps and teen clubs are convened for the children themselves and have made an enormous difference in their lives. Sentebale has also provided assistance to families and caregivers to ensure that they too have opportunities to share experiences and to learn from each other on ways to nurture and support the HIV-positive children in their care.

3.11. TREATMENT, CARE AND SUPPORT

For 2011, it was estimated that of the 289,841 adults and children living with HIV and AIDS, 123,187 or 42% were in immediate need of ART, of which 23,369 or 19% were children under the age of 15 (11,182 or 48% are children under the age of 5). These adults and children also required community-based care and support programmes to assist them to stay on ART and to cope with the impacts of HIV and AIDS on their families and in their households.



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

4.5.1 Provision of ART to Adults and Children

Guided by the country's ART guidelines, which require individuals to collect their ARVs on a monthly basis, at December 2010, 73,226 ART patients collected medicines while 83,624 collected their medicines in December 2011. Overall ART coverage now is 61 %. In 2011, adults the number of adults on treatment were 63% (77,531 adults), and for children under the age of 15 it was 43% (6,093 children).

Voices: People Living with HIV and AIDS

"We are shocked how many people lack information. Some women can believe that they can love an HIV-positive person and even become infected since they felt that HIV could be easily overcome."

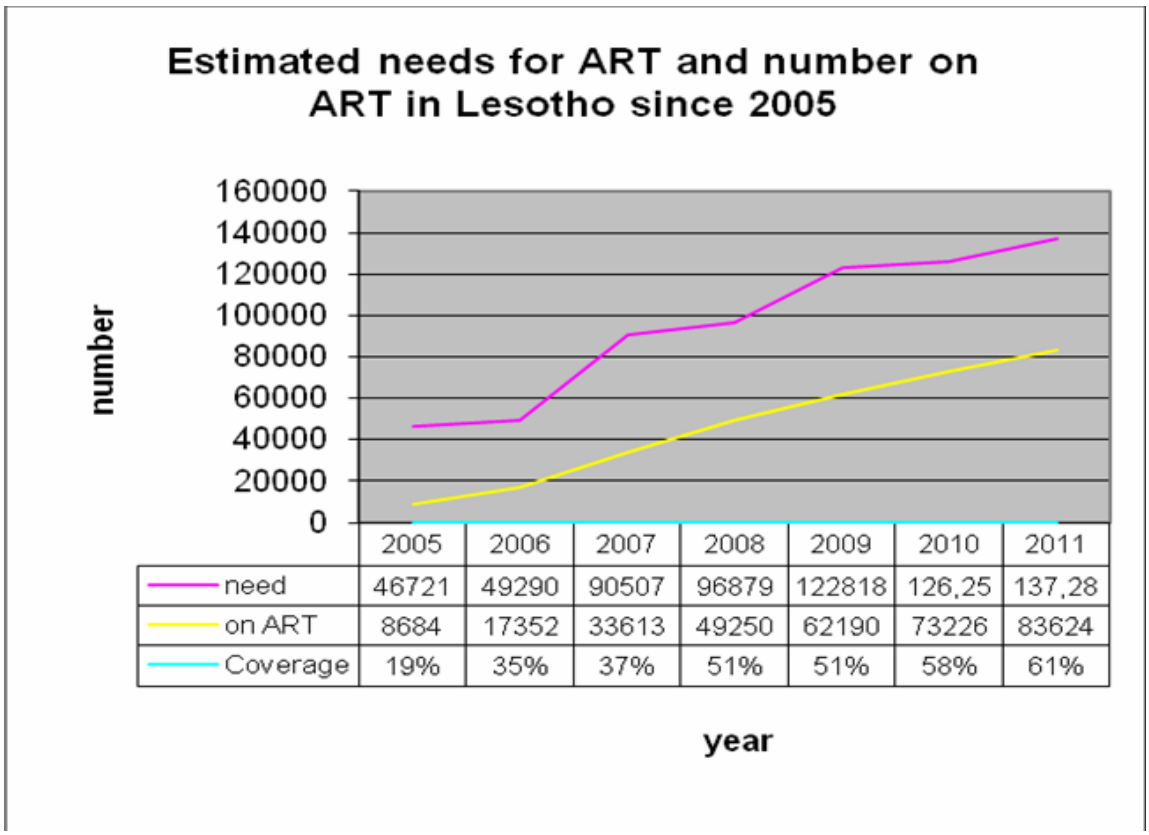
"Taking treatment makes us stand out as HIV-positive people. Treatment changes our physical appearance and marks us as HIV-positive. We can no longer choose not to disclose our status."

"Either the condom is the one *blamed* for fuelling the virus or it means you don't trust someone. It says how much you do or don't love someone. If you don't use condoms, it means that you really love someone."

"People think that once you have tested you should die. If you don't die, then there is no fear. It cannot be that dangerous."

"I think that Lesotho is doing better than some other countries to meet the needs of people living with HIV and AIDS. But there is still room to improve especially with employment creation and livelihoods. It does not help if there are services if people cannot reach them because they lack the money for the transport to get them there."

"It used to be that we were examined by doctors when we went to the hospital for treatment. Now it is only nurses and the service we receive is totally inferior."



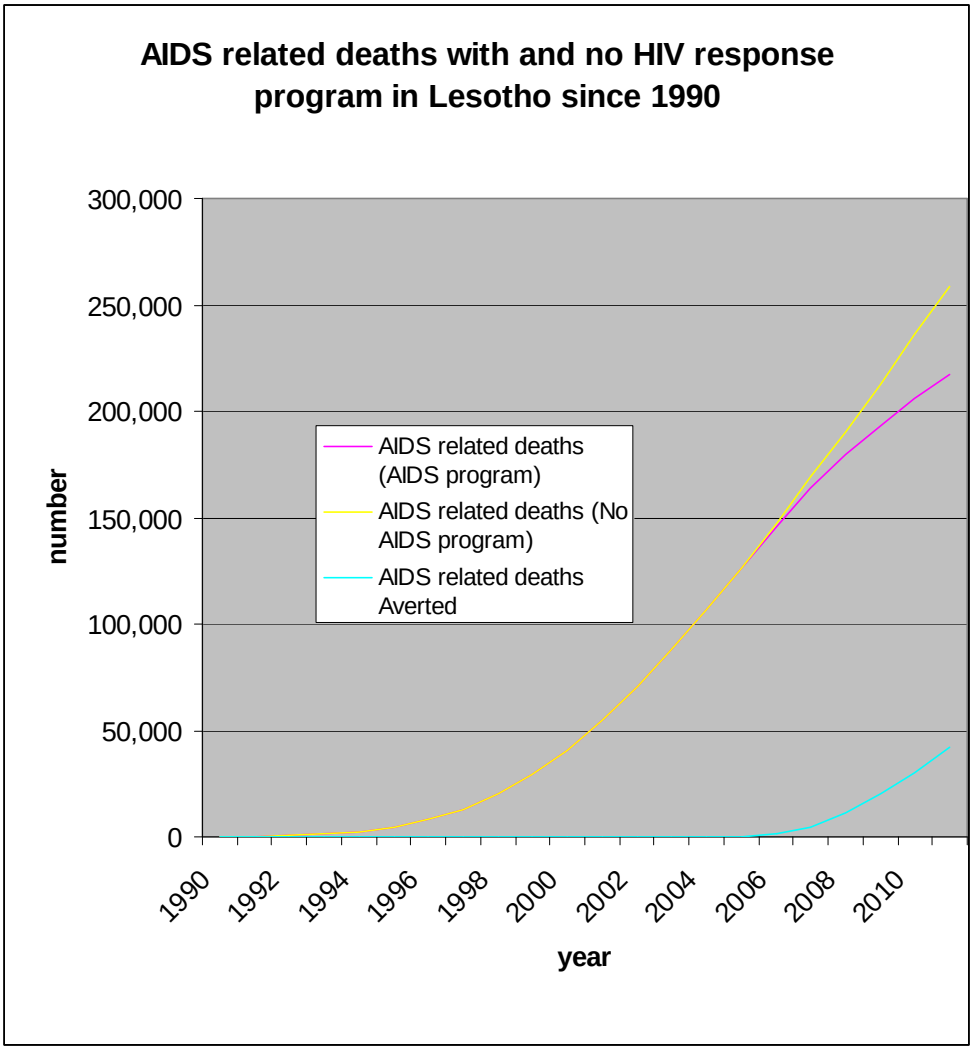
The third revision to the national ART guidelines was completed and released in 2010.[45] The guidelines maintained the increase in the WHO standard for eligibility for ART from a CD+ lymphocyte count of ≤200μ² to a CD+ lymphocyte count of ≤350μ². Changes to the management of children living with HIV and AIDS were also introduced, as well as new guidelines for managing pregnancy and child birth for HIV-positive women.

With regard to the provision of ART to HIV-infected children and adolescents, the country's capacity has steadily improved since 2009. With the shared emphasis on improving child health outcomes generally, between the GOL and its Development Partners, ART services for children and adolescents have been gradually decentralized. The BIPAI initiative, for example, has established satellite paediatric ART treatment centres at the district level and has develop a cadre of mentors that visit ART centres and health facilities to support the delivery of high quality ART interventions for children.

The impact of the ongoing expansion of the national ART programme is shown below in Figure 5.

[45] GOL. 2010. National Guidelines for HIV and AIDS Care and Treatment. Third Edition. Maseru, LS: MOHSW.

Figure 6: Number of AIDS-related Deaths Averted

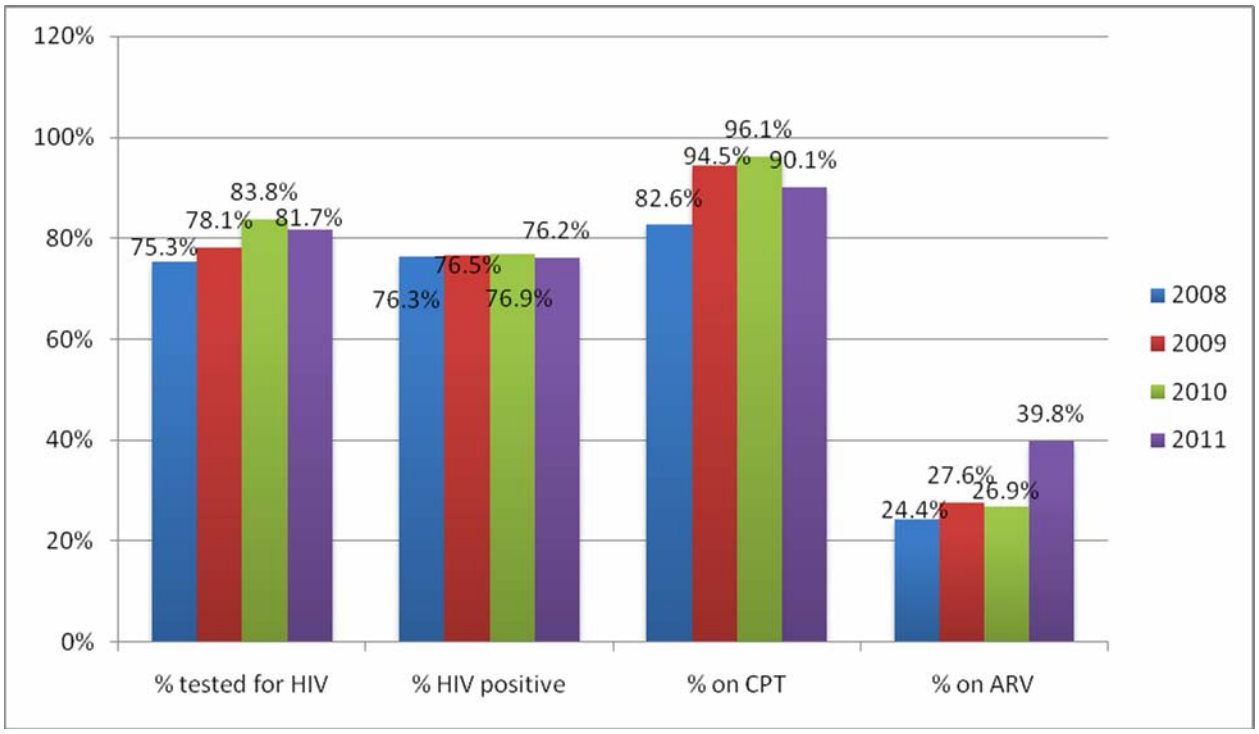


It was estimated that by the end of 2011, there were a cumulative total of about 42,000 AIDS related deaths averted through the provision of ART in HIV and AIDS program in Lesotho since the advent of HIV and AIDS

4.5.2 Management of TB/HIV co-infection

The identification and management of TB and HIV co-infected individuals has improved significantly since 2009. Although the incidence of co-infection has not declined, the proportion of those co-infected being enrolled on ART has increased substantially, from 26.9% in 2009 to 39.8% in 2011.

Figure 7: Management of HIV/TB Co-infection



This has occurred as a result of significant improvements in the diagnosis and management of co-infected patients. Revised national ART guidelines, which now recommend that all HIV-positive individuals with active TB infection be started on ART regardless of CD+ lymphocyte count, have also contributed to this improvement.[46]

There have been other important developments in the identification and management of TB across the country. Notifications of new cases of all forms of TB have declined from 13,520 in 2009 to 12,616 in 2011. Analysis of this data is still ongoing in order to determine whether the meaning of the trend is an actual decline in new incidence of TB or whether it has another cause, including inconsistencies at health centre and district level in case reporting practices. During 2010 and 2011, the National TB Programme (NTP), within the framework of the Global Stop TB Strategy, aimed at achieving an increase in the case detection rate (CDR) and an increase in the treatment success rate (TSR). At the end of 2010, the NTP had achieved a CDR of 93%, well above the WHO-recommended minimum of 70%, and a TSR of 70%, still below the WHO-recommended minimum of 85%.

In 2010, an external review of the NTP was conducted against the six goals of the GOL's TB Strategic Plan 2008-2012.[47] The review recommended that the NTP improve the quality of its disease surveillance activities, increase the amount of buffer stock of

[46] Ibid. p79.
[47] GOL. 2010. Report of the External Mid-Term Review of the National Tuberculosis Control Programme. Maseru, LS: MOHSW.

essential TB medications to eliminate stock outs, engage more community-based organizations and individuals in community-mobilization and advocacy, and improve infection control practices in rural and remote health facilities. It also recommend that the NTP continue to increase the number of trained health professionals able to successfully diagnose and treat TB, provide better motivation for private health care providers to participate in the NTP, and upgrade facilities at high volume laboratories. Finally, the recommended that the NTP increase the frequency at which information on the programme is shared and that it develop a TB research agenda in collaboration with the TB programme partners.

4.5.3 Community and home-based care

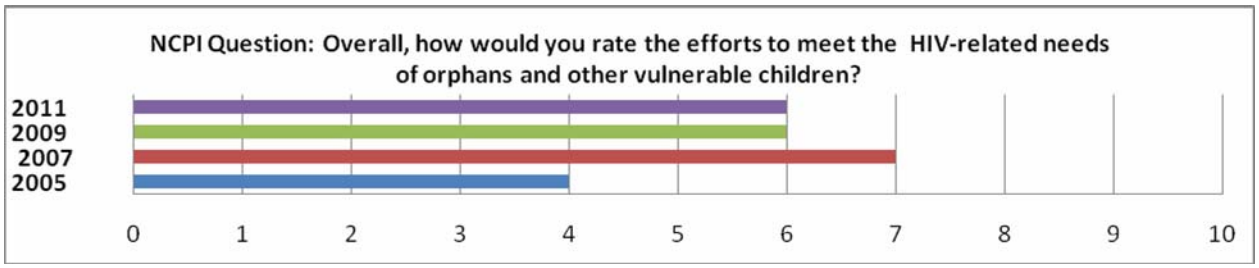
Lesotho's primary health care system is undergoing a process of comprehensive renewal. This includes the provision of new and refurbished infrastructure as well as revised roles and responsibilities for health care providers, particularly at community level. Community-based provision of primary health care services includes providing home-based care and support to chronically ill PLWHAs. With support from Development Partners, the MOHSW has developed the Primary Health Care Revitalization Action Plan 2011-2017. The development of the plan has been guided by the principles Ouagodougou Declaration for the renewal of primary health care services in Africa.[48]

Two key priorities of the Action Plan are strengthening community mobilization and community participation in primary health care programmes; and, strengthening health systems at community level. For the plan to be a success, it states that the following key components of implementation are critical: community participation involving key stakeholders from the village to the district levels; strong inter-sectoral collaboration including involvement of the decentralized local administration; and, the consistent presence of qualified health workers, especially at the front line of health facilities and within communities. The primary health care system relies on Village Health Workers (VHWs) as the first point of contact with the system. In this regards, Lesotho has developed a revised and expanded VHW manual. It has also developed a better system for selecting, equipping and sustaining highly trained and motivated individuals to take on the role of VHW within their communities.

3.12. IMPACT MITIGATION

The number of children orphaned or made vulnerable (OVC) by the impacts of HIV and AIDS on families and communities continues to grow in Lesotho.

[48] WHO. 2008. Ouagodougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium. Geneva, CH: WHO.



Results from the 2012 national HIV estimates indicate that in 2011 there were 191,568 orphans alone in Lesotho and that for 68% of all orphans, HIV and AIDS was the major factor causing Orphanhood and vulnerability.[49] The magnitude of this challenge has caused many of the traditional systems of care and support for orphaned children to disintegrate. In many families, the 'middle generation' has succumbed to the HIV epidemic and children are left in the care of grandparents or on their own in child-headed households.

In 2009, the ratio for school attendance between orphans and non-orphans (10 to 14 years old) was 0.98 overall. Between wealth quintiles, the attendance ratios were 0.99 for the lowest to 1.01 for the highest.[50] However, what this indicated was that access to education was substantially affected by socio-economic status rather than social status as an orphan. The proportion of children attending school in the lowest quintile was 86.7% for orphans and 87.5% for non-orphans. For children in the highest quintile, the proportion attending school was 100% for both groups.

Two recently released studies have added to the evidence-base for understanding the magnitude of children's vulnerability in Lesotho. They are a study on child poverty and a new situational analysis of OVC. As a major cause of children's vulnerability, the Child Poverty Study found that the richest 10% of the population held 40% of the country's wealth, while the poorest 10% held only 1%.[51] An estimated 500,000 children under the age of 18 years were considered to be living in poverty, with 25% of this group being children under the age of 5 years.

The Situational Analysis of Orphans and Other Vulnerable Children in Lesotho looked at the vulnerability of children from a number of different dimensions.[52] If all factors were taken into account, the study found that between 40% and 50% of the country's children could be considered to be vulnerable in one way or another. In order to prioritize the needs of the most vulnerable children, the study proposed a two-tiered definition of vulnerability, with the first being a human-rights based approach where a

[49] MOHSW 2012, op. cit. note 10.
[50] MOHSW and ICF Macro 2010, op. cit. note 17.
[51] UNICEF. 2011. Child Poverty in Lesotho (DRAFT). Maseru, LS: UNICEF.
[52] MOHSW. 2011. Situational Analysis of Orphans and Other Vulnerable Children in Lesotho (DRAFT). Maseru, LS: MOHSW.

child is considered to be vulnerable to the extent that the ability of such a child to realize rights and entitlements is compromised in significant ways. Within this category, a most vulnerable child is a boy or girl in immediate need of external assistance because of harms that are occurring or harms that have a high likelihood of occurring in the immediate future. Such a definition helps to sort the needs of the large group of vulnerable children in Lesotho into those that require immediate attention and those that will need to be addressed through medium or longer term intervention strategies.

The study found serious short-comings in the ability of governmental and non-governmental partners to intervene quickly enough to avoid significant harm to the most vulnerable children. Part of this was due to unrealistic expectations placed on the DSW to be a first-responder in every case. The study noted the relatively small emphasis on building local community capacities to take responsibility for the health and well-being of the vulnerable children in their midst. On a more positive note, the study found that upwards of 90% of children considered to be vulnerable have at least benefited from free primary education and free-of-charge primary health care services.

The study recommended a series of child-rights-focussed interventions to alleviate the vulnerability of children. It concluded with a finding that the main determinants of children's vulnerability stemmed from larger social and economic challenges affecting households, particularly the inability of many of the adult members of these households to find reliable sources of livelihood. It also noted how the burden of HIV and AIDS had also resulted in the erosion of community and household coping mechanisms that had previously protected and nurtured vulnerable children. The study concluded with a sense of urgency for governmental and community-based action to provide job creation and livelihood support for households and, by doing so, to reduce, mitigate or eliminate the main causes of children's vulnerability in Lesotho.

4.6.1 Support for OVC and Improvised Households

To respond to the challenge of the large and growing number of OVC, the GOL, under the leadership of the DSW, continues to work with its multi-sectoral partners to expand programmes and services for vulnerable children in order to alleviate the impact of negative socio-environmental conditions on children. The main achievements since 2009 include the following:

a) In early 2011, the country's Parliament approved and enacted the Children's Protection and Welfare Act (CPWA). The provisions of the CPWA signal a fundamental change in the focus and intensity of Lesotho's efforts to support and protect its children. Overall, the CPWA fully domesticates the provisions of the Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child. The task remains to develop a robust implementation and

monitoring framework to ensure that children in every family and community are empowered to claim their fundamental rights and to improve their life situation as a result.

b) At the end of 2010, the Parliament approved and enacted the Education Act which sets out the legal framework for free and compulsory primary education for all school-aged children. Revised school management regulations are in the final stages of development. These efforts will lead to important changes in the lives of children. The Act sends a direct signal to all families and communities that access to education is a fundamental right for children and that Lesotho is very serious now with respect to its responsibility as a duty bearer to ensure that this entitlement is tangible and claimable by every child.

c) The development and roll-out of the Lesotho Child Grants Programme (CGP) equips the country with a powerful tool to address poverty and deprivation, two of the most prominent causes of vulnerability for children. By December 2011, quarterly grants had been paid to 9,915 households caring for 27,737 vulnerable children located in 21 community council areas across 5 districts. Once the programme has national reach, and is fully implemented, in complementary with other social safety nets, it will become a strong core around which to build a comprehensive, effective and sustainable social protection system to safeguard and enable the well-being of children.

d) With assistance from Development Partners, the technical and operational capacity of the Child and Gender Protection Units, the Child Help Line, and the capability of governmental and non-governmental stakeholders to provide effective, reliable and responsive child protection systems continues to improve. This includes a growing capacity to identify children in distress and to reach them with supportive interventions to protect their well-being and to remove them from situations and environments where they are in danger of sexual or physical abuse, exploitation or neglect. Similarly, more child-friendly, appropriate and effective programmes for assisting children in situations of conflict with laws or customs are being implemented, including restorative justice and diversion processes.

The reality remains, however, that coverage of all of these efforts is still not adequate, leaving too large a proportion of children without safe and immediate access to essential child protection systems. The national, multi-sectoral effort to reduce the vulnerability of orphans and other children continues to be limited in its reach and impact for the following reasons:

a) There are an ever expanding number of children and adolescents who find themselves in situations of extreme vulnerability. Much of this is driven by the scale and impact of the HIV and AIDS epidemic;

b) Regional and global fiscal instability has led to limits or reductions in scale and scope of GOL social protection interventions as well as changes in levels of support and areas of emphasis amongst bilateral and multi-lateral partners;

c) The persistent limits in technical and operational capacity of key units within the GOL, as well as within non-governmental stakeholders at central, district and local levels, have inhibited the strengthening and expansion of social protection and child protection systems. This includes limits in the capacity and reach of core systems and structures necessary to support country-wide delivery of social welfare and child protection programmes;

d) Systems to enable the continuous collection of reliable evidence to guide multi-sectoral efforts and to position them for maximum impact within the target populations are still not fully developed or deployed; and,

e) The magnitude of some of the challenges causing vulnerability, including a firmly entrenched, chronic cycle of poverty and destitution for many households and families, is difficult to effectively contain and resolve within both the multi-sectoral response to OVCs and the broader, country-wide effort to resolve health and development challenges.

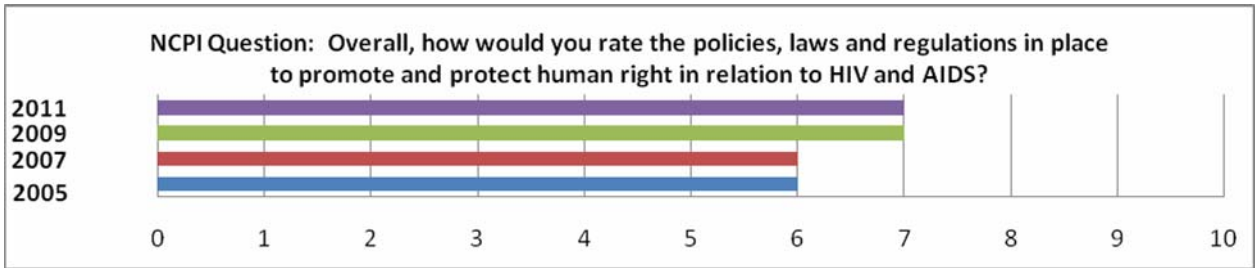
Finally, certain uncontrollable challenges, such as uncommon weather patterns or the effects of environmental degradation, or difficult mountainous terrain and a widely dispersed population in these rural and remote areas, will continue to limit the scope and reach of social protection and child protection systems.

4.6.2 Addressing the needs of women and girls

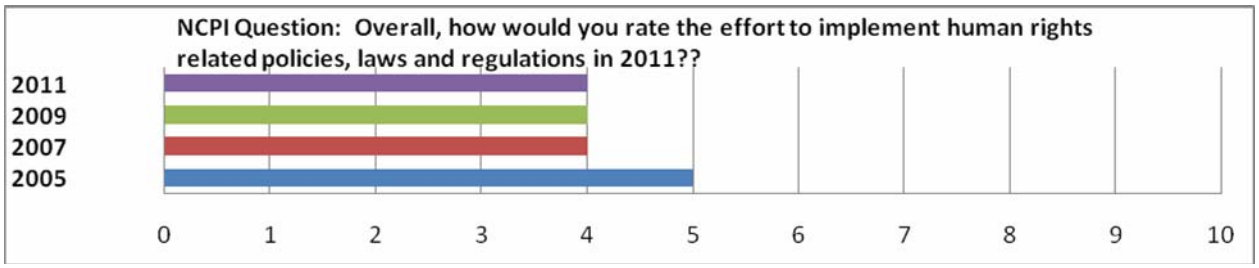
Between 2009 and 2011, the GOL and its partners continued to implement strategies to address the disproportionate effect of the HIV epidemic on women and girls. The country continued to struggle to fully alleviate social, cultural and economic imbalances that place girls and women in positions of moderate to extreme vulnerability to HIV infection. A revised National Action Plan for Women, Girls and HIV and AIDS 2012-2016 has been launched. New statutes protecting children from abuse, and protecting women and girls from human trafficking have been enacted. All of the multi-sectoral partners within the national HIV and AIDS response continue to intensify their efforts at community level to address and resolve gender imbalances and the vulnerability of women and girls. The GOL, Development Partners and CSOs continued to collaborate to strengthen social and child protection interventions for female children and adolescents. Master of the High Court.

4.6.3 Preventing stigma and discrimination against PLWHAs

As the number of PLWHAs starting ART has increased throughout that country awareness and acceptance of individuals and households affected by HIV and AIDS has grown. In 2009, over 80% of the population stated that they would be willing to care of HIV-infected members of their families, would accept HIV-positive teachers in the classroom, or would buy fresh fruits or vegetables from a vendor known to be HIV-positive. This is a significant change compared to 50% to 55% in 2006.



Where attitudes remain equivocal are in relation to disclosing or not disclosing the presence of an HIV-positive member of the family. Roughly 50% of the population would still wish this fact to be kept within the family itself.



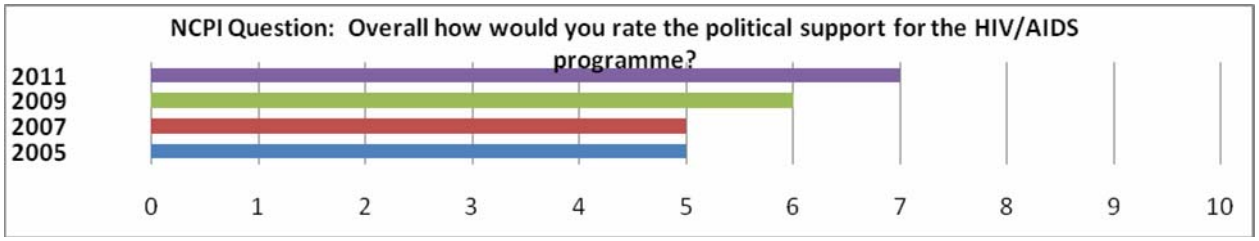
As LENEPWHA and FIDA and other partners have continued to build awareness of the rights and entitlements of PLWHAs at community level, instances of stigma and discrimination against HIV-infected or affected individuals and households have continued to decline. Between 2010 and 2011, over 80,000 individuals were reached with anti-stigma-and-discrimination messages through radio shows, newspaper articles and community meetings and other sensitization activities.

3.13. LEADERSHIP, MANAGEMENT AND COORDINATION

4.7.1 Leadership

The political support for the national HIV and AIDS response continues to be strong in Lesotho. As noted previously, His Majesty King Letsie III launched the new NSP in December 2011. The Prime Minister was the first to sign his name to the Statement of Commitment. He has undergone HIV testing repeatedly to show by example his

personal commitment to the national response. The Minister of Health and Social Welfare, Dr. Ramatlapeng is equally as outspoken and active on HIV and AIDS. Religious and community leaders, traditional leaders and the multi-party political leaders all routinely speak out on the importance for the country of addressing and resolving the HIV and AIDS epidemic.



Within the Office of the Prime Minister, the First Lady, Mrs. Mosisili, leads community-based interventions on HIV and AIDS and also guides the spouses of parliamentarians to be similarly active in response to the epidemic.

4.7.2 Advocacy, policy and legislation

Since 2009, Lesotho has continued to take steps to improve the law and policy environment guiding the national response to HIV and AIDS. Both His Majesty the King and the Right Honourable Prime Minister are routinely outspoken against discrimination and stigmatization of PLWHAs. As described earlier in the report, in 2010 and 2011 important legislation was enacted to alleviate some of the vulnerabilities of children and adolescents to HIV and AIDS. This included the Education Act, the Anti-Trafficking in Persons Action 2010 and the Children's Welfare and Protection Act 2011.

As the reporting period closed, FIDA began the implementation of a project to address legal and ethical issues that arise due to the HIV epidemic. A stakeholder workshop was to be convened early in 2012 to survey the situation and to develop an agenda for deepening the dialogue on critical questions regarding current barriers and opportunities within the national response to HIV and AIDS and the broader legal context for the country.[53]

4.7.3 Coordination and management of the multi-sectoral response

The period 2009 to 2011 saw important changes within the coordination and management of the national response to HIV and AIDS. In 2010, a review process aimed at restructuring the National AIDS Secretariat (NAS) began. After a period of expert analysis and broad consultation, a decision was made to rebuild the NAS to make it more effective and efficient in its role to coordinate and manage multi-sectoral

[53] FIDA. 2011. HIV and AIDS Legal and Ethical Issues in Lesotho. Maseru, LS: FIDA.

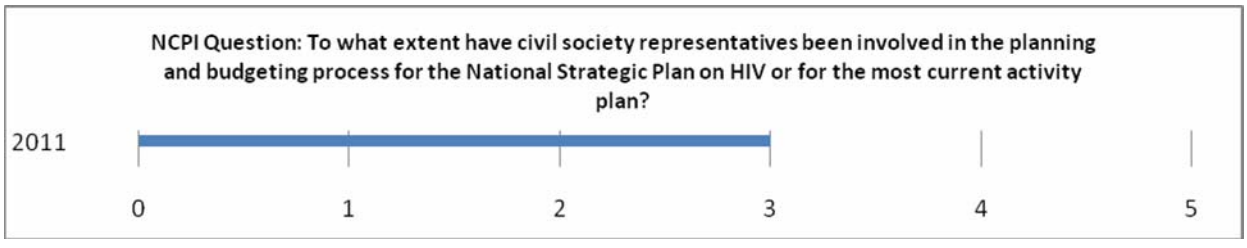
engagement on HIV and AIDS. As the reporting period closed in 2011, the implementation of the restructuring process was underway. Although information was made available to the public regarding the objectives behind the restructuring, at that point, the Office of the Prime Minister and the NAC Commissioners had not yet tabled the plan for the new arrangements for the NAS.

Up until this point, however, NAC continued to play its critical role in bringing stakeholders together to improve the coherence and focus of their joint efforts to address HIV and AIDS. With assistance from Development Partners, NAC facilitated the completion of both the National HIV Prevention Strategy and the new NSP. It also continued to host quarterly forums which brought together key stakeholders from all regions of the country. Finally, national technical working groups for M&E, HIV prevention and other aspects of the response continued to meet.

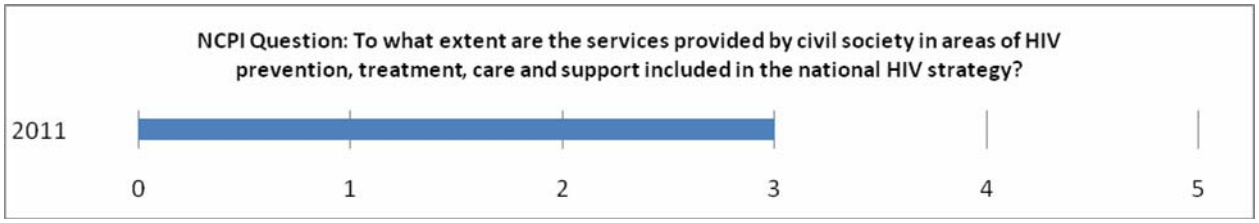
In addition to the role played by NAC in terms of multi-sectoral coordination, other non-governmental entities worked to improved networking and collaboration at the local, district and national level. In 2010, the Lesotho Business and Labour Coalition on HIV and AIDS (LBLC) opened its national secretariat. LBLC will serve as the coordinating body for private sector and labour organizations to enhance their response to HIV and AIDS. National umbrella bodies, such as LIRAC, LENASO, LCN, LNFOD and LENEPWHA continued to bring their members together on a routine basis. With support from PACT Lesotho, LCN convened civil society forums to share information regarding efforts to address HIV and AIDS. Finally, through the Letsema Network, monthly forums were held for both governmental and non-governmental child-focussed organization. The forums complemented quarterly meetings of the multi-sectoral National OVC Coordination Committee.

4.7.4 Civil society engagement and community systems strengthening

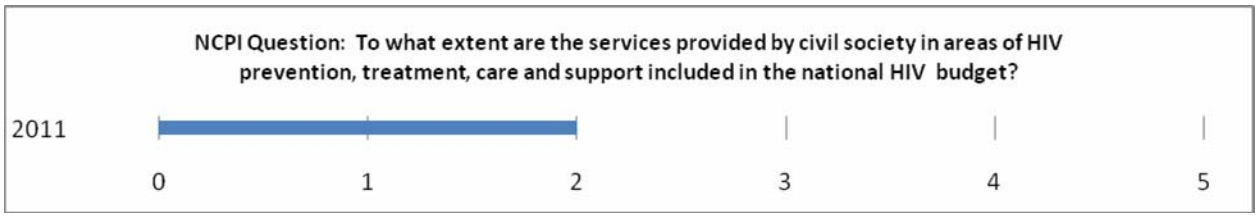
There is no doubt across all stakeholders within the national, multi-sectoral response to HIV and AIDS that civil society participation has become more prominent and more effective since 2009. Civil society organizations are now routinely engaged by the GOL, NAC and Development Partners within all processes affecting the focus and direction of Lesotho's efforts to address HIV and AIDS. CSOs played leadership roles in the development process for both the National HIV Prevention strategy and the NSP. They also played prominent roles in the development of the Elimination of PMTCT strategy.



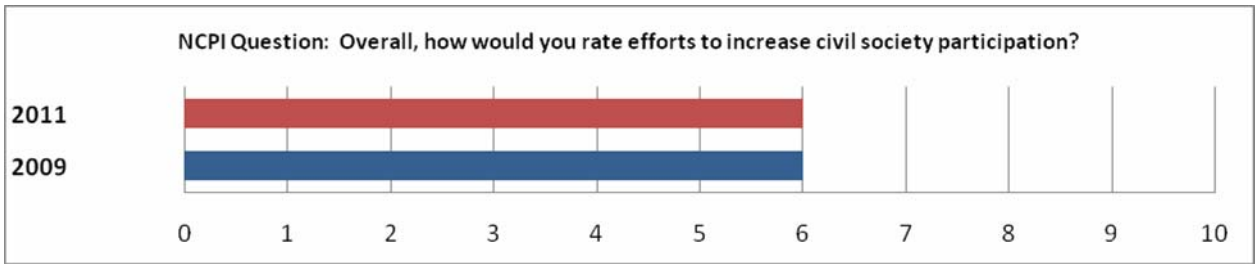
However, challenges remain regarding the strength and the quality of the relationship between civil society and its governmental counterparts. While CSOs applauded the efforts of the country's leadership to keep HIV and AIDS at the top of the development agenda, rarely did they have a direct opportunity to work with the leaderships when important decisions were taken or high-profile public events were planned.



CSOs were critical of the level of minimal engagement that was offered to them during the process of developing a new structure and mandate for the NAS. An important consequence of this process for all CSOs was the suspension of NAC's support to umbrella bodies for institutional strengthening and for support of community-based interventions implemented by their member organizations starting in 2011.

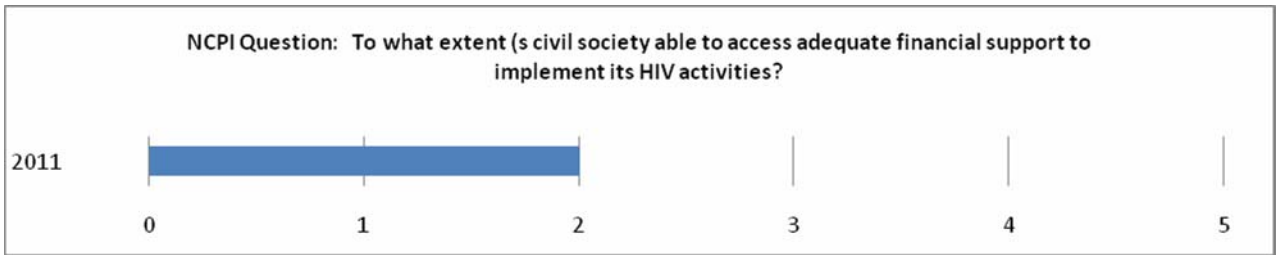


Furthermore, particularly regarding the allocation of resources within the national response to HIV and AIDS, CSOs felt that their involvement in these decisions is minimal if at all. Finally, CSOs felt that their contribution to addressing HIV and AIDS was still not recognized or adequately documented within reports or other activities the country's achievements in relation to the epidemic.

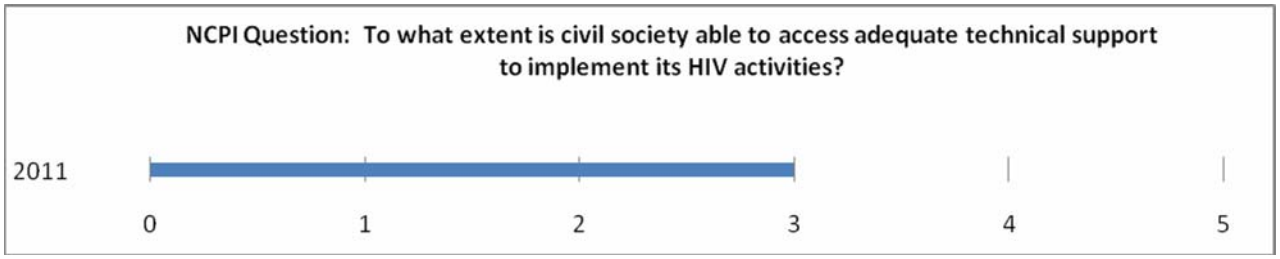


As the NAS restructuring process unfolded, other Development Partners and CSOs maintain their support for the sector and continue to provide capacity development opportunities. In March 2010, the Lesotho Council of NGOs (LCN) began to implement

its component of the Global Fund Round 8 grant to Lesotho. LCN was the first NGO to be appointed as a Principal Recipient (PR) within the country's Global Fund grants portfolio since the first grant was received in 2003.



A major component within LCN's implementation plan was community system strengthening (CSS) in order to strengthen and expand community-based action on HIV and AIDS. The grant had a total value of USD14 million and was to be implemented over a 5-year period. Phase 1 of the grant closed at the beginning of 2012. Once Phase 2 of the grant begins in 2012, the Ministry of Finance and Development Planning will take over the role of PR for the grant, adding this responsibility to its existing portfolio of Global Fund grants.



LCN and its other national and community level partners will move forward with the direct implementation of community-based interventions focussing on prevention for key populations, strengthening support groups, improving food security, and strengthening the overall capacity and the sustainability of civil society engagement on HIV and AIDS.

4.7.5 Health system strengthening

Lesotho's health system, in all of its governmental, non-governmental and private sector aspects, is currently in a state of fundamental and far-reaching change. Major investments by the GOL and its health and Development Partners are addressing virtually every aspect of the system. These changes are occurring, however, at a time when the country's community health outcomes are in a very mixed state. While, for example, coverage of HIV prevention, treatment and care programmes has expanded dramatically during the past five years of health system development, and the improvements in community-related HIV prevention and control have become visible

and tangible, interventions to address maternal and early infant mortality have weakened, leading to serious negative trends. This is indicative of a situation of imbalance where certain priority national programmes are operating within a more general environment of health system instability.

Current achievements of the massive health system renewal programme include the following:

- The recruitment and deployment of over 250 expatriate health workers at health centres with support from health Development Partners;
- Some initial progress in reaching minimum staffing levels at some health centres;[54]
- Review and renewal of compensation levels for health workers across all disciplines and at every level;
- Approval and roll-out of the health sector HIV and AIDS Workplace Policy;
- The development and implementation of a Human Resource Management Information System at central level for both the MOHSW and Christian Health Association of Lesotho;
- The approval and subsequent implementation of a health worker retention strategy;[55]
- Substantial increases in the number of opportunities at health training institutions. In addition, the review and renewal of training curricula as well as the renovation and expansion of health training facilities;
- Recognition of the importance of community health workers and the initiation of a programme to significantly renew and strengthen this critical link in the accessibility of primary health care interventions at community and household level;
- The creation of a new cadre of skilled health worker called health assistants. These new positions will be deployed at health centres in order to alleviate administrative and management burdens on nurses, midwives and nurse clinicians.
- The priority placed on the improvement in working and living conditions for health workers within the programme for the refurbishment of health centres;

[54] See Chapter 4 in MOHSW 2011, op. cit. 16.
[55] MOHSW and MCA. . 2010. Retention Strategy for the Health Workforce. Maseru, LS: MOHSW

- The development and implementation of a continuing education strategy.[56]

Amongst the GOL and its bilateral and multi-lateral Development Partners, health system renewal and, most importantly, primary health care revitalization, continue to be top priorities for the country's health and development agenda.

4.7.6 Decentralization

Soon, the decentralized delivery of a basic package of health and social welfare interventions will become fully operational across Lesotho. The GOL and its health and Development Partners have been moving forward in this direction for most of the past decade. All stakeholders, whether governmental, non-governmental or private sector, have agreed to support the health services decentralization strategy.[57] What remains a challenge, however, is the gap between the urgency for health services renewal at community level to reverse negative trends in key community health outcomes and the measured pace at which decentralization is moving forward to ensure stability and sustainability for the fully-implemented system.

Although DHMTs have been formalized in all districts and have become operational, staff members in these roles are still acclimatizing themselves to their new functions. A number of health workers in these roles have come from a facility-based background of programme management and service delivery. A district-wide focus is a significant change for many in this group. Similarly, as district and community level service delivery is fully transitioned to the Ministry of Local Government and Chieftainship, district level management and supervisory staff must also acclimatize themselves to their new responsibilities for health service delivery. Tools and materials needed to facilitate this change for both groups are not yet fully developed and implemented.[58]

Changes of similar significance are affecting the delivery of services at local health centres. The decline of functionality of the primary health care system that Lesotho has experienced over the past two decades has had a serious impact on the availability and quality of health service delivery at the community level. Major efforts are underway to rectify this. Health centres across the country are being refurbished in order to support the continuous delivery of quality-assured primary health care services. The model of service has been reviewed and work is underway to develop and implement new tools and resources to support the implementation of the model at every health centre and within every community across the country.[59]

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[56] MOHSW. 2011. National Continuing Education Implementation Plan for Lesotho Health Sector 2011-2012. Maseru, LS: MOHSW.
[57] See Chapter 4 in MOHSW 2011, op. cit. note 16.
[58] Ibid.
[59] See GOL/MCA. 2010. Standard Operating Procedures for Outpatient flow in OPDs in District Hospitals and Health Centres (Draft). Maseru, LS: MCA; see also WHO. 2008. Operations Manual for

4.0. NATIONAL M&E SYSTEMS

As the HIV and AIDS epidemic continues to unfold across the Lesotho, and as the national, multi-sectoral response improves and evolves in terms of its scale and complexity, the importance of evidence, in the form of strategic information, becomes even more critical. At the close of the last UNGASS reporting period, country capacity to provide this information had reached important milestones. In particular, by the end of 2009, a new data collection and analysis framework called the Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) had been developed and training of stakeholders in advance of full implementation of the system was underway.

During 2010, these efforts continued to move forward but full deployment of LOMSHA was put on hold when the NAS restructuring process got underway at the beginning of 2011. During this time, however, other activities were implemented to improve M&E capacity and to strengthen the quality and the use of M&E data across the country. As part of its preliminary efforts to lead the implementation of its component of the Round 8 grant, for example, LCN engaged the Southern Africa HIV and AIDS Trust (SAT) to undertake a capacity analysis amongst CSOs and to develop a sector-wide capacity-building strategy. Within this effort, both achievements and on-going challenges regarding M&E systems and organizational competencies were prominently profiled. As LCN began to build the implementation structure for the Round 8 grant and to engage CSOs in this process, efforts were made to address the gaps that had been identified with respect to M&E processes. In addition, in relation to the country's overall portfolio of Global Fund grants, the Lesotho Country Coordination Mechanism (LCCM) improved its own capacity to measure the impact of Global Fund investments on critical aspects of the HIV and AIDS epidemic.[60] During 2011, the LCCM created an Oversight Committee and an Oversight Plan to enable it to take a much more active roll in monitoring the status of grant implementation. This included the creating of a Grant Dashboard which is used to track financial and programmatic achievements for all Global Fund grants.

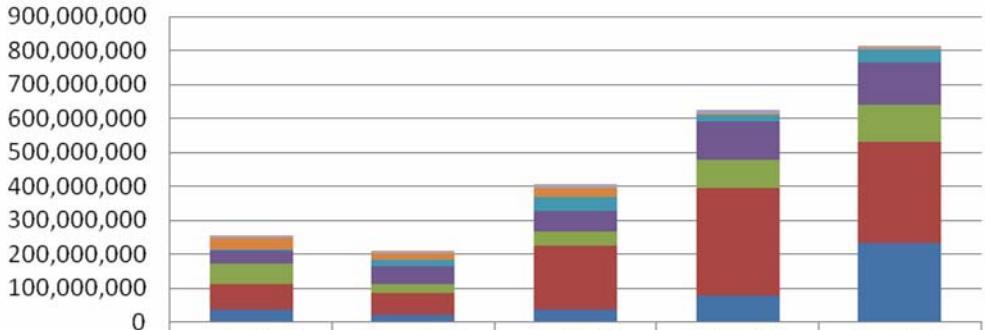
Delivery of HIV Prevention, Care and Treatment at Primary Health Centres in High-Prevalence, Resource-Constrained Settings. Edition 1 for Field Testing. Geneva, CH: WHO.

[60] Details regarding Lesotho's Global Fund grants can be viewed at www.gfcu.org.ls and in the Lesotho country section of www.theglobalfund.org

5.0. FINANCIAL MANAGEMENT AND RESOURCE MOBILIZATION

Since Lesotho's scaled-up response to HIV and AIDS began in 2004, there have been significant changes in the availability and allocation of resources supporting the national HIV and AIDS response. Figure 8 below shows these year- over- year changes.

Figure 8: Total HIV & AIDS Expenditure by Thematic Area (LSL)



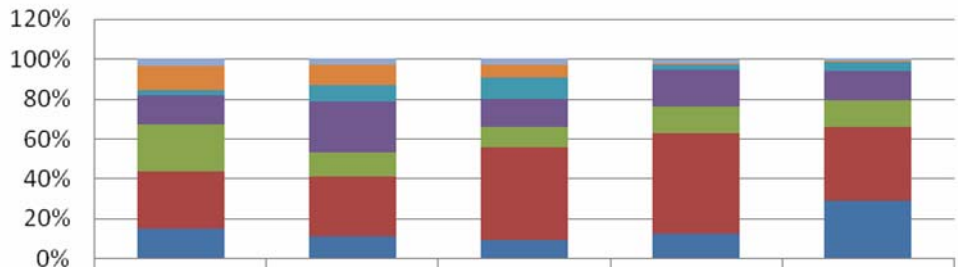
	2005/06	2006/07	2007/08	2008/09	2009/10
Total	257,398,642	209,871,329	408,268,531	626,954,165	813,443,068
HIV and AIDS related research	28,510	199,948	343,946	2,587,170	806,700
Enabling environment	9,633,850	6,075,870	12,059,381	11,318,697	6,824,589
Social protection	31,490,057	20,902,252	26,536,321	3,495,471	3,701,926
Human capital	6,213,599	17,800,137	42,839,344	16,581,065	37,278,733
Programme management	38,316,316	53,402,224	59,383,629	115,944,646	123,210,283
OVC	59,266,049	25,875,234	40,868,517	83,131,734	108,646,497
Care & treatment	73,948,177	62,532,444	190,562,835	316,151,687	299,452,075
Prevention	38,530,594	23,283,168	36,018,504	77,743,695	233,522,265

Between fiscal years 2008/09 and 2009/10, the country's investment in the national HIV and AIDS response increased by LSL186,488,903 or 30% to reach LSL813,443,068.[61]

Changes in level of expenditure between 2009 and 2010 reflect shifts in priorities within the national HIV and AIDS response as shown in Figure 9 below.

[61] LSL is the international symbol for the Lesotho loti.

Figure 9: Proportional expenditure (all sources) by thermatic areas

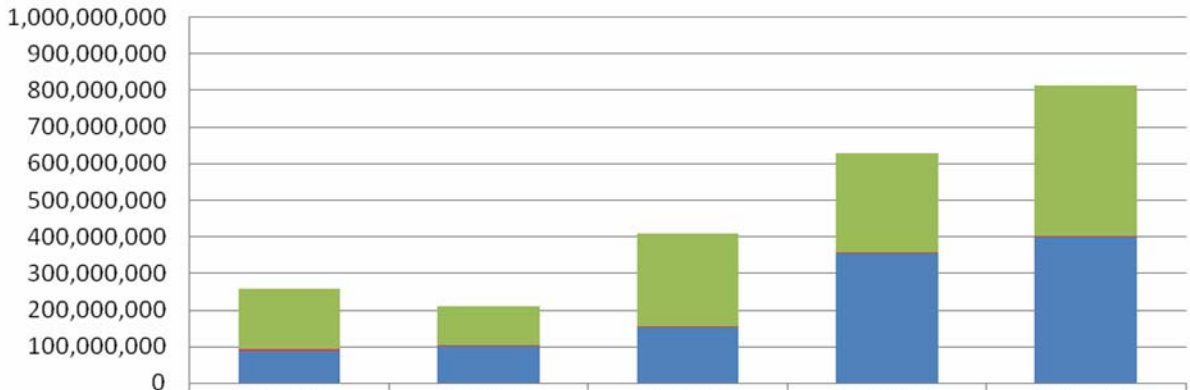


	2005/06	2006/07	2007/08	2008/09	2009/10
Enabling environment	4%	3%	3%	2%	1%
Social protection	12%	10%	6%	1%	0%
Human capital	2%	8%	10%	3%	5%
Programme management	15%	25%	15%	18%	15%
OVC	23%	12%	10%	13%	13%
Care & treatment	29%	30%	47%	50%	37%
Prevention	15%	11%	9%	12%	29%

Increases in 2010 for prevention, for example, reflect the availability of additional resources through Global Fund as well as the scaled-up commitment of key partners. The country's capacity to provide HTC, for example, was increased substantially through the Global Fund Round 8 grant. In addition, starting in 2010, renewed emphasis was placed on the national PMTCT programme. Increases in expenditure on care and treatment, and on provision of material support for OVC, matched the expansion of country capacity to reach more adults and children with these national programmes.

As the country's response to HIV and AIDS has evolved, the GOL has been taking on an increasing share of overall expenditure as shown in Figure 10 below.

Figure 10: Total HIV/AIDS Expenditure & sources of funding (LSL)



	2005/06	2006/07	2007/08	2008/09	2009/2010
Public %	33%	48%	37%	57%	49%
Total	257,427,152	210,284,179	408,768,477	626,954,165	813,443,068
International	164,850,010	105,773,594	252,970,071	268,617,087	411,570,208
Private	7,711,865	3,887,837	5,744,424	3,270,809	348,170
Public	84,865,277	100,622,748	150,053,982	355,066,269	401,524,690

Since 2009, the GOL maintains an investment level of between 50% and 60%. Where the GOL invests most is in the provision of ART. Funds from international sources are largely directed towards prevention.

6.0. ACHIEVEMENTS AND CHALLENGES: 2009/2011 COMPARISON

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
Prevention	Still slow progress in achieving sustained behaviour change in the general population and in key target populations.	Develop and implement operational plan for national BCC strategy. Develop and implement a National HIV Prevention Strategy Strengthen and expand continuous M&E processes attached to prevention interventions. Undertake more targeted operational research to determine effectiveness of prevention interventions.	National HIV Prevention Strategy and Operational Plan completed and released. 2009 LDHS completed and released. New data available to guide prevention interventions Cross-sectional survey of MSM in Lesotho completed and released. Epidemiological and behavioural study within Lesotho Correctional Services completed and released. Development of BCC interventions commenced with support from GF Round 8 grant.	Low level of capacity to use evidence for the development of effective behavioural change interventions. Need for longer-term strategic planning and delivery of interventions. Need for stronger M&E processes to continuously monitor and strengthen interventions. Inconsistent alignment of interventions with national prevention strategies and operational plans.	Engage additional technical support to improve the quality and reach of prevention interventions at community level. Sustain national technical working groups on HIV prevention interventions. Continue to advocate for the human and financial needs of effective behavioural change interventions.

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
	Ongoing need to improve technical and programmatic capacity of multi-sectoral partners to develop and implement country – wide prevention interventions. Ongoing social reticence to openly acknowledge and discuss HIV sexual risk issues. Slow change in cultural and social expectations of women and girls, particularly within sexual relationships. Insufficient commitment on the part of men and boys to address HIV prevention within sexual relationships.	Provide training and technical support to multi-sectoral partners on BCC and other prevention interventions. Scale-up prevention interventions focusing on interpersonal communication skills. Improve availability of female condoms. Develop and implement interventions aimed at empowering women and girls to claim rights and entitlements in all aspects of their lives. Scale-up interventions that engage men and boys in HIV prevention and support.	Convened National HIV prevention Symposium to assess achievements and challenges. The Declaration of Commitment signed on World AIDS Day renews collective commitment to one national strategy and one set of results. 2009 LDHS results showed early evidence of shifts in cultural and social expectations regarding women and girls. Multi-sectoral partners have implemented interventions to improve male involvement in family-focussed sexual and reproductive health.	Lack of technical and operational capacity to implement behavioural change interventions at sufficient scale and scope to show results. Cultural reticence towards open discussion within families of sexual and reproductive health matters persists. Low level of community-mobilization to maintain locally-based prevention interventions.	Engage additional technical support to improve the quality and reach of prevention interventions at community level.

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
Prevention	Ongoing gaps in knowledge regarding HIV-related risks for key populations. Ongoing stigma and discrimination against key populations (sexual minorities, commercial sex workers, inmates). Need for additional technical capacity to design effective interventions.	Work with non-governmental sector to scale-up development and implementation of evidence-based prevention interventions. Strengthen and expand activities at national, district and local level sensitizing individuals and communities regarding rights and dignity of all members of Basotho society. Ensure that key policies, laws and strategies in prevention programmes ensure access to prevention interventions for key populations.	Cross-sectional survey of MSM in Lesotho completed and released. Epidemiological and behavioural study within Lesotho Correctional Services completed and released. Situational assessment of HIV risks for people living with disabilities completed. National strategy and action plan to address HIV related needs of herd boys developed.	Lack of adequate financial and human resources to fully address needs identified in surveys and assessments. Low level of operational and technical capacity of NGOs to develop and implemented appropriate interventions. Key gaps in knowledge still exist, particularly for commercial sex workers, people with disabilities, police officers and health care workers.	Work with non-governmental sector to scale-up development and implementation of evidence-based prevention interventions. Strengthen and expand activities at national, district and local level sensitizing individuals and communities regarding rights and dignity of all members of Basotho society. Ensure that key policies, laws and strategies in prevention programmes ensure access to prevention interventions for key populations.

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
Treatment, care and support	Addressing gaps and weaknesses in logistics systems that support health centres. Recruitment and retention of adequate human resources on a long-term basis. Integrating HIV chronic care within the essential services package offered through primary care programmes at community level. Maintaining reliable supply of home-based care commodities. Securing long-term resource commitments to support ART.	Mobilize additional resources to address gaps in PSM systems (reliable transport, accurate inventory management and forecasting at hospital and health centre level). Develop and pilot integrated service delivery models. Implement health human resource retention strategy. Engage Development Partners in dialogue on long-term support for ART programme.	HIV chronic care integrated within decentralized primary health care service delivery. District mentors provide ongoing support to facility-based staff for HIV chronic care. Refurbishment of health centres and hospital-based ART centres. Includes provision of staff housing and improved security. Engagement of NGOs to assist with transport and logistics at health centre and district levels. Health human resource recruitment and retention strategy completed and launched. Substantial increase in intake capacity of training institutions.		

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
	Expansion of IGAs and food-security programmes at community level with assistance from Development Partners. Evaluation of interventions in order to determine best-practice.	Ongoing vulnerability and food insecurity of rural and remote populations engaging in subsistence farming. Ongoing impact of poverty on HIV-positive individuals and families.	Launch of Lesotho Child Grants Programme to help most destitute households address poverty and food insecurity. Ongoing provision of support through NGOs to local communities for food security solutions. Provision of training and commodities to hospitals and health centres to provide therapeutic feeding to severely malnourished adults and children.	Ongoing vulnerability and food insecurity of rural and remote populations engaging in subsistence farming. Ongoing impact of poverty on HIV-positive individuals and families.	Continue to work multi-sectoral partners to develop interventions to address and resolve food insecurity. Improve nutritional support for adults and children on ART.
	Expert patients, community health workers, village health workers, traditional healers, police officers, correctional officers and others all sensitized and given training on assisting individuals on ART to maintain adherence.	Maintaining long-term adherence to ART. Managing need for 2nd line ART. Identifying, treating and supporting HIV-positive children.	Cohort results continue to improve year-over-year. 3rd line treatment available. Ongoing community sensitization regarding need to support adults and children on ART. Multi-sectoral collaboration has substantially increased outreach to HIV-positive children, including those on ART.	Maintaining community mobilization over the long term regarding supporting adults and children on ART. Managing need for 2nd and 3rd line therapies. Increasing coverage of ART for children. Supporting HIV-positive children, adolescents and youth.	Continue to collaborate with multi-sectoral partners to provide ongoing support to individuals on ART at community level. Undertake more participatory research to identify enabling factors for treatment adherence.

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
HIV and TB Collaborative Activities	Developing integrated patient management strategies of HIV/TB co-infected individuals. Identifying and managing MDR and XDR TB patients. Improving capacity for isolation of MDR and XDR patients. Strengthening community support for adherence of HIV/TB regimens.	Ongoing training of health care providers on HIV/TB co-management strategies. Improvement of district level facilities to identify MDR and XDR TB patients and to refer for appropriate care. Expansion of clinical facilities in northern and southern districts for treatment and management of MDR and XDR TB patients. Implementation of community mobilization and support interventions.	Capacity to identify and management MDR TB patients significantly improved through the Round 8 grant.		

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
Impact Mitigation	Mobilizing sufficient resources to provide for basic needs, including food security, safety, access to education and shelter. Encouraging and strengthening community-ownership of OVC challenges. Limited coverage of social protection services. Limited numbers of paralegals to cover the whole country effectively.	Engage Development Partners in resource mobilization activities. Scale-up implementation of community-oriented interventions addressing OVC. Roll-out LCGP to all districts. Maintain and increase support for school bursaries. Improve opportunities for TVET and provide start-up funds for IGA projects engaging OVC. Improve social protection systems at all levels (enact the Child Protection & Welfare Bill). FIDA should be supported to increase paralegal services.	CGP implemented in selected community council areas in 5 districts. Phase 2 plan to expand to 10 districts funded by EU and to begin in 2012. New OVC situational assessment and national strategic plan completed. Expansion of NFE and TVET opportunities through GF Round 9 grant. Expansion of school bursaries through GF Round 9 grant. Children's Protection and Welfare Act promulgated. Education Act promulgated. FIDA assisted through GF Round 8 grant to maintain and expand community-based support.	Limited human and financial resources to provide full national coverage for child protection programmes. Scale and scope of needs of vulnerable children surpasses what multi-sectoral partners can effectively address. Limited technical and operational capacity to provide effective safety nets for orphaned and vulnerable children.	

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
	National coordination mechanisms not functioning at full capacity. Inconsistent coordination and collaboration of multi-sectoral partners addressing OVC. Need for review and revision of national policy and coordination frameworks.	Build technical and programmatic capacity of NOCC and NOCC secretariat. Review, revise and strengthen national coordination frameworks. Continue support for NGO networking and collaboration activities.	Publication in-print and on-line of Letsema Directory of organizations working with children. Convening of monthly networking forums by Letsema. Capacity-strengthening plan for NOCC completed. New structure for Social Welfare leadership proposed.	National coordination mechanisms not functioning at full capacity. Inconsistent coordination and collaboration of multi-sectoral partners addressing OVC. Need for review and revision of national policy and coordination frameworks.	
	Incomplete coverage of OVC registration systems. Gaps in M&E framework, particularly at community level. Incomplete commitment from all stakeholders to improve M&E activities and to strengthen evidence-based interventions.	Ensure availability of birth registration in all districts. Strengthen M&E tools and coordination systems. Continue training and support to stakeholders on M&E systems.	Technical and operational capacity of DSW was strengthened. New M&E tools were developed and implemented. Some additional training on M&E systems and processes was provided.	Incomplete coverage of OVC registration systems. Gaps in M&E framework, particularly at community level. Incomplete commitment from all stakeholders to improve M&E activities and to strengthen evidence-based interventions.	

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
	Insufficient capacity to collect data on acts of stigma and discrimination at community level. Social environment remains hostile to the needs of key populations. Tension between social and cultural traditions and human rights perspective protecting fundamental rights and entitlements.	Improve media monitoring and other activities to measure intensity of stigma and discrimination. Increase support to key populations to develop public education materials. Scale-up community dialogue interventions to resolve apparent conflict s between cultural beliefs and the fundamental dignity of all Basotho	FIDA assisted through GF Round 8 grant to maintain and expand community-based support.	Insufficient capacity to collect data on acts of stigma and discrimination at community level. Social environment remains hostile to the needs of key populations. Tension between social and cultural traditions and human rights perspective protecting fundamental rights and entitlements.	
Leadership, management and coordination.	Some among the multi-sectoral partners still resist to be coordinated by the relevant structures. Duplication of coordination mechanisms. Insufficient technical capacity amongst stakeholders to develop effective and sustainable coordination mechanisms.	Review and revised coordination frameworks. Seek technical assistance to improve management and coordination mechanisms.	National Strategic Plan on HIV and AIDS 2012-2016 completed and released. New structure for NAS released and restructuring process commenced.	Prolonged process for restructuring of NAS caused gaps to widen in technical and operational capacity to lead and coordinate multi-sectoral response. New coordination framework remains outstanding.	Operationalise restructured NAS as soon as possible. Develop new management and coordination framework aligned to the restructured NAS and the new NSP.

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
Monitoring and Evaluation	Need for ongoing training and support for all stakeholders to improve data quality and to improve commitment to national M&E systems. Volume of ART patients and HTC clients that goes beyond current paper-based data collection systems. Ongoing differences amongst stakeholders regarding common indicators and common data collection and analysis processes (still too many partners who collect their own data for their own purposes).	Continue to provide training and support on M&E for all stakeholders. Invest in newer technologies to capture and analyze data from the community to the national level. Review and revised national M&E framework. Build consensus on national core indicator framework. Strengthen commitment to national goals and targets, including Universal Access and MDG goals.	Recruitment and deployment of data clerks at health centres to assist with data collection and management. Expansion of HMIS to district level for reporting and monitoring of ART and HIV/TB data.	Revised national M&E framework for new NSP remains outstanding.	Expedite completion and release of revised M&E framework. Re-engage national technical working groups through restructured NAC. Move forward on M&E systems strengthening activities.

NSP Component	2009		2011		
	Challenge	**Proposed Remedial Action**	**Achievements**	**Ongoing Challenges**	**Proposed Remedial Actions**
	Capacity to develop and manage research programmes still needs improvement.	Mobilize additional support for training and technical assistance for development and management of research programmes. Engage all stakeholders in the establishment of a national research council together with strong sectoral research coordination structures. Strengthen national coordination mechanisms for research initiatives. Identify and engage knowledge-brokers to translate research results into operational improvements for HIV and AIDS interventions.	Additional training and technical support secured through World Bank. National HIV and AIDS research agenda completed and released. 2009 LDHS completed and released. Epidemiological and behavioural study of LCS completed and released.	Prolonged restructuring of NAC has significantly delayed progress in addressing research needs.	Capacity to develop and manage research programmes still needs improvement.

7.0. CONTRIBUTIONS FROM DEVELOPMENT PARTNERS

Lesotho's national response to HIV and AIDS receives significant support from its Development Partners. These contributions are summarized below.

8.1 JOINT UN COUNTRY TEAM

Since 2008 in Lesotho, the UN system in Lesotho has been integrating their development assistance within one overall framework as part of the UN's global 'Delivering as One' initiative. This includes its efforts with respect to HIV and AIDS. The Joint UN Country Team on HIV and AIDS (JUNCTA) is guided by the Joint UN Plan of Support on HIV and AIDS (JUPSA).[62] The JUPSA is fully aligned to Lesotho NSP as well as the UN Development Assistance Framework 2008-2012. The UN family provide assistance to GOL and its non-governmental partners in all thematic areas within the NSP and the national response to HIV and AIDS, including prevention, treatment and care, impact mitigation and the creation of an enabling environment. Approximately 25% of the USD85 million budgeted within the UNDAF are targeted towards its HIV and AIDS priorities. UN-supported activities include capacity development within the health sector, particularly for provision of high quality ART to adults and children; systems strengthening both within the national HIV and AIDS response and across the health sector; support for evidence-based programming planning, implementation and review; advocacy and law and policy development; support to vulnerable groups; and, strengthening of country capacity to effectively coordinate the national multi-sectoral response to HIV and AIDS for high impact results. The JUPSA recently underwent external review for the period 2009 to 2011. The review found that the UN family had achieved significant results through its partnerships with the GOL and other non-governmental stakeholders.[63]

8.2 GLOBAL FUND TO FIGHT AIDS, TB AND MALARIA

Lesotho is currently implementing four grants under the Global Fund. The Round 6 grant supports capacity-building for TB prevention and treatment. The Round 7 grant supports paediatric HIV treatment as well as interventions for youth, both in and out of school, including high school bursaries for OVC. The Round 8 grant, the largest and most comprehensive in the country's portfolio, support all aspects of the HIV and AIDS response, including prevention, treatment and care. It also support health system strengthening, with a primary focus on improving health service delivery as well as health human resource retention. Finally, the Round 9 grant primarily supports high school bursaries for OVC and basic education for children and adolescents not enrolled in primary school.

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[62] The full programme document is available at http://www.undp.org.ls/hivaids/default.php

[63] Owolabi T and H. Woldemedhin. 2011. Report on the Review of the Joint UN Plan of Support on AIDS (2009-2011). Maseru, LS: UNAIDS.

8.3 PEPFAR AND OTHER UNITED STATES GOVERNMENT (USG) PARTNERS

PEPFAR remains one of Lesotho primary partners in the national response to HIV and AIDS. The partnership operates within the context of a 5-year partnership agreement covering the period 2010-2015. The nominal value of the partnership is USD29.2 million per year; however, the annual budget is still subject to approval by the US government. Between 2009 and 2011, PEPFAR support assisted the country to provide HTC, to enrol adults and children on ART, to manage HIV/TB co-infected individuals, to provide PMTCT and to support OVC. Going forward, PEPFAR will focus its support on HIV prevention interventions, care and support for OVC, and health systems strengthening. This latter category of support will include improving health human resource recruitment and retention, strengthening laboratories services, and support the construction of regional centres for the Lesotho Blood Transfusion Service. Finally, PEPFAR has assisted the MOHSW to establish the Institute for Health Measurement as way of institutionalizing the collection and use of comprehensive, valid and reliable data on health system and public health trends, more particularly HIV and AIDS.

8.4 MILLENNIUM CHALLENGE ACCOUNT

Since the signing of the Country Compact with the US government in 2007, the implementation of Lesotho's USD362 million Millennium Challenge Account (MCA) programme has been steadily moving forward. For the health sector component, MCA is support a variety of infrastructure projects, including refurbishment of health centre, construction of a national reference laboratory, expansion of facilities at the country's tertiary health training facilities, and construction of a new central blood bank. The MCA programme also has a substantial health systems strengthening component which supports health human resource recruitment and retention and, primarily, full decentralization of the country's health care delivery services, and improvement to the national Health Management Information System.

8.5 CLINTON HEALTH ACCESS INITIATIVE

The Clinton Health Access Initiative (CHAI) continues to operate its Lesotho Country Programme. CHAI's priority areas of intervention in Lesotho involve assisting the MOHSW to strengthening and expand paediatric HIV treatment, strengthen and improving quality assurance for country-wide laboratory services, strengthening the ability of health providers to provide high quality care to HIV-positive adults and children, contributing to health human resources recruitment and retention through the Rural Health Access Initiative, supporting the expansion of PMTCT, and assisting the country to develop operational research capacity.

8.6 WORLD BANK

Starting in 2010, the World Bank launched a second HIV and AIDS Technical Assistance Project. The 5-year programme, worth USD5 million, will assist a number of stakeholder to improve their participation within the national, multi-sectoral response to HIV and AIDS. This includes systems strengthening interventions for NAC, primarily in the domain of coordination and expenditure tracking, capacity strengthening for LCN in its role as a PR under the Global Fund Round 8 grant, and strengthening the capacity of the MOHSW to manage and promote health-related research programmes. In 2011, the World Bank began an initiative with the MOHSW in order to strengthen compliance with PMTCT protocols at the community level.

8.7 EUROPEAN UNION

The EU's primary contribution to the national HIV and AIDS response is through the CGP. In 2011, in collaboration with the GOL and UNICEF, the project launched in 2007 to support OVC came to a close. The CGP alone reached over approximately 10,000 destitute households support some 30,000 vulnerable children. The project also supported strengthening child protection systems, HIV prevention interventions for adolescents and youth, practical support to OVC (including food assistance and funds for educational needs), strengthening of capacity within the DSW, and strengthening of national programme coordination mechanisms, in particular the NOCC. A second phase of the CGP, also financed by the EU, will begin in 2012. In this phase, coverage of the CGP will be expanded from 5 to 10 districts. This new project will also continue to support capacity strengthening within the DSW and stronger mechanisms for multi-sectoral coordination for interventions addressing the needs of OVC.

8.8 IRISH AID

Irish Aid (IA) contributes to the national HIV and AIDS response through three main priorities: PMTCT, health human resources, and education sector programmes. IA works with the MOHSW and its other Development Partners to strengthen the national PMTCT programmes and, more broadly, to reduce high incidence of maternal, infant and early childhood death. Since 2006, in collaboration with the MOHSW and CHAI, IA has been the major contributor to the Rural Health Initiative. Through the partnership, IA has provided funding for human resources in health, in particular the temporary reinforcement of 150 additional nursing staff in mountain clinics. It has also supported the clinical mentorship programme (a form of on-the-job training), the engagement of PLWHAs to work in ART centres as 'expert patients' in order to provide help and support to others enrolled on ART, and additional resources for improvement of the country's programmes for training and continuing education of health care professionals.

IA also provides support for HIV and AIDS programmes within schools. This includes support for the MOET's life-skills curriculum taught at all levels of primary and secondary school. The programme combines information about general health and well-being with specific information on sexual and reproductive health and preventions of HIV-infection. IA also partners with a number of faith-based organisations, teachers unions and other grassroots groups to strengthen their response to HIV and AIDS.

8.9 DEUTSCHE GESELLSCHAFT FÜR INTERNATIONALE ZUSAMMENARBEIT (GIZ)

GIZ's primary contribution to the national HIV and AIDS response is through its work to support local government structures and decentralization. GIZ has provided financial and technical support to ensure that response to HIV and AIDS is a priority within local governments' community development and poverty reduction plans.

8.10 JAPANESE INTERNATIONAL COOPERATION AGENCY (JICA)

JICA continues to provide assistance to the MOHSW to improve the country's M&E capacity within the national, multi-sectoral response to HIV and AIDS. This involves providing opportunities for key stakeholders, such as CHAL and the National Health Training College, to strengthen their ability to collect, analyse and use data for the purposes of impact assessment and quality improvement.

8.11 OTHER EXTERNAL PARTNER CONTRIBUTIONS

Lesotho has many other external partners that contribute to its efforts to address HIV and AIDS. These include:

- Baylor International Paediatric AIDS Initiative for its support of the Children's Centre of Excellence for HIV treatment and care, both the Maseru and country outreach components;

- Partners In Health for its rural health initiatives and for its leadership in building country capacity to address MDR and XDR TB;

- Elizabeth Glazer Paediatric AIDS Foundation for its support of PMTCT and paediatric HIV and AIDS care;

- Boston University and the Kellogg Foundation, through the Lesotho Boston Health Alliance, for health system strengthening;

- Department for Foreign International Development (UK) for its interventions supporting children protection;

- Norwegian Agency for Development Co-operation for its support for programmes for people with disabilities; and,

- Canada Fund for Local Initiatives for supporting community-based projects for poverty reduction and health improvement.

Other partners include The Princes' Fund for its support of Sentebale and child protection and support interventions, the Mennonite Central Committee, the Swiss Development Corporation and the Government of China.

8.0. DOCUMENTATION OF BEST PRACTICE IN THE HIV/AIDS RESPONSE IN LESOTHO

8.1. MOTHER-BABY PACK

8.1.1 Background

The concept of mother-baby pack originated in Lesotho, where health-care workers would put medicines in plain brown envelopes for pregnant women living with HIV to take home and to use throughout the duration of their pregnancy. In 2007, the GOL included these packs in their national PMTCT strategy. They were known as minimum packs.

From this idea, UNICEF along with its partners developed the Mother-Baby Pack, which went beyond the initial pack and contained anti-retroviral drugs and antibiotics consistent with the latest WHO guidelines. With support from UNICEF, the Mother-Baby Pack is being rolled out in four countries: Cameroon, Kenya, Lesotho, and Zambia.

The Mother-Baby Pack is a colour-coded box with medications for use starting from week 14 of pregnancy until six weeks after the birth of the infant. After six weeks, mothers are asked to return to the clinics for regular immunizations, an early infant diagnosis test and further ARVs to stop potential infection during breastfeeding.

The Mother-Baby Pack was put in place to overcome the problem of women being unable to make repeated trips to health facilities during and after pregnancy, largely for reasons of geography and poverty. The Mother-Baby Pack overcomes these problems by giving all pregnant women, including those living with HIV, a complete, pre-packaged set of drugs to protect their own health and that of their infant before, during and after delivery.

8.1.2 Purpose

Everyday more than 100 children are infected with HIV during their mothers' pregnancy, labour or delivery, or through breastfeeding. In Lesotho, this can be attributed to pregnant women being unable to visit clinics and attend checkups regularly during pregnancy. The mountainous terrain of the country plays a huge role such that people reside in areas that are far from health centres with no roads or proper means of transportation.

The purpose of the Mother-Baby Pack is to tackle these logistical challenges in delivering critical medicines to pregnant mothers and their new-born babies. It contains antiretroviral drugs and antibiotics with instructions on how to properly take the drugs. These instructions are written in Sesotho so that they can easily be understood by the people using them. Health care workers take advantage of all pregnant women's first antenatal visit to provide them with the pack.

8.1.3 Effectiveness

The 2009 DHS demonstrated that over 90% of pregnant women attend anti-natal care at least once during their pregnancy, most often at 14 to 16 weeks. The provision of the Mother-Baby

Pack during this visit ensures that all pregnant women have means to maintain their health and that of their new-born child throughout and immediately after delivery. By providing the pack to all pregnant women, the potential for stigma or involuntary disclosure of HIV status within the family and the community is greatly reduced.

8.1.4 Cost-effectiveness

The provision of the pack, and its impact on maternal and infant morbidity and mortality, has not yet been comprehensively assessed from the perspective of cost-effectiveness. However, given its potential to reduce HIV transmission, and its potential to improve maternal and early infant health regardless of HIV status, the reduce costs in terms of lifetime mother or infant HIV treatment is likely to be substantially higher than the cost of the pack itself and the health system costs to provide it to all pregnant women.

8.1.5 Relevance

The Mother-Baby Pack is highly relevant in Lesotho where pregnant women regardless of social status or place of residence in the country engage the health system at least once during pregnancy. This represents the first and only time to screen and assist over 90% of pregnant women for the need for additional interventions, both PMTCT and maternal and early infant health generally.

8.1.6 Replicability

Since the Mother-Baby Pack builds on experience with the minimum package intervention for PMTCT, it has been relatively problem-free to roll-out quickly to all health centres in communities across the country. Through the global effort of UNICEF, it has been shown that such an intervention can be replicated in a variety of different settings in HIV-affected developing countries around the world.

8.1.7 Innovativeness

The particular innovation of the Mother-Baby Pack intervention in Lesotho is that it is offered to all pregnant women regardless of HIV status. This is highly appropriate given serious rates of maternal and infant death prior to, during and after child-birth. three types of packages are being provided; (1) for pregnant women who are HIV-negative, (2) for pregnant women who are HIV positive and on prophylaxis, and (3) for pregnant women who are HIV positive and on ART.

8.1.8 Sustainability

In addition to the GOL, the Mother-Baby Pack programme in Lesotho is receiving support from UNICEF, EGPAF and CHAI. UNICEF provides the packaging materials and contributes to the printing of instructional pamphlets and labels. The packs are made at NDSO which provides the ARVs and other health-promoting contents of the package. EGPAF and CHAI also contribute to the contents of the pack as well as providing clinical support to health centres

distributing the packs. The GOL is currently moving to include more of the ongoing costs of the programme within its annual recurrent budget.

8.2. STATEMENT OF COMMITMENT FROM HIV PREVENTION SYMPOSIUM NOVEMBER 2011

We, the participants in the national HIV Prevention Symposium held from November 29-30, 2011, at the Manthabiseng Convention Centre, which brought together 300 delegates from public and private sectors, including faith leaders, traditional leaders, political leaders, people living with HIV and AIDS, women's groups, young people, academia, civil Society, most at risk population and people with disabilities;

Having deliberated on the status of HIV prevention in the country and taking cognizance of the United Nations High Level Meeting's Political Declaration on AIDS and the UNAIDS strategy for zero new infections, zero discrimination and zero AIDS Related deaths by 2015;

Having agreed that:

- The current HIV incidence levels of 18,000 new infections per year are unacceptably high;
- Multiple and concurrent sexual partners and intergenerational sex are the drivers of the epidemic;
- There is poor male participation in HIV prevention efforts;
- There is poor utilisation, availability and accessibility of male and female condoms;
- There has been no national roll out of male circumcision; and, that
- Women and young people are the most vulnerable groups.

We therefore commit to the following:

- Ensuring elimination of new paediatric HIV infections and keeping mothers alive;.
- Scaling up of male circumcision including collaboration between the Ministry of Health and Social Welfare and the initiation schools;
- Engaging in high level advocacy for greater involvement of people living with HIV and AIDS at all stages of HIV Prevention Revitalisation Plan;

- To use evidence to plan for interventions, including setting of targets and determining progress and performance of the HIV Prevention Revitalisation Plan;
- Ensuring accessibility of user-friendly HIV information, education and communication material for people with the disabilities;
- Advocating to all stakeholders to include HIV prevention services for people with disabilities in their programmes;
- To developing a private sector HIV and AIDS strategic plan that is aligned to the new National Strategic Plan on HIV and AIDS 2011/12- 2015/16;
- To implement the Public Service HIV and AIDS Policy at individual ministries;
- Advocating for a posting policy which ensures family cohesion and stability;
- Being the change we want to see in our communities through role modelling;
- Knowing our HIV status and encouraging others to do the same;
- To practise safer sex by observing the ABCs of HIV prevention;
- To strengthen pre-marital and post –marital counselling to reduce instances of multiple and concurrent partnerships;
- To promote sexual and reproductive health education among couples and youth;
- To promote and support youth movements for HIV prevention;
- To mobilizes recourses for the implementation of the National Action Plan for Women, Girls and HIV and AIDS;
- To identify and strengthen positive traditional practices that support HIV prevention and discourage harmful practices;
- To promote and implement positive prevention by people living with HIV and AIDS;
- To ensuring healthy and responsible youth within educational institutions;
- To support development of local research on HIV and AIDS, infrastructure and utilisation of research for policy formulation and implementation.

These commitments will be translated into actions in the national HIV Prevention Revitalisation Plan and resources mobilized for implementation. The status of the implementation will be reported to the next symposium.

9.0. LIST OF ORGANISATIONS THAT PARTICIPANTED IN THE 2011 UNGASS PROCESS

LINE MINISTRIES AND GOVERNMENT AGENCIES

Ministry of Agriculture, Food Security and Disaster Management
Ministry of Education and Training
Ministry of Finance and Development Planning
Ministry of Gender, Youth, Sports and Recreation
Ministry of Health and Social Welfare
Ministry of Local Government and Chieftainship
Lesotho Correctional Services
Lesotho Defence Force
Lesotho Mounted Police Services

DEVELOPMENT PARTNERS

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

UN AGENCIES

UNAIDS and WHO (for the UN Country Team)

NON-GOVERNMENTAL ORGANIZATIONS

Apparel Alliance Lesotho to Fight AIDS
Baylor Children's Clinical Center of Excellence on HIV and AIDS
CARE Lesotho/South Africa
Elizabeth Glazer Paediatric AIDS Foundation
ICAP
Lesotho Council of NGOs
Lesotho Inter-religious AIDS Consortium
Lesotho National Federation of Organizations for the Disabled
Lesotho Network of AIDS Service Organizations
Lesotho Network of People Living with HIV and AIDS
Lesotho Red Cross Services
Lesotho Youth Federation
Matrix Discussion Group
Monna ka Khomo/Lesotho Herd Boys Association
Non-governmental Coalition on the Rights of the Child
PACT Lesotho
Partners in Health
Population Services International
Solidarmed
Touch Roots Africa
National University of Lesotho
Sentebale
Private Medical Practitioners
Private Medical and Nursing Clinics

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