The Kingdom of Lesotho

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

September 2013

The Kingdom of Lesotho

National HIV and AIDS Strategic Plan 20011/12 – 2015/16

Government of Lesotho
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Acronyms

ABC	Abstinence Be faithful and Condomise
AIDS	Acquired Immuno-Deficiency Syndrome
AIS	AIDS Indicator Survey
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ANC	Ante Natal Care
ART	Antiretroviral Therapy
AU	African Union
BCC	Behaviour Change Communication
BOS	Bureau of Statistics
BSS	Behavioural Surveillance Survey
CBO	Community Based Organisations
CCAC	Community Councils AIDS Committees
CCM	Country Coordinating Mechanism
CCP	Comprehensive Condom Programming
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CGPU	Child and Gender Protection Units
CHBC	Community Home Based Care
CITC	Client Initiated Testing and Counselling
CPWA	Children's Protection and Welfare Act (2011)
CRC	Convention on the Rights of the Child
CRIS	Country Response Information Systems
CSO	Civil Society Organisations
DAC	District AIDS Committee
DHS	Demographic and Health Survey
DPSC	Directorate of Policy Strategy and Communication
EID	Early Infant Diagnosis
ESP	Essential Services Package
EU	European Union
FBO	Faith Based Organisations
FIDA	Federation of Women Lawyers
FP	Family Planning
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS Tuberculosis and Malaria
GIPA	Greater Involvement of People Living with AIDS
GOL	Government of Lesotho
HAART	Highly Active Antiretroviral Therapy
HASI	HIV and AIDS Stigma Index
HDI	Human Development Index
HIV	Human Immune Virus
HMIS	Health Management Information Systems
HTC	HIV Testing and Counselling
IC	Infection Control
ICF	Intensified Case Finding
IDU	Injecting Drug Users
IEC	Information Education and Communication
IPPA	Independent Private Practitioners Association

IPC	Interpersonal Communication
IPT	Isoniazid Prevention Control
ISIA	Independent Sector Institute Assessment of the HIV and AIDS Sector
KAP	Knowledge Attitudes and Practice
KYS	Know Your HIV Status
LBTS	Lesotho Blood Transfusion Services
LCMPA	Legal Capacity of Married Persons Act
LCS	Lesotho Correctional Services
LDHS	Lesotho Demographic and Health Survey
LMPS	Lesotho Mounted Police Service
LOMSHA	Lesotho Output Monitoring system for HIV and AIDS
LVAC	Lesotho Vulnerability Assessment Commission
M&E	Monitoring and evaluation
MARP	Most At Risk Populations
MC	Male Circumcision
MCHC	Maternal and Child Health Care
MCP	Multiple Concurrent Partners
MDG	Millennium Development Goals
MDR-TB	Multi-Drug Resistance Tuberculosis
MGYSR	Ministry of Gender, Youth, Sports and Recreation
MOAFS	Ministry of Agriculture and Food Security
MOET	Ministry of Education and Training
MFDP	Ministry of Finance and Development Planning
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MOJCS	Ministry of Justice and Correctional Services
MOLCA-HR	Ministry of Law, Constitutional Affairs and Human Rights
MOLE	Ministry of Labour and Employment
MOLGC	Ministry of Local Government and Chieftainship
MOP	Ministry of Police
MOSD	Ministry of Social Development
MOT	Modes of Transmission (study)
MSM	Men who have sex with other Men
MTCT	Mother To Child Transmission
MTR	Mid-Term Review
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment
NISSA	National Information System for Social Assistance
NCPI	National Composite Policy Index
NSDP	National Strategic Development Plan
NDSO	National Drug Service Organisation
NGO	Non-Governmental Organisation
NOCC	National OVC Coordinating Committee
NOP	National Operational Plan
NSP	National Strategic Plan
NSPVC	National Strategic Plan for Vulnerable Children
NTCP	National Tuberculosis Control Programme
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children

PREP	Pre Exposure prophylaxis
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PHDP	Positive Health Dignity and Prevention
PEPFAR	President's Emergency Programme for AIDS Relief
PITC	Provider-initiated Testing and Counselling
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PNC	Post Natal Clinic
PWD	People With Disability
RBM	Results Based Management
RH/FP	Reproductive health / Family planning
S&BC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SACU	Southern African Customs Union
SADC	Southern African Development Community
SAM	Services Availability Mapping
SGBV	Sexual and Gender Based Violence
SOA	Sexual Offences Act
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex Worker
TasP	Treatment as Prevention
TB	Tuberculosis
TIP	Trafficking in Persons
TTI	Transfusion Transmissible Infections
TWG	Technical Working Group
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VC	Vulnerable Children
VMMC	Voluntary Medical Male Circumcision
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WLSA	Women and Law in Southern Africa Research and Education Trust
XDR-TB	Extensively Drug Resistance – Tuberculosis

Foreword

The national multisectoral and decentralised HIV response has been guided by a series of National Strategic Plans (NSP) for HIV and AIDS. The current strategic plan was launched by, His Majesty the King Letsie III, on December 2011. The plan covered interventions around four thematic areas of HIV prevention, treatment care and support, impact mitigation, response coordination and management.

The development of the NSP emphasised the use of available evidence to inform decisions and choices on interventions, focused on results, and mainstreamed gender and human rights in all aspects of the plan from the design, implementation, to monitoring and evaluation of the response. The implementation of the NSP is multi-sectoral, multi-layer and decentralised in order to provide equal opportunities for all stakeholders to actively participate based on their institutional mandate and comparative advantage. The involvement and participation of communities, civil society organisations (CSO) and PLHIV has been particularly strategic to the implementation of the plan.

In June 2013, the Government of Lesotho commissioned an independent rapid mid-term review (MTR) of the strategic plan. The purpose of the MTR was three fold. First, to assessment the extent the NSP has been implemented and the efforts made towards achieving the outcomes and output results articulated in the NSP Results Framework. Second, the MTR was intended to generate strategic information necessary to inform the revision of the NSP for the remaining period between 2013 and 2015. Third, determine the programmatic and financial gap of the national response.

The midterm review was conducted against a background that Lesotho remains among the countries with a high HIV prevalence and incidence in the world. Despite all the efforts and investments in the national HIV and response, Lesotho had not realised the desired outcomes. This has necessitated changing the planning and operational paradigms of the national response.

The review of the NSP is therefore premised on the “investment thinking” – investing for results. The thinking requires prioritisation of core programmes that have the potential to achieve the desired outcome results by 2015, based on adequate and bold investments, coupled with strong political leadership, country ownership and complemented by a global solidarity. In the case of Lesotho, the investment thinking also dictates that we do business differently, by investing our resources for results, in addition to improving on the quality of services, expand access and utilisation, and in particular strengthen efficiencies and effectiveness in planning, coordination and service delivery.

Lesotho is committed to reduce new HIV infections in adults and children, reduce AIDS-related deaths, and TB deaths associated with HIV and AIDS by 50% by 2015. The Kingdom is also committed to eliminate new infections among children while keeping mothers alive. Our focus should be first and foremost, aiming to get value for money we invest in the response, and secondly getting better health outcomes – improved quality of life of our people. It is only two years to 2015 – a very short time by any means. It is my sincere hope that all stakeholders will accord the implementation of the NSP the urgency it deserves. It is our duty to insure the future of our children through the actions we take today. An AIDS Free generation is possible within our times.

It is my sincere hope that all stakeholders will join work together to stop the spread of HIV. We have the means and the ability to win the battle.

Dr. Thomas Motsoahae Thabane
The Rt. Honourable Prime Minister
Prime Minister’s Office

Acknowledgements

The revision of the NSP has been a joint effort between the Government of the Kingdom of Lesotho and the many and diverse stakeholders and development partners. The review process was facilitated by, the Ministry of Health. The joint efforts have generated the data and information useful in making informed decision on interventions that Lesotho should invest in for better health outcomes.

The Government of Lesotho wishes to acknowledge with gratitude the valuable support and contribution of the different stakeholders and development partners who made the midterm review and the revision of the NSP possible.

In particular, the Government of Lesotho wishes to express its special thanks and appreciation to the Ministry of Health for coordinating the process in the absence of the National AIDS Commission secretariat, the various technical and thematic working groups that provided technical and policy oversight and advice. The Government further wishes to thank all the organisations and individuals who have participated in the midterm review and the revision of the NSP. Their participation ensured the quality, technical soundness and comprehensiveness of the revised NSP.

Special thanks goes to Global Fund Coordinating Unit (GFCU) for providing the financial support to the process and to Joint United Nations Programme on HIV and AIDS (UNAIDS) – Lesotho Country Office, for coordinating technical and financial assistance from the United Nations (UN) agencies. The Government further wishes to acknowledge the technical backstopping including by facilitating a programmatic gap analysis by the UN Regional AIDS Team Eastern and Southern Africa (RATESA) team and the UNAIDS Technical Support Facility (TSF) for East and Southern Africa for their support in identifying international consultants to support the process.

The Government is grateful to the team of consultants who facilitated the process and put together the information into the midterm review report and the revised strategic plan. The team of consultants composed of Dr Simon Muchiru - Lead consultant, Dr. Limpho Maile, Dr. Joan Manuel Claros, Adv. Libakiso Matlho, Ms. SeforaTšiu, and Ms. Mantiti Khabo. Without their dedication and commitment the compilation of the MTR report, the revised NSP and the programmatic gap would not have been possible.

Finally I want to express my sincere gratitude to the staff of the Ministry of Health and in particular Mr. John Nkonyana, Director of Disease Control Directorate, and Ms. Puleng Ramphalla-Phatela, Manager of STI, HIV and AIDS programme for their special commitment and tireless efforts in ensuring that the success of the project. They worked beyond the call of duty to make sure we succeeded in finalising the documents

Dr. Pinkie Rosemary Manamolela
Honourable Minister
Ministry of Health

Executive summary

The National Strategic Plan (NSP) – 2011/12 to 2015/16 is a five-year multisectoral and decentralised HIV and AIDS plan. In developing the strategic plan Lesotho shifted the planning paradigm to evidence-based planning and investing for results. The NSP has also mainstreamed gender and human rights in its operational strategies and performance indicators.

In June 2013 the Government of Lesotho commissioned an independent mid-term review (MTR) of the strategic plan. The results of the mid-term review have been used to inform the revision of the NSP for the remaining period 2013 to 2015, developing a programmatic gap analysis, and re-positioning the national response in line with the "strategic investment for results" thinking.

The MTR and the revision of the NSP process has been participatory involving many stakeholders ranging from public and private sector representatives civil society organisations (CSO), people living with HIV and representatives from the districts and development partners.

Synopsis of the epidemiology of HIV in Lesotho

The epidemic remains the most important obstacle to sustainable human and socioeconomic development in Lesotho. Lesotho is one among the countries with the highest HIV incidence and prevalence in the world. In 2012, the annual incidence was estimated at 2.47% among adults aged 15-49 years and HIV prevalence at 23%. Prevalence is higher in urban (27.2%) compared to rural (21.1%) areas. Among young people aged 20-24 years HIV prevalence is estimated at 16.3%. Prevalence is highest (+40%) among people aged 30-39 years. Overall prevalence is higher in women (26.7%) compared to men (18%)[1] (LDHS, 2009).

The midterm review noted that the epidemic has not changed since the last Lesotho Demographic and Health survey of 2009 and neither the epidemic drivers. However, poverty and food insecurity has been identified as additional new drivers of the epidemic.

Alignment of the National HIV and AIDS response to the National Socio-economic Development

The national multisectoral response is anchored in the broader national social and economic development framework. At national level the response priorities are aligned to Vision 2020, National Strategic Development Plan 2012/13 -2016/17, National health policy and the National Multisectoral HIV and AIDS Policy. At the global level the NSP is responsive to Lesotho's regional and global commitments and in particular the Millennium Development Goals (MDG), the 2011 Political Declaration on HIV and AIDS, the SADC Maseru Declaration, and the African Union Roadmap for Shared Responsibility and Global Solidarity for HIV, TB, and Malaria in Africa.

Lesotho's priority commitments on HIV and AIDS

The following are the priority commitments for the Kingdom of Lesotho for its national HIV and AIDS response

i. Reduce new HIV infections by 50% by 2015.
ii. Reduce AIDS related deaths, and in particular PLHIV with TB/HIV co-infection.
iii. Eliminate mother to child transmission while keeping mothers alive.
iv. Improve efficiency and effectiveness of the national response planning, coordination and service delivery.

NSP Core Programmes, Critical Enablers and Development Synergies

To achieve the above commitments, Lesotho has prioritised five-core programme, whose effective and efficient implementation is likely to result to the desired results. The prioritisation is premised on both national and global evidence of the programmes efficacy. It is in these programmes that Lesotho will invest adequately to ensure achievement of desirable results. These programmes are -

i. Treatment, Care and Support.
ii. Elimination of Mother to Child Transmission of HIV.
iii. Voluntary Medical Male Circumcision.
iv. Condom promotion and distribution.
v. Prevention of new infections among key populations through targeted programmes.

Available global evidence shows that treatment is the most effective strategy for prevention and for improving the quality of life for those already living with HIV and AIDS. With improved provider initiated testing and counselling, and the adoption of CD4 350 eligibility criteria treatment uptake has significantly improved. The Government of Lesotho also provides funding for 70% of all ARV drugs. Between 2013 and 2015 ART coverage will be scaled to 80%. It is also suggested that the eligibility criteria be reviewed from 350 CD4 cell count and adopt a threshold of 500 CD4 cell count in line with the new WHO guidelines. Lesotho will also continue providing test and treat for HIV+ mothers, HIV+ children under 5 years and people with TB/HIV co-infection and those with HIV / Hepatitis B co-infection. Treatment of the positive partner in sero-discordant couples will also be introduced.

Lesotho aims to eliminate mother to child transmission (MTCT) of HIV. Emphasis will be on prevention of new infections among children while keeping their mothers alive. Primary prevention interventions will be integrated at PMTCT sites to ensure that pregnant women who are not HIV positive remain HIV negative. Services will be scaled up and integrated in all related paediatric care and support services. Special attention will be paid to providing services to avert unintended pregnancies amongst PLHIV and teenage girls. Lesotho will accelerate the roll out of option B+, in addition to test and treat to all under age of 5. All infected mothers will be offered ART to prevent MTCT

Interventions on voluntary medical male circumcision will target sexually active men aged 15 to 39 years, while continuing targeting of neonates and males less than 14 years—for long-term sustainability.

Strategies to facilitate promotion and distribution of condoms will be intensified and coverage expanded, condom outlets established in user-friendly locations especially for young people and key populations. Condom use awareness will target key populations at higher risk of HIV infection including discordant couples, migrant workers and mobile populations in addition to the general population.

There is a lack of data on key populations, except on prison inmates. A Behavioural Surveillance Survey (BSS) on key populations will be in 2014. Support will be provided to CSO working with key populations to intensify their targeted programmes and expand coverage. Advocacy work will be intensified to strengthen the social, policy and legal enabling environment.

Social and behaviour change communication and HIV Testing and Counselling are considered cross as cutting themes in all core programmes. Key focus will be on demand creation, making services available and accessible, client retention in HIV treatment, and ensuring efficiency and effectiveness of service delivery. Social and behaviour change communication (SBCC) is a key strategy for demand creation, and improvements in retention especially on treatment. The involvement of CSO and communities, PLHIV, political, religious and community leaders is a pre-requisite for SBCC. SBCC interventions will be target specific, implementation will be intensified and coverage expanded. Service providers (duty bearers) will be

held accountable for services while service beneficiaries (rights holders) will be encouraged to access and utilise services

Successful implementation of the above-prioritised core programmes will also depend on the extent critical social and programme enablers are identified and adequately implemented. The social enablers that have been identified include: political commitment and advocacy, laws, legal policies, and practices, community engagement and mobilization, stigma reduction, use of mass media and local responses to change risk environment. The programme enabler's range from community centred design and delivery, programme communication (to galvanise support for behaviour change programmes), procurement and supply chain management, gender equality and gender-based violence interventions, research and innovation in addition to engaging local policy decision makers.

Development Synergies between social protection, systems (health and community) strengthening, food security, care and support of orphan and vulnerable children will be strengthened. The NSP will support interventions promoting a paradigm shift from social welfare to social development through multi-sectorial coordination with joint work plans and budgets

Impact of Scaling up Treatment and HIV Preventions Services

Scaling up programs to meet the targets of the Investment Framework would produce significant benefits including averting nearly 100,000 new HIV infections, nearly 60,000 AIDS-related deaths and close to 180,000 orphans and three fold reduction in MTCT rate. The incremental expenditure for the Investment Framework scenario results in a finding of $7,153 per infection averted and $11,953 per death averted. The most cost effective individual interventions are male circumcision, condom promotion, and prevention programs for sex workers and clients. About USD 674 million will be required to invest in impactful HIV programmes. The total resources available to fund the HIV and AIDS in Lesotho between 2013 and 2016 is USD437 million resulting in a USD237 million financial resource gap required to be mobilised to fully fund the HIV and AIDS response in Lesotho between 2013 and 2016. With this investment, about USD100million will be saved per year as a result of averting new HIV infections and deaths. These saved resources would have been required to put patients on lifetime ARV treatment.

Section 1: Introduction

1.1 Background Information

The National Strategic Plan (NSP) is a five-year multisectoral and decentralised HIV and AIDS plan that covers the period from April 2011 to March 2016. In developing the strategic plan Lesotho shifted the planning paradigm to evidence-based planning and focused on strategic investments for measurable results. The NSP also mainstreamed gender and human rights strategies and indicators.

In June 2013 the Government of Lesotho commissioned an independent mid-term review (MTR) of the strategic plan. The results of the mid-term review have been used for revising the NSP for the remaining period between 2013 and 2015, developing a programmatic gap analysis, and re-positioning the national response in line with the "investment for results" thinking. The MTR and the revision of the NSP process has been participatory involving a wide range of stakeholders from government ministries and parastatal organisations, civil society organisations (CSO), faith based organisations (FBO), Community-Based Organisations (CBO) people living with HIV and AIDS, private sector, representatives from the districts, and development partners.

1.2 Country Context

The Kingdom of Lesotho is landlocked and surrounded by South Africa with a surface area of 30,355[2] square kilometres. The population is estimated to be 1,876,633 people[3]. Seventy-seven percent (77%) and 23% of the population live in rural and urban areas respectively. Fifty eight percent (58%) of the population is under 19 years of age. Women make up 51% of the total population. Fifty six percent (56.6%)of the population live below the national poverty line. 43.4%[4] live on one dollar a day and are considered to live in vulnerable households often headed by a female[5]. The intensity of deprivation is estimated at 44.1%. The male to female ratio is estimated to be 95:100[6]. The population growth rate has declined from 1.5% in 1996 to 0.08% in 2006. This is the lowest population growth rate in Southern Africa countries. Life expectancy at birth has improved from 45.9[7] in 2010 to 48.7 years in 2013[8].

UNDP estimates the Human Development Index for Lesotho has improved from 0.427 in 2010 to 0.461 in 2013[9]. The current Gross Domestic Product (GDP) is US$1.6 billion with an estimated growth rate of 4.4% in 2010[10]. The richest quintile of the population controlled 60% of the income while the poorest quintile shared 2.8% of the total income in 2010[11]. The adult literacy rate is estimated at 89.6%, with 13% of the people aged 25 years and older having at least a secondary education. Agriculture contributes 7% of the GDP while manufacturing contributes 17%. Diamond mining and quarrying contribute approximately 9% of the GDP. The contribution of service industry is estimated at 60%. The average growth rate of imports has stagnated at 2% since 2009[12]. The main sources of revenue for Lesotho have been remittances from Basotho employed mainly in South Africa and other foreign countries, revenue from the Southern African Customs Union (SACU), and royalties from the export of natural resources such as water and diamonds. These exports were affected by the global credit crisis at the end of 2008. The Government of Lesotho, the mining sector in South Africa and the Lesotho textile industry are the major sources of employment[13].

Despite the socio-economic progress made in the last decade approximately 56.3% of the population continue to live below the national poverty line[14]. In 2008, the Bureau of Statistics (BOS) estimated 22.7% people were unemployed.

The HIV and AIDS epidemic in Lesotho is fuelled mainly by behavioural, social and structural drivers. In 2009, HIV prevalence marginally declined from 23.2% to 23%, in 2008[15]. The mid-term review of the drivers and other factors that fuel the spread of HIV shows that this has not changed. However, it seems that food insecurity and poverty have worsened increasingly becoming notable drivers of the epidemic.

Lesotho has made significant progress in bio-medical prevention of HIV. What remains a challenge are the social and structural drivers and factors that influence the epidemic. For this reason, Lesotho has anchored HIV and AIDS in the broader socioeconomic development framework that includes HIV and gender as cross cutting issues in the National Strategic Development Plan (NSDP).

1.3 National Priority Commitments

The following are the priority commitments for the national multisectoral HIV and AIDS response by 2015/16:

i. Reduction of new HIV infections by 50% by 2015
ii. Reduction of AIDS related deaths among people living with HIV and AIDS by 50% by 2015.
iii. Elimination of mother to child transmission and keep mothers alive
iv. Improve efficiency and effectiveness of the national response planning, coordination and service delivery

1.4 Alignment and Linkages with National, Regional and International Frameworks

The national multisectoral response is anchored in the broader national social and economic development framework. At national level the response priorities are aligned with the goals of Vision 2020, National Strategic Development Plan (NSDP, 2012), National Health Policy and the National Multisectoral HIV and AIDS Policy. At the global level the NSP is responsive to the Lesotho's regional and global commitments and in particular the Millennium Development Goals (MDG, 2000), the 2011 Political Declaration on HIV and AIDS, the SADC Maseru Declaration (2003) and the Africa Union Roadmap on Share Responsibility and Global Solidarity for AIDS, TB, and Malaria for Africa.

1.5 The Epidemiology of HIV in Lesotho

Lesotho has a generalised HIV epidemic, with possible small pockets of concentrated (i.e. men who have sex with men) sub-epidemics. HIV prevalence among people aged 15-49 is estimated 23%[16, 17]. HIV prevalence in urban areas is 27.2%, higher when compared to that of rural areas at 21.1%. The increased urban prevalence may be attributed to a number of factors including rural urban migrations where most people settle in informal settlements where vulnerability to HIV is increased when they exhibit higher risk taking behaviours such as transactional sex. The Modes of Transmission analysis report of 2009 noted that both urban and rural prevalence seems to be stabilising.

In 2012, approximately 23,000 new adult infections and 4000 new infections among children occurred. Fifteen thousand (15,000) women are infected annually compared to 12,000 men. However, available evidence indicates that the annual HIV incidence in adults (15-49) has stabilised at approximately 2.3% (2012), having dropped from 3.55% in 2000[18] and a peak of 5.05% in 1997. Between 2002 and 2012, new infections in children 0-14 years dropped from 6,100 to 3,700. The decrease in incidence is associated with a number of reasons including a decrease in adult incidence, reduction of the risk of mother to child transmission of HIV due to improved uptake of PMTCT and ART interventions. PMTCT uptake has increased from 51% in 2010 to 59.2% in 2012[19].

Data form the 2009 LDHS 2009 show that HIV prevalence is lowest (3.5%) among young people aged 15-19 years (women - 4.1%; men - 2.9%). Among adults aged 20-24 years, the prevalence is estimated at 16.3% (women - 24.1%, men - 5.9%)[20]. The highest prevalence is among people aged 30-39 years at over 40%. Overall prevalence is higher in Women (26.7%) than in men (18%)[21] aged 15-49 years[22]. It is highest (42.3%) among women aged 35-39 years and men (40.2%) aged 30-34 years. The Modes of Transmission analysis of 2009 indicates that the prevalence differentials between women and men could be due to biological susceptibility, age of sexual debut and age-mixing patterns in sexual relationships[23].

Sentinel survey results from 2009 to 2011 show improvements in HIV prevalence. The overall HIV prevalence among ANC clients declined from 27.7% in 2009 to 24.3% in 2011. Among STI clients, HIV prevalence improved but remained high going from 54.5% to 47.9% in the same period of time. The percentage of mothers who know their HIV status increased from 63.3% to 66.35% from 2009 to 2011 respectively (it was 41.9% in 2007)[24]. The prevalence of HIV among ANC clients who had Syphilis improved from 55.9% in 2009 to 38.8% in 2011 (42.1% in 2007). Among syphilis non-reactive clients HIV prevalence was 27.2% in 2009 and 23.9% in 2011. Among ANC clients Syphilis prevalence was 1.5% in 2009 and 2.5% in 2011. The high HIV prevalence among ANC with STIs points at the presence of STIs as one of the drivers of HIV and AIDS (47.9% in 2011). STI is among the top ten causes of OPD attendance in Lesotho. The number of STI clients increased from 2009 to 2012. In 2009 of the 1,321,838 new OPD contacts, about 69093 (5.2%) were STI clients. In 2012, 8% (101,777) of the total number of new OPD patients had an STI. In 2012, vaginal discharge was the most common syndrome at 37.8% followed by urethral discharge at 15% and lower abdominal pain at 7.5%.[25]

In 2011, the proportion of ANC mothers who had been treated for TB was 3.3% compared to 2.7% in 2009. Among the clients who were treated for TB, 41.8% were found to be HIV positive compared to 63% in 2009.[26]; and, 75% of those treated for TB were found to be HIV infected In 2012[27]

The Modes of Transmission (2009) data analysis[28] shows that almost half of new infections are likely to come from individuals with one sex partner 48.5% (35.2% - 61.8%). Individuals with more than one sexual partner will contribute 23.75% (16.5%-21.0%) while partners of individuals with more than one sex partner will contribute 21.5% (15.3% - 27.7%). Sex workers will contribute 0.5%, while their clients are expected to contribute 0.7%. However, the partners of clients of sex workers will contribute up to 1.75% (1.7%-1.8%). Overall discordance in males is estimated at 7.2% while in women it is estimated at 9.2% (LDHS, 2009).

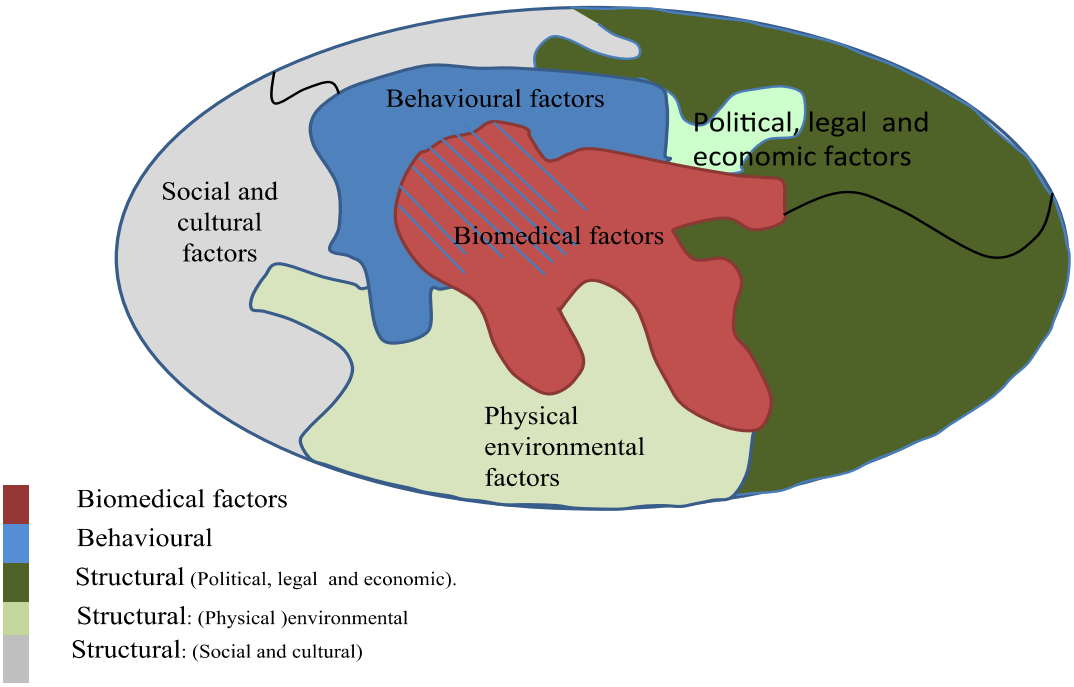
An estimated 3-4% of all new infections is likely to occur among men who have sex with men (MSM) and their female partners. At the time of this review, there were no data on injecting drug users (IDU) in Lesotho. It is assumed that blood transfusion will not contribute to new infections because 100% of donated blood is screened for HIV as a standard procedure.

Drivers of the epidemic

The MTR findings indicate that there is no new data showing any changes in the drivers and other factors influencing the spread of HIV in Lesotho since 2011. This finding confirms the evidence presented in the LDHS (2009), MOT (2009), GARP report (2011), and the Situation Analysis for the National Multisectoral HIV prevention strategy 2011-2015 (2011).

Figure 1 - Illustrates the interacting causes of HIV risk and vulnerability and table 1 unpacks these interaction causes in the context of Lesotho.

Figure 1: Interacting Causes of HIV Risk and Vulnerability



Source: *UNAIDS (2010): Combination HIV Prevention – Tailoring and coordinating biomedical, behavioural and strategies to reduce new HIV infections; Discussion paper*

Table 1: Unpacking the interacting causes of HIV risk and vulnerability

Bio-medical	Behavioural	Social	Structural
• Low levels of safe MMC • Presence of STIs • Early age of sexual debut among young females. • High viral load levels.	• Low, and inconsistent condoms use. • Multiple and concurrent partnerships • Alcohol and drug abuse. • Low perception of personal risks to HIV infection.	• Peer pressure. • Inter-generational sex. • Transactional sex. • Male dominated gender norms. • Sexual and gender based violence. • Erosion of traditional values	• Gender inequality. • Poverty / Income disparities. • Mobility and migration • Food insecurity

1.6 The NSP implementation Arrangement

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

A National Operational Plan (NOP) will be developed (in 2013) to guide the overall multisectoral operationalisation and implementation of the NSP. The NOP will articulate output results and the corresponding activities. It will further indicate suggested activity implementation timeframes, lead and collaborating implementing partners.

The National M&E Plan will also be developed to facilitate the joint monitoring and evaluation of the national response. The M&E will provide among other information a results-framework, priority indicators and targets for the national response. The M&E plan will also define all the national indicators to avoid misinterpretation.

Coordination of the response will be premised on the structures described in Section 3.7 below.

Section 2 Core Programmes

Overview

The following core programmes were prioritised based on national and global evidence of their efficacy and their potential to contribute to the desired impact results. The prioritisation is also aligned to the "investing for results" thinking that is premised on empirical evidence.

For the period 2013 to 2015, Lesotho has prioritised the following core programmes -

i. Treatment, Care and Support,
ii. Elimination of Mother To Child Transmission (eMTCT)
iii. Voluntary Medical Male Circumcision (VMMC)
iv. Condom promotion and distribution
v. Prevention of new infections among key populations

Table 2: Impact Indicators

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	Prevention	*Result 1 General Population, Key Populations and their clients adopt safer sexual behaviour , reduce sexual transmission of HIV by 50% & keep at least 85% of PLHIVs on treatment alive by 2015/16*			
Impact	Prevention	Percentage of young women and men aged 15–24 who are HIV infected	Women 13.6% Men 4.2% LDHS, 2009	Women 10% Men 3.2%	Women 7% Men 2.1%
Impact	Treatment	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	2010-74%	72%	85%
Impact	Prevention	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	MTCT at 6 weeks –10.02% (2010) MTCT including breastfeeding – 24.97% (2010) (2012 Spectrum)	8.4% 17.9%	1.3% 5.0%

Treatment is prioritised given its efficacy in prevention and in improving the quality of life of people living with HIV and AIDS. Social and behaviour change communication (SBCC), and HIV Testing and Counselling will be treated as cross cutting issues. They are necessary in influencing demand and retention in the core programme especially treatment.

SBCC is also critical in influencing behaviour change. Demand creation will target to key populations (sex workers, men who have sex with men, prison inmates), and groups that are considered vulnerable such as migrant workers, women and girls, discordant couples, young people - aged 15-24years), and people with certain disabilities. Core programmes are designed to be complimentary with improved synergy between them.

In order to ensure effective implementation of the core programmes relevant critical social and programme enablers have been identified and their implementation will be concurrent with the activities of the core programmes. Programme specific critical enablers are articulated in the relevant programmes sections. Cross cutting critical enablers are presented in Section 3 of the NSP.

The critical enablers identified in the NSP range from political commitment and advocacy, laws, legal policies, and practices, community mobilization, stigma reduction, use of mass media to local responses to change risk environment. The programme enabler's range from community centred design and delivery, programme communication, coordination and management, nutrition, procurement and distribution to research and innovation. Given the multisectoral nature of the response, specific synergies have been identified that will complement service delivery in prevention, treatment and social protection.

In addition to critical enablers and where appropriate, synergies with development sectors have been identified and will be strengthened. Synergies are presented in Section 4 of the strategic plan. This approach will consolidate the multisectoral approach of the NSP, and enhance sector accountability. For HIV and AIDS

The following are the anticipated impact level results of the NSP.

Impact 1 New HIV infections reduced by 50% by 2015.

Impact 2 Mother to child transmission of HIV eliminated (to <2%)

Impact 3 TB deaths in people living with HIV reduced by 50% by 2015

Impact 4 HIV and AIDS stigma and discrimination eliminated

2.1 Treatment Care and Support

Overview

This section discusses the use of ARVs as part of treatment as well as prevention in order to improve quality of life of PLHIV and reduce AIDS related deaths. The provision of comprehensive treatment, care and support has enhanced the quality of life of PLHIV. The programme has adopted an integrated approach that includes HIV counselling and testing, management of opportunistic infections including TB and STIs, referral services and nutrition. Services will be scaled up while maintaining quality, ensuring universal access and an equitable distribution. Health systems will be strengthened to support this strategy and ensure sustained provision of services. Specific attention will be paid to development of human resources, review and strengthening service delivery system and improvements, in procurement and supply chain management. Communities will be mobilised through community-based organisations to generate demand for HIV counselling and testing and the subsequent need for treatment. Some of the PLHIV may not require immediate enrolment on ART and hence provision of quality pre-ART becomes necessary.

Food and nutrition (FN) are critical enablers of successful programmes and treatment outcomes. FN plays a role in improving quality of life while improving patient's immunological status. FN also facilitates access to care, as well as retention and adherence to treatment especially for malnourished HIV patients. According to the national treatment guidelines, the nutritional status of HIV infected patients should be addressed as part of a comprehensive package (page 27) (MOH, 2010). The NSP also described a Nutrition support package consisting of nutrition assessment, education, counselling and, when necessary, rehabilitation support and a midterm target to provide therapeutic food to 100% adults and children clinically malnourished. Civil society, NGO's and International Organizations distributing food to PLHIV have programmes that are aligned to the NSP.

Community mobilization is a critical enabler for treatment care and support. Communities in all the districts are mobilising and organising themselves in community action and support groups of PLHIV and AIDS, and in other forms of community based organisations (CBOs) to support those who are affected by HIV and act as change agents.

Treatment, care and support is comprised of four programmes i.e. prevention, pre-ART, ART and TB/HIV.

2.1.1 Treatment as Prevention (TAsP)

Situation Analysis

The goal of treatment as prevention (TAsP) is to reduce infectivity by increasing the mean CD4 at HIV diagnosis and decreasing the mean community viral load. This will be achieved by ensuring that HIV-infected patients are linked to and retained in treatment. In Lesotho TAsP has already been extended to HIV-infected pregnant women and TB co-infected patients. Going forward Lesotho will also scale-up TAsP by offering treatment to partners with HIV in sero-discordant couples to reduce the risk of infection of the uninfected partners. The strategy involves administering antiretroviral therapy (ART), to PLHIV who meet the eligibility criteria based on the national ART guidelines. The strategy is important as ART reduces the amount of the virus in the body, and hence reduces the chances transmitting HIV by as much as a 96%. At this level the viral load in the body is almost undetectable. To maximise individual and public health benefits adherence to ART will be critical.

However, while treatment as prevention has proved effective, the strategy should be implemented as part of the broader combination prevention strategy involving bio-medical and behavioural interventions. It is envisaged that combining the approaches will strengthen synergies and have a greater impact. These include biomedical interventions that reduce HIV risk practices and/or the probability of HIV transmission per contact event e.g. male and female condoms and VMMC. Behavioural interventions reduce the frequency of potential transmission events and structural and supportive interventions affect access to, uptake of and adherence to behavioural and biomedical interventions.

Gaps and Challenges

i. Treatment of sero discordant couples is still using 350 CD4 cell count as the threshold.
ii. To get the best of treatment as prevention in the general population the threshold should be 500 CD4 cell count.
iii. Low couple testing and counselling.

Priority Strategies

i. Develop norms and standards for the strategic use of ARVs—including TasP.
ii. Intensify community outreach and mobilisation to increase knowledge of HIV status with priority focus on couples, families, pregnant women, adolescents and children. .
iii. Strengthen effective linkages to HIV care following HTC, acceptance, long-term adherence and retention on ART; chance to reinforce HIV-TB integration and immediate treatment for TB patients found to be HIV positive.
iv. Facilitate a national equity study to establish groups of people and or populations that are not accessing treatment, in all aspects.
v. Strengthen community engagement and participation in HIV treatment for HIV prevention.
vi. Advocate for the provision of treatment as prevention for positive partners among discordant couples irrespective of their CD4 count.
vii. For adults and adolescents, there is a need to increase the threshold to 500 CD4 cell count.

2.1.2 Pre-ART

Situation Analysis

Not all PLHIV are eligible for ART and, of those eligible, not all will be able to access ART immediately. However, it is important to stress the need to access treatment as early as possible. This enables both early assessment of their eligibility for ART and timely initiation of ART. It also facilities access to HIV prevention interventions and prevent other infections and comorbidities. Enrolment in care provides an opportunity for close clinical and laboratory monitoring and early assessment of eligibility for ART and timely initiation, and aims to minimize loss to follow-up.

The number of patients enrolled into care in 2010, 2011 and 2012 were as follow 21,143, 25,155 and 39,418 respectively. There was also limited information on those patients who were diagnosed as eligible for ART but not yet initiated on ART. For TB patients who are HIV positive it is easier to ensure (through SOPs) that ART is 100% to remove any excuse for loss-to-follow up during pre-ART.

Communities will play a significant role in providing community-based support and care to PLHIV during the pre-ART period, and thereafter after the patients are enrolled on ART. PLHIV will be encourage and supported to join community-based support groups.

Gaps and Challenges

i. The pre-ART monitoring system remains weak.
ii. Inadequate human, financial and infrastructure resources to support an efficient Pre-ART model.
iii. Very high mortality rate and loss to follow up in pre-ART period

Priority Strategies

i. Strengthen monitoring and tracking systems for patients on pre-ART with clearly identified early warning indicators on changes in quality of life.
ii. Train service providers on pre-ART minimum package with particular attention to screening of opportunistic infections (including STIs etc.), and monitoring of CD4 and viral load, nutrition etc.
iii. Define a minimum pre-ART package incorporating on-going regular medical follow up, education, psychosocial support, rehabilitation and nutrition support.
iv. Introduce ART into TB clinics to close the pre-ART gap for this population in the public and private sector. By doing so, coverage is likely to increase from the current 53% to 100%

2.1.3 ART

Situation Analysis

Lesotho is aligning its provision of ART to the newly (2013) released WHO ART Guidelines[29]. The guidelines suggests that countries consider starting ART at CD4 cell count of 500 cells/mm³ or less, giving priority to those with advanced HIV disease or a CD4 count of 350 cells/mm³ or less, with active TB disease and Hepatitis B virus (HBV) co-infection with severe liver disease, all pregnant and breastfeeding women with HIV, all children younger than five years living with HIV and all individuals with HIV in sero-discordant relationships, regardless of CD4 cell count.

By mid-term (2012) 92,747 adults and children were on treatment representing 57.3% of those requiring treatment. Among children 0-14 years less than half (24.5%) of the planned target number of children have been enrolled on care. The demand for ART will be increased as more people access treatment based on the new WHO recommendations. The increased demand for ART will also trigger an increased demand for other services and in particular for adherence counselling, clinical and laboratory patient monitoring. The capacity of the health system is inadequate to cope with the expected increase in demand of services.

Gaps and challenges

i. Inadequate human resources (quantity and quality) for scaling up ART.

ii. Large number of children in need of treatment not yet receiving ART due to Lack of confidence of nurses to initiate infants and children on ART.
iii. Lesotho does not have a clear ART scale up plan and retention strategy that includes psychosocial and nutritional support.
iv. Inadequate integration of ART services with other health care services including nutrition services, CHBC, Child health services etc.

Priority Strategies

i. Strengthen health systems (i.e. technological resources, procurement and supply chain management, strategic information management) to support ART services.
ii. Develop and implement a minimum human resource package for facilities providing ART including nurses, counsellor, data clerks, and pharmacy technologists.
iii. Strengthen capacity for scaling up and sustaining paediatric diagnosis and ART services.
iv. Develop and execute a clear ART scale up and retention strategy (i.e. roll out ART services to all health facilities)
v. Increase community engagement and mobilisation which act as enabler supporting the provision of treatment and community based HTC with clear linkages with the local health facilities.

Results and Indicators

The goal for Lesotho is to achieve universal access on ART enrolment and improve survival rate of PLHIV on ART by 2015/16. The indicators shown in Table 3 below will be used to measure progress in ART.

Table 3 Antiretroviral Therapy (ART) & TB/HIV

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	TREATMENT, CARE & SUPPORT				
	Treatment	*Result 1: At least 80% of eligible Adult and Child PLHIVs reached with lifesaving antiretroviral treatment and ART services scaled up by 2015/16* *Result 1: TB deaths in people living with HIV reduced by 50% by 2015/16*			
Outcome	ART	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	2010 - Adults 58.7%	70%	80%
			2010 - Children 21%	65%	80%
Outcome	TB/HIV	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	2010- 26.9% (MoH)	60%	80%

2.1.4 TB/HIV co-infection

Situation Analysis

Tuberculosis (TB) poses greater challenges in managing the HIV epidemic, as it remains the single most serious opportunistic infection for PLHIV. The World Health Organisation (WHO) notes that TB is a major cause of mortality in PLHIV[30]. In 2012, the TB/HIV co-infection prevalence was 75% among newly diagnosed TB patients with approximately 80% of new TB patients being tested for HIV. From 2011 to 2012 the proportion of PLHIV co-infected with TB enrolled on ART increased from 39.8% to 52.9%. The increase is a result of improved diagnosis and management of co-infected patients. Investing on TB/HIV co-infection has the potential of reducing HIV related mortality by 50%. National statistics suggests that majority of deaths among TB patients occur in patients with HIV.

Implementation and coverage of effective strategies such as the WHO's "Three I's" strategy that entails **I**ntensified Case Finding (ICF), provision of **I**soniazid Preventative Therapy (IPT) and TB **I**nfection Control (IC) will be intensified. HIV surveillance amongst TB patients[31] and TB among HIV patients has been intensified.

Gaps and Challenges

i. Slow pace in scaling up TB/HIV co-infection collaborative actions.
ii. Initiation of HIV positive patients who do not have active TB on IPT prophylaxis is low.
iii. A significant number of TB patients who tested positive for HIV have not yet been enrolled on ART as per national guidelines.
iv. Triple burden of poverty and disease in TB/HIV patients who are in the lowest quintile.
v. Insufficient community awareness of TB/HIV interactions

Priority Strategies

i. Roll out TB/HIV services in all health facilities including private sector. To Accelerate HIV testing in TB patients and their enrolment on ART and intensify TB case finding on those who are on ART. Strengthen the capacity of health facilities to provide TB/HIV services including diagnosis, testing, counselling, and referral services.
ii. Include adequate nutrition assessment, education and counselling and rehabilitation aligned with ART nutrition services while acknowledging direct TB-nutrition interactions and vulnerabilities
iii. Build community capacity to increase awareness and support DOTs TB and HIV interventions and in particular adherence to treatment.
iv. Strengthen community mobilisation as a critical enabler for treatment, care and support.

Results and indicators

The goal for Lesotho is to reduce TB deaths in people living with HIV reduced by 50% by 2015/16. The indicators shown in **Error! Reference source not found.** below will be used to measure progress in this rogramme area.

2.2 Elimination of Mother to Child Transmission (eMTCT)

Situation Analysis

Lesotho's HIV prevalence among pregnant women is 24.3%[32]. It is estimated that there are 57,000 annual births in Lesotho. Approximately 14,706 infants are born to HIV positive women each year. In the absence of any intervention to prevent vertical transmission of HIV, this would result in approximately 5,882 new paediatric infections per year.[33] . Viral, maternal, obstetric, foetal and infant factors all influence the risk of mother to child transmission (MTCT). However the most significant of the risk factors is the amount of virus (viral load) in the mother's blood. Most children get infected during labour and delivery and hence the importance of improving the quality of services[34]. It is estimated that an effective PMTCT programme can reduce HIV mother-to-child transmission (MTCT) to less than 2%. PMTCT services are available in 207 out of 216 health facilities (2012). PMTCT coverage has increased from 51.1% in 2010 to 59.2% in 2012.

Only 47% of women (26,938/57,000) delivered in a health facility in 2012.

The PMTCT programme is integrated into routine maternal and child health care services and ANC. A national plan Elimination of Mother to Child Transmission of HIV was approved in 2011 and National PMTCT guidelines (see Table 4) were revised to support PMTCT Option B Plus in 2013. Lesotho will implement a comprehensive combination strategy that targets all the four components of PMTCT.

Table 4 Four components of a comprehensive approach to PMTCT

Component	Target Population	Additional Information
1. Primary prevention of HIV infection	Women and men who are sexually active.	This aims to prevent men and women from ever contracting HIV. If new HIV infections are prevented, fewer women will have HIV and fewer infants will be exposed to HIV. The immediate contribution to this strategy by the Health sector is implementation of TasP for the positive partner in a discordant couple
2. Prevention of unintended pregnancies among women infected with HIV	HIV infected women	This addresses the long-term family planning and contraceptive needs of women with HIV. If women who are infected with HIV have information, services and commodities to avert unintended pregnancies there will be fewer infants exposed to HIV.
3. Prevention of HIV transmission from women infected with HIV	HIV infected women	This focuses on; • Access to HIV testing and counselling for women and their partners before, during ANC, labour and delivery, and the postpartum period. • Provision of ART to mother and infant. • Safer delivery practices to decrease the risk of infant exposure to HIV • Infant feeding information, counselling and support for safer practices and provision of ART during breastfeeding
4. Provision of treatment, care and support for women infected with HIV, to their infants	HIV infected women, their children and families	This addresses the treatment, care and support needs of HIV-infected women, their children and families.

Source: National Guidelines for the prevention of Mother to Child Transmission of HIV, 2013.

Gaps and challenges

i. Underutilization of community-based structures for community mobilization, demand creation, care and support and defaulter tracking.
ii. Inadequate primary HIV prevention services (SBCC on safe sexual behaviour, promoting HTC with specific attention to couples testing and promoting male circumcision) involving men and women of reproductive age.
iii. Inadequate interventions to prevent unintended pregnancies in women with HIV infection in line with Prong 2 of the PMTCT strategy
iv. Lack of human resources and underutilization of the available resources compromising the scaling up of PMTCT.
v. Low coverage of skilled birth attendant.
vi. Frequent stock outs of HIV test kits and CD4 reagents as a result of a poor procurement and supply chain management of laboratory reagents and consumables.
vii. Inadequate male engagement in PMTCT
viii. Inadequate engagement with communities and in particular men
ix. Inadequate community engagement in PMTCT

Priority Strategies

i. Intensify and strengthen coordinated community engagement, including male engagement and participation in eMTCT services, and oversight from local councils. Prevention of HIV infections among HIV uninfected women and men of reproductive age including through TasP

ii. Prevention of unintended pregnancies to women infected with HIV.
iii. Prevention of transmission of HIV from women infected with HIV to their children closely coordinated with ART
iv. Increase access to quality treatment, care, support and retention for HIV infected women, their male partners and their families
v. Accelerate access to earlier quality paediatric HIV treatment, care and support for all HIV infected infants, children and adolescents

Successful implementation of eMTCT depends on effective community mobilization and stigma reduction. This will also depend on strong partnerships with mass media participating in community driven eMTCT initiatives. It is also anticipated that the mainstreaming of SRH in eMTCT services will enhance effectiveness of interventions.

Results and indicators

The goal for Lesotho is to eliminate mother to child transmission, and keep mothers alive of HIV by 50% by 2015/16. The indicators shown in Table 5 below will be used to measure progress in this programme area

Table 5 Elimination of mother to child transmission (eMTCT)

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	ELIMINATION OF MOTHER TO CHILD TRANSMISSION OF HIV				
	eMTCT	*Result 1: Mother-to-child transmission of HIV during pregnancy, child birth and breastfeeding reduced to less than 5% by 2015/16* *Result 2: Access to lifesaving treatment for HIV+ pregnant women increased to 90% by 2015/16 and AIDS-related maternal deaths substantially reduced*			
Outcome	eMTCT	Percentage of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission	50.3% (MoH, 2010)	80%	90%
Outcome	eMTCT	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	2012 - 35%	80%	100%

2.3 Voluntary Medical Male Circumcision (VMMC)

Situation Analysis

Modelling studies in Lesotho indicate that every 5 male circumcisions will avert 1 HIV infection. Male circumcision has the potential to reduce the probability of HIV infection from HIV positive females to HIV negative males by over 60%. In Lesotho, out of the 52% of men aged 15-59 years who are circumcised (LDHS, 2009) only 17.7% have gone through VMMC. The other people were circumcised as part of the traditional ritual of young boys passage to manhood. The procedure is not considered to be compliant to the guidelines on male circumcision as a prevention strategy. The number of clients who were circumcised in CHAL and public hospitals is 18,175 from February 2012 to April 2013. Lesotho had a medical male circumcision prevalence of approximately 10 – 15% in 2009. VMMC has catalysed improved uptake of HTC and control and management of STIs. HTC uptake is about 97% and HIV prevalence among MC clients of approximately 5%.

Only medical doctors are authorised to perform medical male circumcisions in Lesotho. The availability of VMMC is confined to district hospitals, filter clinics and private surgeries where doctors operate. However, the health system does not presently have the capacity to meet the growing demand.

The scaling-up of male medical circumcision in Lesotho would require not only an expansion of service provision but also a dramatic increase in demand. A national awareness campaign will be done to increase people's understanding and demand creation for male circumcision. This would also need to address the misconception that once you have been circumcised you cannot be infected. VMMC has the potential of reduce the probability of HIV infection by 60% at individual level.

Social and behaviour change communication interventions will increase demand and awareness of VMCC. Consistent and correct use of condoms will provide additional protection from HIV infection.

Gaps and Challenges

i. As the programme continues to scale-up there will be a need for increased demand creation
ii. Insufficient human resources in the health system to manage VMMC services
iii. Inadequate engagement of community and religious leaders in VMMC programme

Priority Strategies

i. Intensify VMMC demand creation through community participation, targeted awareness creation focusing on men.
ii. Outsource male circumcision services to competent and accredited private sector and civil society organisations to complement government efforts.
iii. Integrate condom provision, HTC, STI diagnosis and management, SBCC services to MC clients
iv. Increase engagement of community and religious leaders in VMMC.
v. Explore introduction of task shifting for VMMC services
vi. Explore innovative strategies to increase service delivery options (eg new devices)

Community mobilization will facilitate successful VMMC programmes. At local level, active involvement of communities, community and religious leaders, and people who are circumcised will help influence behaviour change and hence reduce the risk of infection.

Results and indicators

The goal for Lesotho is to reduce sexual transmission of HIV by 50% by 2015/16. Voluntary male circumcision will contribute to this target. The indicators shown in Table 6 below will be used to measure progress in voluntary male circumcision.

Table 6 Voluntary Male Medical Circumcision (VMMC)

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	MEDICAL MALE CIRCUMCISION				
	MC	*Result 1: Quality Male Medical Scaled Up and 80% of males circumcised by 2015/16*			
Outcome	MC	Percentage of men age 15-49 who report having been circumcised	15-24 = 42.1% 15-49 =51.6% LDHS, 2009	15-24 = 53% 15-49 =65%	15-24 = 70% 15-49 =80%

2.4 Condom Promotion and Distribution

Situation analysis

Condoms use remains low; 37.5% of women and 50.5% of men who had two or more sexual partners reported using a condom during the last sexual intercourse (LDHS, 2009). Urban and rural condom coverage is estimated at 69% and 33%, respectively (PSI TRaC Survey).

Lesotho will continue with free condom distribution through the public sector and through social marketing. Condom procurement and distribution will be strengthened. Condom outlets at the community and work place will be increased by at least 50% to ensure adequate coverage and access. Special condom outlets will be established in user-friendly locations for key populations (sex workers and MSM) including places they congregate. In the past condom procurement was based on available resources. For the remaining duration of the NSP, condom procurement will be based on need.

Condoms use as HIV prevention strategy cuts across a number of other interventions (in the context of combination prevention strategy) ranging from male medical circumcision, prevention among discordant couples, PMTCT, and in the prevention and control of sexually transmitted infections. Current condom supplies can be divided into three main categories: (i) free issue male and female condoms distributed through public and private outlets at no cost to the client; (ii) not-for-profit male condoms sold on cost recovery basis; and commercial male condoms sold for profit through private retailers.
To accelerate condom promotion and distribution, the government is establishing strategic partnerships with civil society organisations. Stakeholders will be mobilised to participate in condom education and awareness in addition to actual distribution at community level.

Gaps and Challenges

i. Condom promotion demand creation strategies are inadequate especially for young people and key populations.
ii. Very low usage of male condoms.
iii. Low availability and accessibility of condoms at national, district and community levels
iv. Low levels of acceptability of the female condoms.
v. Gender inequality remains a key bottleneck to negotiating use male and female condoms especially by women.
vi. A weak condom procurement supply chain management at community and district levels that causes frequent stock outs.
vii. Monitoring of condom distribution and usage is weak.

Priority Strategies

i. Intensify demand creation for consistent and correct use of condoms, by establishing and strengthening partnerships for condoms distribution (i.e. public and private sectors, civil society and social marketing channels)
ii. Ensure a reliable and efficient supply of male and female condoms, including adequate provision for buffer stocks.
iii. Strengthen negotiation skills for condom use especially for women and promote female condom acceptability and use
iv. Integrate condom use in all HIV and AIDS related programmes coupled with adequate education and awareness. It is anticipated that condom awareness is likely to reduce the incidence of GBV associated with condom use.
v. Increase availability and accessibility of condoms at all levels by increasing the numbers of condoms procured and distributed at national, district and community level. Increase condom distribution outlets at community level.

Results and indicators

The goal for Lesotho is to reduce sexual transmission of HIV by 50% by 2015/16. Effective condom promotion and distribution will contribute to this target. The indicator shown in Table 7 below will be used to measure progress on condom use

Table 7 Condom promotion and distribution

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	CONDOM PROMOTION AND DISTRIBUTION				
	Condom Promotion	*Result 1: Condom use among general population engaged in risky sexual behaviour increased by at least 50% by 2015/16*			
Outcome	Condom Promotion	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	15-49yrs women 38.5% Men 52.3% LDHS, 2009	15-49yrs women 48% Men 65%	15-49yrs women 60% Men75%
			15-24yrs women 64.0% Men 64.4% LDHS, 2009	15-24yrs women 70% Men 70%	15-24yrs women 80% Men 80%

2.5 HIV Prevention among Key Populations at Higher Risk of HIV Infection

Situation Analysis:

Key populations are groups within the larger society who engage in behaviours that increase their risk of HIV infection. These groups include sex workers (SW) (women and men), men who have sex with other men (MSM), injecting drug users (IDU), and prison inmates. With the exception of prisons inmates, strategic information and knowledge on MSM, IDU and sex workers is largely unavailable. These are groups that are often stigmatised, discriminated and marginalised. In Lesotho both sex work and men who have sex with other men are illegal. This makes it difficult to develop and sustain targeted interventions for sex workers and MSM.

Sex workers (SW)

Although Sex work is illegal in Lesotho it is a common practice. This makes it difficult to develop and provide targeted programmes for them. A focus on sex workers alone is not sufficient to address the challenges of HIV and there is a need to primarily target sex workers but also target clients of sex workers, and sexual partners sex worker's clients. Three civil society organisations are providing limited services such as condoms, SBCC, referral to other services, and HTC among others. According to the Lesotho GARP report 2012, 60% of female and male sex workers reported using a condom in with their most recent client.

Men who have sex with men (MSM)

There is no sufficient data on MSM in Lesotho. The only available data is based on a limited study by conducted by MATRIX Support Group in 2010. The study shows that 58.6% (n=234) of people surveyed were gay. Of these 26.5% were reported to be bisexual and 16.7% (n=222) were married. 19% (n=248) knew that anal and oral sex all carry the risk of HIV infection. Self reported HIV prevalence was 11.6% and that 54.5% had been tested for HIV in the last 12 months preceding the survey. MSM is illegal in Lesotho and hence MSM live in fear of being stigmatised, discriminated and marginalised. This has compromised uptake of services by MSM. Stigma and discrimination has also made it difficult for MSM to acknowledge publically their status or disclose their sexual orientation to their partners.

Inmates

In 2011, the Lesotho Correctional Services conducted a national sero-prevalence among the inmates. The survey estimates HIV prevalence among inmates at 31.4%. Inmates are able to access HIV prevention and treatment services including HTC and ART. Despite policy restrictions, condoms are also made available to inmates, while having sex with another man remains illegal. The Correctional services have developed a strategic plan to address the challenges of HIV in prisons.

Mobile and migrant populations

While mobility and migration increase the number of concurrent sexual partners and the individual vulnerability, they also shape the distribution of the epidemic and the rate in which the epidemic spreads.[35] Many people migrate in search of employment in in Lesotho-based textile factories and large plantations or move to South African to work in mines.

The NSP recommends provision of a minimum prevention package for key populations that would include SBCC, HTC, Condoms, MC, ART, and management of TB/HIV co-infection and STIs respectively. The services will be intensified in hotspot areas frequented by key populations.

To improve access and utilisation of services by key populations will require developing appropriate policy and legal instruments in addition to ensuring effective implementation and compliance monitoring. NSP strategies will also address reduction of stigma and discrimination. This will also demand strong political commitment and accountability for human rights.

In the case of mobile and migrant population, stakeholders will intensify targeted advocacy to ensure that employers and unions, mainstream HIV in their practices to improve access to HIV prevention and treatment services.

Gaps and Challenges

i. There is a lack of specific targeted programmes for key populations despite the adoption of a human rights approach to HIV and AIDS programming. The National Policy on HIV and AIDS is also silent on key populations.
ii. Sex work and MSM are illegal practices in Lesotho.
iii. There is a lack of strategic information on key populations especially population size estimation and hot spots mapping.
iv. Stigma and discrimination are prevalent and key population continue to be marginalised
v. Community based organizations working with these key populations, especially MSM and sex workers are under-resourced and hence provide limited services. Services are often not sustainable.

Priority strategies

i. Conduct a nation-wide behavioural surveillance survey and key population size estimation study that will inform and guide the development and provision of appropriate policy guidelines, and targeted services.
ii. Advocate for a human rights-based approach to provision of HIV related services to key populations and vulnerable groups premised on the concept of “quality health for all” people.
iii. Strengthen the capacity of community based organizations/ civil society organisations to provide comprehensive HIV services to key populations other vulnerable groups such as migrant workers
iv. Facilitate the development and provision of a comprehensive package of services for key populations.
v. Advocate for the review of existing laws to make it easier for key populations access and utilise HIV and AIDS services and in particular treatment

Results and indicators

The goal for Lesotho is to reduce new infection among key populations (sex work and MSM) and thereby contribute to the overall national goal of reducing sexual transmission of HIV by 50% by 2015/16. Prevention among key populations will contribute to this target. The indicators shown in Table 8 below will be used to measure progress in preventing new HIV infections among key populations.

Table 8 - Key populations

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	KEY POPULATIONS				
	Key Populations	*Result 1: Comprehensive knowledge about HIV and AIDS increased by at least 50% by 2015/16 and key populations adopt safer sexual behaviour* *Result 2: Condom use among key populations engaged in risky sexual behaviour increased by at least 50% by 2015/16* *Result 1: HIV testing and counselling services scaled up and at least 80% key populations who know their HIV status by 2015/16*			
Outcome	SBCC	Percentage of key populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	CSW 15-24 yrs 15-49 yrs	CSW 15-24 yrs 15-49 yrs	CSW 15-24 yrs 15-49 yrs
			MSM 15-24 yrs 15-49 yrs	MSM 15-24 yrs 15-49 yrs	MSM 15-24 yrs 15-49 yrs
Outcome	Condom Promotion	Percentage of CSW and MSM reporting use of a condom with their most recent partner	CSW -TBD MSM - TBD	CSW = % MSM = %	CSW =80% MSM=80%
Outcome	HTC	Percentage of CSW and MSM aged 15–49 who received an HIV test in the last 12 months and who know the results	CSW -TBD MSM - TBD	CSW = % MSM = %	CSW =80% MSM=80%

2.6 Social and Behaviour Change Communication (SBCC)

Situation Analysis

Social and behaviour change communication (SBCC) programmes cut across all the prioritised core programme of the NSP. SBCC interventions are critical for demand creation and in influencing behaviour change. Interventions will target key populations (i.e. SW, MSM, prison inmates) and vulnerable groups at higher risk of HIV infection. Effective implementation of SBCC will improve demand creation in VMMC, PMTCT, ART, HTC and condoms promotion for all targeted populations groups including key populations.

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

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

The implementation of the SBCC interventions will also depend on effective critical social and programmatic enablers such as meaningful engagement and participation of the mass media, political commitment by community and other leaders, advocacy, addressing teen age pregnancies and gender-based violence. Effective implementation of SBCC will also depend on a strengthened and functional health and community systems.

Schools will be encouraged and supported to intensify health education for in-school young people, while the capacity of community-based organisations (CBOs) will be strengthened to provide similar programmes for out of school youth. Synergies will be strengthened with Ministries of Education, Social Development and Ministries responsible for Youth

Gaps and Challenges

i. Inadequate targeting of interventions for specific population groups while taking into consideration their age and gender.
ii. Inadequate targeting, intensity and coverage of interventions that focus on society norms, values and practices that influence the spread of HIV in targeted population groups.
iii. Inadequate alignment and harmonization and dissemination of existing prevention strategies and policies.
iv. Inadequate skilled and experienced human resources in SBCC interventions including health education and promotion especially at district and community level.
v. Inadequate M&E of social and behaviour change and research.
vi. Low level of comprehensive knowledge of HIV and AIDS.
vii. Inadequate sustained engagement with community and religious leaders in HIV prevention.

Priority Strategies

i. Develop and accelerate implementation of targeted SBCC programmes, with greater community and CSO and political leaders' involvement.
ii. Strengthen the development and implementations of strategies to address stigma and discrimination reduction.
iii. Strengthen national and district level human resource capacity to deliver coordinated comprehensive SBCC.
iv. Strengthen partnerships and the capacity of mass media to play a critical role in SBCC and advocacy especially for key populations.
v. Engage community and political leaders to address social norms and practices that make people vulnerable to HIV infections.
vi. Embed gender; cultural norms; parental guidance, comprehensive sexual education and communication; and male involvement elements into behavioural, biomedical, and structural HIV prevention initiatives.
vii. Strengthen M&E and research for SBCC programmes.

Results

It is anticipated that effective implementation of SBCC will significantly improve demand and retention creation for critical programmes such as treatment and care, and promote adoption of behaviour change. The following indicators will be used to measure effectiveness of the SBCC strategies.

Table 9 Social and behaviour change communication (SBCC)

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION				
	SBCC	*Result 1: Comprehensive knowledge about HIV and AIDS increased by at least 50% by 2015/16 and general population adopt safer sexual behaviour*			

Outcome	SBCC	Percentage of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by age and sex)	15-24yrs: women 23.7% Men 32.9% LDHS, 2009	15-24yrs: women 30% Men 41%	15-24yrs: women 36% Men50%
			15-49yrs: women 42.3% Men 32.2% LDHS, 2009	15-49yrs: women 53% Men 40%	15-49yrs: women 63% Men 48%
Outcome	SBCC	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (disaggregated by age and sex)	15-24yrs women 7.8% Men 22.1% LDHS, 2009	15-24yrs women 6% Men 16%	15-24yrs women 4% Men 11%
			15-19yrs women 8.5% Men 25.5% LDHS, 2009	15-19yrs women 6.5% Men 19%	15-19yrs women 5% Men 13%
			20-24yrs women 6.9% Men 17.6% LDHS, 2009	20-24yrs Women 5.2% Men 13.2%	20-24yrs women 3.5% Men 9%
Outcome	SBCC	Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months (disaggregated by age and sex)	15-49yrs women 8.8% Men 29.2% LDHS, 2009	15-49yrs women 6.6% Men 22%	15-49yrs women 4.5% Men 15%
			15-24yrs women 7% Men 33.5% LDHS, 2009	15-24yrs women 5% Men 25%	15-24yrs women 3% Men 17%

2.7 HIV testing and Counselling

Situation Analysis

HIV counselling and Testing (HTC) is a strategic entry point for treatment and a critical enabler for individual to know their HIV status for purposes of accessing other services such as PMTCT and VMMC. For purposes of this NSP HTC is considered a cross cutting strategy for all core programmes.

It is estimated that two thirds of people living with HIV do not know their HIV status. By 2009, among women and men aged 15-49yrs only 42% and 24% respectively knew their HIV status. The goal for HTC is to have people known their HIV status as early as possible and access appropriate services in time. Those who test HIV negative will be encouraged to participate in preventions programmes and services such BCC, condom use, VMMC and encouraged to repeat HIV testing. For those who are HIV positive they will be referred to and offered treatment and care and support services based on national ART Guidelines.

While HTC services are available for the general population, it is not the case for key populations. CSO will be capacitated to intensify HTC services to key population groups.

However all groups including key populations can access HTC as part of the community-based HTC services and during the annual national Know Your Status (KYS) HIV testing campaigns. Provider-initiated testing and counselling (PITC) will continue being provided within health facilities. The two approaches will accelerate identification of PLHIV and link them to ART and for HIV negative persons to comprehensive HIV prevention interventions.

Testing and counselling of couples will be strengthened in order to identify sero concordant positive couples who will be linked to treatment and receive treatment adherence support. It also identifies couples with sero discordant HIV test results that will be linked to HIV prevention interventions and HIV treatment regardless of CD4 count. According to LDHS (2009) a third of all couples are HIV positive. More than 40% of all couples are "discordant couples" where one partner is HIV positive. The survey estimates that discordance in males at 7.2% and 9.2% in women.

Successful uptake of HTC is dependent on reduction of stigma and discrimination, availability, affordability, reduction in waiting time, and if HTC is provided in a conducive environment that ensures confidentiality. Accessibility will be greatly increased through the utilisation of innovative delivery models, such as household testing and counselling through expert clients (clients who have already been identified as HIV-positive and have granted permission to disclose status, as well as specifically trained for the task), mobile services, and moonlight testing, after-hours services and targeting families of HIV-infected people. Couple counselling will be encouraged as a strategy to enhance HTC uptake in men.

Gaps and Challenges

i. Demand for HTC services exceeds supply of the service. The available number of HTC counsellors has declined over time compromising the overall uptake. This has significant implications on waiting time, and people coming late for testing
ii. Stock outs of test kits and CD4 count reagents.
iii. Inadequate targeted HTC services for key populations (SW and MSM) and discordant couples. Services are also inadequately monitored.
iv. HTC uptake for men remains very low (24% in 2009).
v. There are no specific targeted interventions for people who test HIV negative.
vi. Increase couple counseling and VMMC as a strategy to increase HTC uptake in men.
vii. Lack of integration of HTC with other HIV/SRH/NCD services.

Priority Strategies

i. Intensify demand creation and expand coverage for HTC in the community and health facilities.
ii. Scale up early infant diagnosis (EID) at 4 to 6 weeks.
iii. Intensify prevention programmes targeting discordant couples (i.e. couple HTC) and strengthen the capacity of service providers to monitor discordance.
iv. Intensive innovative HTC strategies including community based testing services, household testing moonlight testing, providing services after hours, and using mobile testing to reach out to key populations in friendly environments.
v. Facilitate integration of HTC with other HIV, Sexual Reproductive Health, Non Communicable Diseases and other health services.

Community and health facility based HTC will depend on sustained community mobilisation, intensified health education, and stigma reduction. HTC is often associated with gender-based violence where one partner or family members may find it difficult to accept the HIV status of the individual due to the sexual violence. This may require providing legal and social protection support to such individuals. Lesotho is also encouraging and offering couple counselling and testing.

Results and indicators

The goal for Lesotho is to have every person test and know their HIV status. This will contribute to people accessing treatment early and hopefully adopt key prevention behaviours. The indicators shown in Table 10 below will be used to measure progress in HTC.

Table 10 HIV Testing and Counselling (HTC)

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	HIV TESTING AND COUNSELLING				
	HTC	*Result 1: HIV testing and counselling services scaled up and at least 50% people who know their HIV status by 2015/16*			
Outcome	HCT	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results	15-49yrs women 42.0% Men 24% LDHS, 2009	15-49yrs women 53% Men 30%	15-49yrs women 63% Men 50%
			15-24yrs women 40.4% Men 17.1% LDHS, 2009	15-24yrs women 50% Men 22%	15-24yrs women 60% Men 40%

Section 3. Strengthening the Enabling Environment for the National Response

This section focuses on critical social and programme enablers necessary to ensure effective and efficient implementation of the NSP core programmes.

3.1 Laws, legal policies and practices

Situational Analysis

The existence of an enabling policy and legal environment is a pre-requisite for the success of the national multi-sectoral response. An enabling environment is largely dependent on the degree and extent of advocacy at all levels of the response. Such advocacy will place and maintain HIV on the national socio-economic development and political agenda.

Lesotho has put in place policies and legislation necessary to support the implementation of the national multi-sectoral response. Implementation and enforcement of these polices and legislation remains a critical challenge. This is partly because monitoring and compliance are very weak. This challenge is compounded by lack of awareness of the existence and understanding of their implications by those responsible to ensuring implementation and also those intended to benefit from them.

On the other hand several government agencies and private sector have not reviewed their operational policies to incorporate HIV and AIDS, gender and human rights dimensions necessary to support the sector strategies for HIV and AIDS.

Laws such as the Sexual Offences Act (2003) and Legal Capacity of Married Persons Act (2006) are being disseminated and enforced. However, effective implementation is hindered by insufficient knowledge and understanding of the legal provisions by members of the public. The Gender and Development Policy that is currently being reviewed does not adequately address issues of HIV. Similarly the National HIV and AIDS Policy (2006), is considered to be out dated and needs to be reviewed. The policy does not address among other issues those of key populations such as MSM and sex workers. The National HIV and AIDS Bill is still under consideration. The delays have implications on decision making on how to address human rights from a HIV and AIDS response perspective.

During the implementation of NSP, stakeholders will intensify education and awareness of existing policies and laws. Advocacy will also be intensified targeting community, religious and political leaders to influence policy review and formulation where applicable, implementation and enforcement. It is anticipated that effective implementation of policies and laws will enhance adherence to human rights. This approach will also improve gender equality, and minimise gender–based violence. The capacity of law enforcement officers and the judiciary will also be strengthened based on the "human rights-based approach to ensure effective implementation of policies and legislation.

Gaps and Challenges

i. Existing HIV related policies and legislation not adequately disseminated, implemented and enforced. Their implementation and compliance monitoring remains inadequate.
ii. Critical stakeholders such as the Parliamentarians, law enforcement officers and the Judiciary are not adequately involved in the implementation of the existing policies and legislation.
iii. Slow process of adoption of strategic policies and laws such as the National HIV and AIDS Bill, 2006. Delays cause confusion and delay the process of harmonisation of the already fragmented policies and legislation that have impact on HIV and AIDS response.

Priority Strategies

i. Facilitate broad public awareness and dissemination of existing strategic policies and legislations relevant to the national HIV and AIDS response.
ii. Advocate for acceleration of the adoption of the HIV and AIDS Bill.
iii. Ensure effective and efficient dissemination, implementation; enforcement and compliance of existing HIV related policies and laws.
iv. Strengthen national capacity for the review of existing social, health and development policies and laws to ensure that they adequately address HIV and AIDS issues. The review process will also take into consideration the needs of key populations in terms of service delivery and protection of their human rights.

Results and indicators

The goal for Lesotho is to strengthen an enabling social and legal environment for PLHIV, key populations and the general public to freely access and utilise HIV and AIDS services. The indicators in Table 11 will be used to measure progress in policy, legislation and advocacy.

Table 11 Policy, legislation and Advocacy

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	PLA	*Result 1: Enabling social and legal environment for PLHIVs, key populations & general public to freely access and utilise HIV and AIDS services strengthened by 2015*			
Outcome	PLA	Existence of an enabling policy and legal framework that promotes and protects human rights	NCPI (not available)	5 (NCPI 2012)	7

3.2 Stigma reduction and Discrimination

Situational Analysis

Global evidence shows that stigma has significant negative impact on HIV services uptake. Lesotho is not exception. In the case of Lesotho people test late, or don't test because they are afraid of being stigmatised and discriminated against. Stigma has also compromised retention and adherence to HIV treatment.

According to the LDHS (2009) over 80% of the population stated that they would be willing to take care of PLHIV of their families, would accept HIV-positive teachers in the classroom, or would buy fresh fruits or vegetables from a vendor know to be HIV-positive. Community programmes by various multi-sectoral partners have contributed to stigma reduction in some extent, evident from the number of people joining community based support groups of PLHIV, or participating in HIV related activities.

Gaps and Challenges

i. Stigma has negatively impacted on HIV service access and utilisation due to lack of awareness on human rights.
ii. Lesotho has not undertaken a stigma index assessment, and assessment on the attitudes of HIV service providers in a health facility setting towards PLHIV

Priority Strategies

i. Intensifying awareness and education among individuals and communities regarding rights and dignity of people affected and infected with HIV, including human rights of vulnerable children and key populations;

ii. Intensify advocacy work targeting policy makers, political leaders and law enforcement officers to enforce policies and legislation on stigma and discrimination reduction[36]
iii. Undertake a national stigma index study to inform development of specific interventions and policy formulation and implementation strategies.
iv. Generate evidence-based information on HIV, gender and human rights mainstreaming in all NSP programmes

Results and indicators

The goal for Lesotho is to ensure protection, respect and fulfilment of people infected and affected by HIV and AIDS from being stigmatised and discriminated. The indicators shown in Table 12will be used to measure progress in stigma and discrimination reduction.

Table 12 Stigma reduction

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	S&D	*Result 1: Stigma and discrimination towards PLHIV and key populations reduced by 2015*			
Outcome	S&D	% Of women and men 15-49 years with comprehensive knowledge of HIV and AIDS	W=37.6% M=28.7%	W=n/a M=n/a	75%
Outcome	S&D	% Of women and men 15-49 years with accepting attitudes to PLHIV	W=42.3% M=32.9%	W=n/a M=n/a	W: 70% M: 65%

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3.3 Human Rights, Gender Equality and Gender-Base violence

Situational Analysis

In Lesotho gender is an issue of development effectiveness. It is evident that when women and men are relatively equal, the economy tends to grow faster, the poor move out of poverty quickly, the wellbeing of women, men and children is enhanced, and development efficiencies improved. It is also evident that the relationship between gender inequality, poverty and vulnerability are reciprocal as they increase the susceptibility of individual women and men to gender inequality and HIV infection.

Strengthening gender equality is a prioirity of the Government of Lesotho as illustrated in Vision 2020 and the NSDP. The Government has further enacted the Legal Capacity of Married Persons Act, 2006, and developed the Gender and Development Policy to address these challenges.

Gender-based violence (GBV) is considered as any act that results in, or is likely to result in, physical, sexual, or psychological harm or suffering, including threats of coercion, or arbitrary deprivation of liberty, whether occurring in public or private life. Women and girls are the most affected by GBV. In Lesotho GBV is prevalent and is often sanctified by cultural practices and reinforced by institutions that limit women's rights, their decision-making power, and their recourse to protection from violence. In a study on sexual violence against women in Lesotho, 61% of women reported having experienced sexual violence in their life. 40% reported coerced sex and 50% assault and 22% rape. A household survey conducted in 2006, in two urban areas of Lesotho among sexually active women ages 18-35 had similar findings. 25% of respondents reported ever being physically forced to have sex, and 13% reported attempted forced sex. The most common perpetrators of actual and attempted forced sex were boy friends, at 66% and 44% respectively. According to LDHS (2009) 37% of women and 48% of men (15-49 years) agreed with at least one reason that justifies a husband hitting a wife (the reasons include burning food, arguing with the

husband, going out without telling him, neglecting the children, and refusing to have sexual intercourse). Among men aged 15-49, 26% thought that men are justified in withholding financial support from his wife if she refused to have sex with him, and 16% thought forced sex was justifiable (2009 LDHS).

GBV also affects children living in violent households. Such children are often at a greater risk of infant and early-child mortality either due to neglect or to direct exposure to violence. According the State of the World's Children (UNICEF, 2007), "every year as many as 275 million children world wide become caught in the cross fire of domestic violence and suffer the full consequences of a turbulent home". These children include those from Lesotho.

The Government has enacted the Sexual Offenses Act (2003), and developed National guidelines for the management of survivors of sexual abuse, as tools to address GBV. Section 5.6 of Gender and Development Policy (2003) commits government to address Gender Based Violence (GBV). Child and Gender Protection Unit (CGPU) have also been established within the Lesotho Mounted Police Service to provide care and assitance to GBV survivors. CSO are also actively involved in responding to GBV and supporting survivors at community level. Annually Lesotho participates in the global annual 16 Days of Activism against Gender Violence event.

During the implementation of the NSP stakeholders will strengthen community systems to support implementation of strategies that promote human and rights and gender equality. Synergies will be strengthened within the police service (Child and Gender Protection Units) to ensure adequate response and management of sexual and gender-based violence (SGBV) cases.

Gaps and Challenges

i. Inadequate implementation of existing policies and lack of enforcement of legislations that address gender inequality and GBV.
ii. Lack of targeted programmes that empower women to improve their gender status
iii. Inadequate protection of GBV survivors by law enforcement officers.
iv. The implementation of current programmes to advance gender equality and address GBV remains inadequate and weak. This is compounded by lack of clear linkages between HIV, human rights, gender equality, sexual and gender based violence..

Priority Strategies

i. Strengthen the capacity of law enforcement officers and the judiciary to protect survivors of GBV and deter future occurrences.
ii. Strengthen the capacity of community to address issues of GBV
iii. Strengthen national capacity to use human rights based approach to programming.
iv. Advocate for support for the development and implementation of women empowerment strategies.
v. Facilitate a national survey on HIV linkages with human rights, gender equality, sexual and gender based violence.

Results and indicators

The goal of the NSP is to support strategies that improve gender equality, eliminate GBV and promote social and legal protection of vulnerable groups from GBV. It is anticipated that this will reduce the probability of exposure to HIV. The indicators shown in Table 13 will be used to measure progress in the promotion of human rights, gender equality and elimination of GBV.

Table 13 Gender Equality and Sexual and Gender-Base Violence (GBV)

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	SGBV	*Result 1: Human Rights and gender equity enhanced and sexual and gender based violence reduced by 2015/16*			
Outcome	SGBV	Proportion of women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	N/A	Not available	30%
Outcome	SGBV	Lesotho Gender equality index (value)	0.685 (Human Development Report 2010)	0.534 Human Development Report 2013)	0.400

3.4 Coordination and Management

Situation Analysis

Lesotho has adopted a multisectoral and decentralised coordination and management of the multisectoral response. Given the many and diverse stakeholders involved at national, district and community levels coordination has increasingly become complex and dynamic due to the different stakeholders' mandates, roles and responsibilities, and accountability channels. However coordination structures have been established in national, district and community levels. The national multisectoral response coordination is premised on the three ones principle.

The National AIDS Commission (NAC), under the Office of the Prime Minister is responsible for coordinating the overall national response. Ministry of Health has the responsibility of coordinating the health sector response, while the Ministry of public service is responsible for facilitating coordination of the public sector HIV workplace programmes. The Ministry of Social Development coordinates national response for vulnerable children majority of whom are those affected by HIV and AIDS, adult groups and households. The Country Coordinating Mechanism (CCM) supports the coordination of the Global Fund initiatives in Lesotho. District AIDS Committees (DAC) are responsible for coordinating district level response while the Community Councils AIDS Committees (CCAC) are responsible for coordinating community based responses. Self –regulating coordinating structures also facilitate coordination among the civil society organisations, support groups of PLHIV, the private sector and development partners. The Government has structured the CCAC, and reduced the number from 128 to 65 in total. The National coordinating Framework identified 11 CSO and 2 private sector coordinating structures.

Coordination has revolved around the issues of policy making, joint planning and programming, resource mobilisation, policy development, technical assistance, monitoring and evaluation, harmonisation and alignment of development partner programmes with national policy frameworks and programmes. Now that the structures exist, the focus of the NSP will be is strengthening strategies that promote efficiency and effectiveness of the national response. Particular attention will be paid to effective coordination in planning and programming to remove duplication and overlaps, strengthen programme synergies, and remove bottlenecks that increase the cost of service delivery and access.

However, the closure of NAC secretariat has compromised effective coordination of the national multisectoral HIV and AIDS response. It is anticipated that the Government will re-establish the NAC secretariat based on the recommendations of the Independent Sector Institutional Assessment for the HIV and AIDS sector report (2012). In the meantime Ministry of Health has assumed the responsibility of coordinating the national HIV and AIDS multisectoral response.

Given the multisectoral nature of the response other sectors will play a key role in the coordination of sector specific interventions as shown in the table below.

Table 14 Strategic roles and responsibilities of core coordinating structures

Coordinating Structures	Core Roles and Responsibilities
National AIDS Commission	• Coordination of the national multisectoral response • Development of the National Multisectoral HIV and AIDS strategic plan, National Operational Plan, The National M&E Framework • Coordination of the National HIV and AIDS Fund
Ministry of Health and Social Welfare	• Coordination and development of the health sector HIV and AIDS response • Development of the health sector HIV and AIDS programme plans, strategies, and action plans that inform the National Strategic Plan • Coordination of the national response for orphans and vulnerable children
Ministry of Public Sector	• Coordination and facilitation of the HIV and AIDS internal and external mainstreaming in all sectors
Ministry of Finance	• Coordination of the national financial planning for HIV and AIDS response, including funding earmarked for mainstreaming within sector budgets
Ministry of Local Government and Chieftainship	• Coordination of the community HIV and AIDS interventions through the Gateway approach based on the Essential Services Package
Umbrella Organisations	• Umbrella organisations (civil society and private sector) will coordination the respective sector HIV and AIDS interventions.
Country Coordinating Mechanism	• The CCM is responsible for coordinating the implementation of the Global Fund funded projects in collaboration with the appropriate national structures and the Principal Recipient (PR)
National Partnership Forum	• The forum is used to facilitate coordinating, networking and information sharing among HIV and AIDS stakeholders. The forum is also used to mobilise stakeholders for National HIV Partnership Reviews and District HIV Partnership Reviews at the national and district level and Planning.
Health Development Partners Forum	• The forum is used to facilitate coordinating, networking and information sharing among resident development partners. The forum is also used to mobilise stakeholders for Annual Joint Programme Reviews and Planning
UN Country Team	• The UN country Team is ultimately responsible for coordinating the UN country support for HIV and AIDS. The day to day coordination is facilitated by UNAIDS

Gaps and Challenges

i. The closure of NAC secretariat has compromised the coordination of the multisectoral response increase the burden on MOH and creating bottlenecks the implementation and monitoring of the response.
ii. The NAC Board, DACs and CCACs are dysfunctional
iii. Civil society coordination is fragmented and largely un-coordinated between the umbrella organisations.
iv. The coordination of the private sector institutions remains inadequate and weak.

Priority Actions

i. Review and implement the recommendations of the Independent Sector Institutional Assessment (ISIA)
ii. Review and update the National Coordination Framework – focus on clarify roles and responsibilities of the various coordinating structures.

iii. Strengthen the leadership and governance capacity of the national and decentralised coordinating structures.
iv. Intensify advocacy to strengthen the coordination and management of the response and in particular promote strategies of efficiency and effectiveness.

Results and indicators

The goal for Lesotho is to improve the efficiency and effectiveness of the response coordination, shared responsibility and accountability for the AIDS response. The indicator shown in Table will be used to measure the efficiency and effectiveness of the national response.

Table 15 - Coordination and management of the multisectoral response

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	coordination	*Result 1: Efficient and effective national coordination system re-established and strengthened*			
Outcome	coordination	Efficiency and effectiveness of the national and decentralised response coordination improved	NCPI rating	5	8

Note: *NCPI is a global composite indicator that measure performance based on a scale of 1 to 10. The questions are asked to government agencies and to CSO based on a pre-determined national questionnaire*

3.5 Resource Mobilisation and Management

Situation Analysis

The total resource needs of the national response are premised on the costed National Strategic Plan and the National Operational plan. These costing also include costs related to M&E activities.

As the epidemic unfolds demand for services have increased and so has demand for financial resources increased overtime. According to the National AIDS Spending Assessment (NASA, 2010) Lesotho spend M1, 440,397, 233 on HIV and AID response. 49% of the funds came from domestic resources while 51% came from international sources. The three main funding sources are the Government of Lesotho, The Global Fund and PEPFAR. Additional funding has come from other partners including the UN agencies, Irish Aid, European Union, Millennium Challenge Account, Clinton Foundation and the World Bank.

Table 16 provide an analysis of the NSP funding requirements for the entire period from 2011/12 to 2015/16 by thematic areas.

Table 16 - NSP Financial requirements in Millions of US Dollars

Funding Area	2013	2014	2015	2016	Total
Prevention	13.8	33.8	40.8	24.2	112.6
Treatment , Care and Support	36.4	58.3	83.4	90.6	268.7
Impact Mitigation	20.2	25.6	31.5	39.3	116.6
Management and Coordination	23.7	47.1	60.8	44.0	175.6
Total	**94.13**	**164.86**	**216.54**	**198.06**	**673.6**

The Government funds 70% of the ARV, and has allocated 2% of individual public ministries budgets for HIV workplace programmes. The Government has further approved the establishment of the National HIV

Fund that is yet to be formally established and operationalised. NASA report has noted that in 2009/10, 43% of the funding was allocated to treatment care and support, while prevention received 22%. Programme management received 17% and 13% was allocated for OVC.

Given the global decline in resources for HIV, the Government is committed to identifying strategies for funding the national response. This will include increasing domestic funding, and improving the efficiency and cost effectiveness of service delivery systems. The Government will also expand and diversify its external funding sources. In this regard the Government has committed itself to invest strategically for results in high impact core programmes and the resources for the development synergies will be cost shared with other Ministries by minimizing the resources provided from the HIV budget.

The costing of the NSP is premised on these core programmes and the associated critical social and programmatic enablers. Table 17 shows the resource needs for the national response between 2013 and 2015 and the corresponding available resources.

Table 17 – Financial Gap Analysis, 2013 to 2016 in Millions of US Dollars

Fiscal Year	Resource Needs	Available Resource Envelope	Gap to be mobilized
2013	94	87	7
2014	165	116	48
2015	217	116	100
2016	198	116	82
Total	**674**	**437**	**237**

Gaps and challenges

i. While demand for services exceeds available funding, Lesotho also faces a capacity challenge to absorb available funding.
ii. Lack of prioritisation of programmes and hence the mismatch of available resource.
iii. Lesotho response is dependent on external funding with the exception of ART procurement. The Government provides 70% of funds to procure ARVs.
iv. Although the Government has approved the establishment of the National HIV Fund, this is yet to be established.
v. Lesotho has challenges in in absorbing available funding.

Priority strategies

i. Develop a sustainable funding strategy for the national HIV response based on a comprehensive study that should also include aspects of cost savings, efficiencies and effectiveness.
ii. Intensify resource mobilisation including advocating for increased domestic funding and external donor diversification
iii. Prioritise core programme funding along the “investing for results” thinking.
iv. Accelerate the development of a comprehensive the national HIV Fund, with emphasis on innovative local mobilisation strategies.
v. Strengthen national human resources capacity to improve financial resources absorption capacity.

Results and indicators

The goal for Lesotho is to improve the financial sustainability with investment thinking and increase domestic financial resources for the national HIV response. The indicator shown in Table 18 will be used to measure sustainability and cost efficiency of the response.

Table 18 - Resource mobilisation and management

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	Resource Mobilization	*Result 1: Domestic Resources mobilised to fund the AIDS response and external dependency reduced to 40% by 2015/16*			
Outcome	RM	Domestic resources allocated for the AIDS response	49% (NASA 2010)	55%	60%

3.6 Strategic Information Management

The NSP Strategic Information Management will focus on generating new data and knowledge on HIV Lesotho and improved management of existing data and knowledge. The information will be generated through routine monitoring, periodical evaluation, and through research surveys, surveillance and special studies. Strategic Information is necessary to inform HIV planning and programming, and resource allocation.

The national HIV and AIDS M&E system consists of Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) and the Health Management Information System (HMIS). LOMSHA is designed to collect routine HIV data outside the health sector while the focus of HMIS is collecting data within the health sector. LOMSHA was coordinated by NAC secretariat before its closure in December 2011. The HMIS is coordinated by MOH. Operational linkage between LOMSHA and HMIS remains very weak. The closure of NAC secretariat has negatively impacted on the sustained operationalisation of LOMSHA.

3.6.1 Strengthening National HIV and AIDS M&E system

Capacity development is necessary to ensure efficiency and effectiveness in data collection and management. Capacity development will revolve around the 12 components of a functional M&E system. The core areas of capacity development will include improving skills on data collection, analysis, packaging, management and dissemination of strategic information.

The MTR (June 2013) noted that many organisations especially CSO and district and community-based organisations lack the pre-requisite M&E capacity. The lack of capacity has implications on the quality of data and the frequency of data collection and reporting. M&E capacity development will target people responsible for HIV and AIDS M&E functions in government, private sector, CSO, and in the decentralised structures at district level.

Efforts will also be made to facilitate harmonisation of the sector M&E systems with the national M&E framework. The harmonisation will focus on national priority programmes, indicators, data collection tools and targets.

Currently, implementing partners do have independent M&E systems. At the launch of the NSP, it becomes a pre-requisite that all stakeholders to harmonise and align their M&E systems with the National M&E system. Therefore there will be one M&E system for HIV and that will be linked with other existing key

databases. Still there are challenges as some stakeholders have attempted to do so, however, many have not. This is attributing to the lack of a national M&E plan, containing strategic M&E information such as priority indicators, indicator definitions, and targets and data collection tools.

The mid term review of the NSP noted that some indicators were missing baselines. This was noted during the development of the NSP and it was planned that baseline data would be collected first two years of NSP implementation. However this was not done as none of the proposed surveys and studies intended to generate that data were conducted.

Given, the importance and the urgency of strategic information the NSP will prioritise the development and dissemination of the national M&E plan. Implementation priority of the M&E plan and related research work will be to generate data for all the missing baselines. This will also include surveys and behavioural studies targeting key populations. Secondly, policies and guidelines will be developed to support strengthening of an enabling M&E environment where systems are harmonised and aligned to the national M&E, (b) routine HIV data collection, analysis and reporting and finally (c) promotion of the use of M&E and HIV research information for decision making and planning. It is anticipated that an effective M&E system will contribute to improved HIV knowledge management.

3.6.2 Strengthening the an enabling environment for M&E

Strengthening an enabling environment for M&E will be characterised by having clear M&E guidelines, clearly define process of data collection, reporting and feedback. Systems for accessing data by stakeholders from the LOMSHA and HMIS databases will be improved and simplified. Support will be provide to stakeholders to harmonise their HIV indicators and data collection tools with national ones. Advocacy will be intensified with development partners to simplify reporting requirements and where necessary harmonise the reporting systems and tools with national systems. Support will be provided to ensure existing M&E structures at national, district and sector levels are functional.

3.6.3 Generating age and sex disaggregated data

Stakeholders will be capacitated to generate reliable, accurate and comprehensive gender sensitive and human responsive data. Where possible data will be disaggregated in the first instance by age and sex in addition to any other disaggregation that may be defined based on need. The indicators and data collection tools will be reviewed periodically to ensure that they remain gender and human rights responsive.

3.6.4 Strengthening the national capacity to generate empirical data through research

Research is a strategic activity for the national HIV response to generate new empirical data to fill in information gaps, baselines and provide new knowledge and understanding of HIV in Lesotho. Capacity for HIV and AIDS research is largely lacking. The national research agenda is biased towards the general health and hence HIV specific research work does not feature strategically. As a result none of the NSP planned surveys and surveillance, behavioural and bio-medical studies have been conducted despite their importance in determining emerging issues, coverage, access and quality of services and emerging challenges and epidemic trends. Existing periodical surveys are also fragmented, and do not necessarily address all the identified research needs.

Lesotho has adopted evidence and results-based management approach of the national response. This approach demands the use of the most recent data and knowledge available to inform the planning process. Lesotho will continue collecting routine and programme data using the existing M&E systems. To generate new data Lesotho will undertake an AIDS Indicator Survey (AIS) by 2014. The AIS will fill in data gaps between the Lesotho Demographic and Health Surveys (LDHS). In the absence of AIS, the DHS planned for 2014 will rely on old data other than Estimates and Projections.

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

3.6.5 Generating demand for M&E and HIV research strategic information

With the adoption of evidence and results-based management of the response, the use of evidence-based information is a pre-requisite. Currently there is a lot of strategic programme data and information that is not being used for various reasons. First, not everybody knows that the information exist and where to find it. Strategic information dissemination has been compromised by weak information dissemination systems and poor demand creation for such information.

The use of strategic HIV information has also been compromised by inadequate analysis and packaging of information for use by policy and decision makers. The quality of information is often compromised by inadequate data collection systems.

During the implementation of the NSP, capacity will be strengthened, first in data analysis and the use of the strategic information. Data dissemination strategies will be improved and expanded. Innovative information dissemination strategies will be developed to ensure that information reaches key populations. The national HIV and AIDS website managed by National AIDS Commission will be revived, updated and expanded. Access to information on the website will be reviewed and improved to make it user friendly.

The national HIV data base will be strengthened and appropriate linkages with other national databases such as the Bureau of Statistics (BOS), Health Management Information System (HMIS), the National Orphans and Vulnerable Children (OVC) database and Education Information Management system among others.

Gaps and Challenges

i. The National M&E Framework was initiated in 2010 and was not completed and hence information on national indicators and targets, and indicator descriptions has not been done.
ii. LOMSHA remains dysfunctional given the closure of NAC secretariat. The secretariat was responsible for coordinating operationalisation of LOMSHA.
iii. Few stakeholders have harmonised their M&E systems with national M&E system. It is anticipated that stakeholders would harmonise the indicators, data collection and reporting tools.
iv. Most indicators are missing baseline data. Surveys and studies that were intended to generate that data have not been implemented. Populations based data is dependent on LDHS of which the next version is anticipated in 2014.

Priority Actions

i. Facilitate the finalisation of the National M&E Plan. The M&E should also include the definition of NSP indicators.
ii. Facilitate the operationalisation of LOMSHA. In the absence of NAC secretariat a surrogate home for LOMSHA needs to be identified until such time the Government makes a decision on the future of NAC secretariat.
iii. Strengthen the human, technological and funding capacity for capacity for the national and decentralised M&E systems.
iv. Facilitate undertaking of the planned surveys and studies to generate missing baseline data.

Results and indicators

The goal for Lesotho is strengthen the generation, management and use of new HIV data, improve the national knowledge base and increase the use of evidence in decision making and planning. The indicators shown in Table 19 will be used to measure sustainability and cost efficiency of the response.

Table 19 Monitoring and Evaluation

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	M&E	*Result 1: M&E system strengthened and functional, and all data reported in an efficient, effective and accurate manner to all stakeholders by 2015/16*			
Outcome	M&E	The M&E system has generated baseline values (data) for all the NSP indicators	Not available	85%	100%
Outcome	M&E	The national M&E system is functional	5 NCPI rating	5	8

Section 4: Strengthening Synergies with Development Sectors

4.1 Overview

The challenges of HIV are complex and transcend sector boundaries demanding a multisectoral response. The epidemic is spreading along socio-economic development fault lines such as poverty, income disparities, food insecurity, unemployment, work migration, inadequate social protection, lack of accessing to education and comprehensive health care among others. Some of these have been identified as key drivers of the epidemic and unless they are addressed, the likelihood of achieving the desired outcomes of the NSP core programmes or the Millennium Development Goals (MDGs) is unlikely.

While HIV prevention work is necessary to inform and motivate people to protect themselves, it cannot overcome deeply rooted societal and socio-economic causes of susceptibility. Similarly, HIV treatment, care and support programmes can reduce the impact of AIDS on affected individuals and households, but cannot address the underlying reason for their vulnerability. Many of these factors might only be addressed through strengthening development synergies with other Government sectors. The development sectors are also reviewing how the epidemic is affecting them in terms of productivity, reductions in investments, the quality of human capital, and quality of labour and overall their ability to meet their development goals and targets.

Development synergies are investments in other Government sectors that have positive effects on HIV outcomes, by presenting opportunities for effective engagement and collaboration of relevant key development sectors. Development synergies usually impact across health and other development sectors, as their reason for being is not typically for HIV. Meaningful integration of HIV into other development sectors not only creates opportunities for increasing the effectiveness of the national AIDS response but also broadens and diversifies its financing base with cost sharing, helping to promote sustainability thereof.[37]

The contribution of development sectors is anticipated that it will contribute to the empowerment of vulnerable individual people, groups and households to claim their basic rights protect their dignity and improve their vulnerability to HIV. These strategies will complement the impact and influence of all critical social and programme enablers on specific programmes (i.e. stigma and discrimination reduction).

4.2 Social Protection for households affected by HIV and AIDS

Overview

HIV and AIDS have largely contributed to the deterioration of human development and human capital. Fifty six (56%) percent of the population live below the national poverty line, while 43.3% live on less than one dollar a day[38]. This is group that the NSP will target with programmes with social protection. This presents an entry point for social development, where preventive (e.g. health insurance) or protective (e.g. cash transfers or school feeding) programmes may play an important role in supporting and maintaining the productive participation of the poor in economic activities, and in breaking the poverty cycle and intergenerational transmission HIV.

The United Nations presents the overall benefit of social protection as contributing and extending beyond households and people affected by HIV, but also promotes HIV programmes that are equitable, inclusive, non-stigmatizing and non-discriminatory. Hence the revised NSP recommends and provides for HIV-sensitive and inclusive rather than HIV-exclusive social protection programmes.

Table 20 shows the UNICEF 2008 framework and strategy for Social Protection in Eastern and Southern Africa,to illustrate social protection interventions.

Table 20: Social Protection Interventions

Social Protection Programs[39]			
Transformative	**Promotive**	**Preventive**	**Protective**
Social protection law. Legislative and regulatory Reform. Sensitisation campaigns Social communication to promote behavioural change. Strengthening legal system for protection of vulnerable populations.	Second chance education. Skills training Integrated early childhood development. Conditional cash transfers Asset building and livelihood development	Contributory social Insurance / social security (pensions, maternity, disability, etc.) Universal social pensions Universal child allowances Health insurance Savings and credit schemes Burial societies Disaster/crop insurance	Public employment schemes Feeding programs Child protective services Cash transfers Fee waivers Family support services Humanitarian relief

Source: adapted from UNICEF (2008): Social Protection framework in Eastern and Southern Africa,

HIV sensitive social protection as a development synergy for core programmes would help to

i. Mitigate social and economic impacts of HIV on affected households and individuals, provided that programmes are focused to the particular needs of people living with and affected by HIV.
ii. Address the multiple social determinants of the epidemic such as income inequalities; gender inequalities; social exclusion and thus contribute to a reduction in new infections.
iii. Address demand side barriers to access HIV services with potential to improve prevention, treatment and care and support outcomes

4.2.1. Vulnerable children

Situation analysis

The Situation Analysis of Orphans and Vulnerable Children (OVC) in Lesotho of 2011, estimates that vulnerable children in Lesotho are between 10% and 13% (125,000) of the total population of children (1,072,974) between the ages 0-17 years. The total estimated number of orphaned children is 363,526, of whom 213,248are paternal orphans, 64,647 maternal orphans and 85,631 double orphans. In 2009, 7,850 of the children aged 0 – 14 were living with HIV and were in need of ART and by 2013 the number reached with ART is 5695 (females: 2737, M: 2658) and this is 23% of 12,690, the target for 2013[40].

The Situation Analysis of OVC of 2011 redefined a vulnerable child as “a child whose rights to survival, development, protection and participation are not met” because of certain conditions or circumstances. Vulnerable Children (VC) are more susceptible to risk of early sexual debut due to lack of parental guidance and sexual abuse to due to lack of adequate social protection. Vulnerable children also experience stigmatisation and discrimination both at home, in the community or at school. Anecdotal data indicates that more often VC, especially girls, assume the role of caregivers and heads of households compromising their right to attend school and making them more vulnerable to abuse, neglect and rejection, additionally blocking their access to education and health care.

The NSP strategies that address the challenges of HIV and vulnerable children are aligned to the National Strategic Plan for Vulnerable Children (NSPVC) (2012). These strategies aim to enhance synergies and maximise results for HIV prevention, treatment, care and support programmes. Among the core strategies are ensuring social and legal protection of vulnerable children, strengthening families and communities capacity to protect, care, and support of vulnerable children, and scaling up availability and access to services by vulnerable children and their families.

The provision of ART to PLHIV has significantly changed and postponed orphanhood in many cases, as parents living with HIV live longer. However, the challenges social and economic challenges that face vulnerable children persist.

Gaps and challenges

i. The National Policy for OVC is not adequately aligned to new and emerging issues of child vulnerability that need policy guidance.
ii. The Children's Protection and Welfare Act (CPWA) 2011 regulations are not yet developed. This makes operationalising the Act difficult.
iii. Communities and families with vulnerable children lack adequate knowledge, skills and capacity to care for vulnerable children.
iv. Inadequate access and optimal utilisation of basic services by vulnerable children.
v. Lack of reliable data to inform policy and planning for vulnerable children. Current data is from different sources and is not harmonised.

Priority strategies

i. Advocate and review the National Policy for Orphans and Vulnerable Children to strengthen it and to incorporate new and emerging issues and for its effective implementation and monitoring
ii. Develop regulations for the Child Protection and Welfare Act 2011 to ensure its effective implementation and enforcement.
iii. Design, implement and monitor HIV and gender sensitive social protection interventions that include community-based capacity development, sustainable livelihood and entrepreneurship programmes for households with vulnerable children.
iv. Strengthen synergies with appropriate sectors and Government line Ministries and share the responsibility for the programme as well as share the cost in order to improve access to health care, education, psychosocial support, food and nutrition and protection[41] for vulnerable children.
v. Strengthen the National Information System for Social Assistance (NISSA) as one central database that incorporates data from other service provider including CSO. This will also entail including relevant indicators..
vi. Improve the effectiveness of the National OVC Coordinating Committee (NOCC). This will require considering human resources, funding, and use of strategic information

Results and indicators

The goal for Lesotho is to provide social protection for vulnerable children. The indicators shown in Table 21 will be used to measure sustainability and cost efficiency of the response.

Table 21- Vulnerable Children (VC)

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	Vulnerable Children	*Result 1: By 2016, all vulnerable children will be provided with social protection*			
Outcome	VC	Current school attendance among orphans and non-orphans aged 10–14*	Orphans = 86.7% Non-orphans =87.5%		100% (for both)
Outcome	VC	% Of vulnerable children 0-17 years who received basic external support **	Not available	60%	100% (125,000)

*Baseline is from OVC Situational Analysis (SitAn), 2011. ** Support provided include social protection, provision of health, education, food and nutrition and or economic livelihood

4.2.2 Other Vulnerable Groups

Situation Analysis

The success of any multi-sectoral response to HIV is dependent on meaningful participation and involvement of PLHIV. The NSP MTR has shown that the total cumulative number of PLHIV has increased from 148,791 in 2011 to 181,510 in 2012. The number of children is 11,402 from 9,594, women is 113,665 from 93,385 and 56,443 from 45,812 men. The presented scenario indicates the levels of vulnerability this group is exposed to, which calls forth rigorous measures for changing results in this sector.

Vulnerable groups and individuals have a higher risk of HIV infections given the risks and vulnerability factors that confront them. Table 22 below illustrates key HIV and socioeconomic vulnerabilities that require sustained response over a longer period to yield results. These vulnerabilities were identified through mid-term review of the NSP. To ensure effective implementation of strategies that address these issues, synergies will be developed with appropriate sectors.

Table 22 - Socioeconomic vulnerabilities affecting vulnerable groups

Vulnerable Group	Population Size	HIV related vulnerabilities	Socio-economic vulnerabilities
People with disability	61,874	Sexual abuse, risks to HIV infection, access to health care, access to food and nutrition care	Abuse, neglect and rejection, inhibits access to education social, legal and judicial protection, property dispossession, lack of parental guidance, caregivers and heads of households, compromised right to attend school, sustainable livelihoods and micro-enterprise
Orphans	363,526	Denied HIV information on transmission and prevention, stigma and discrimination, access to food and nutrition care	
Vulnerable children	125,000	Early sexual debut, access to health care, access to food and nutrition care	
Herd boys	16,227	Risk-taking behaviour (MSM), sexual abuse, access to food and nutrition care	Compromised right to attend school, risky cultural and social practices, reaching services,
Women and girls (15-49)	494,967	Access to information, education, freedom of expression and association, sexual abuse, risks to HIV infection, access to health care,	Compromised legal status, lack of respect for the rights of women, risky cultural and social practices, sustainable livelihoods and micro-enterprise and GBV
PLHIV	238,977	Risk and exposure to re-infection, access to health care, denial, fear, stigmatisation and discrimination, access to food and nutrition care	Barriers for participation and inclusiveness, risky cultural and social practices, sustainable livelihoods and micro-enterprise
Mobile population	Not available	Sexual abuse, risks to HIV infection, access to health care, access to food and nutrition care	Barriers for participation and inclusiveness, risky cultural and social practices, compromised legal status, lack of respect for the rights of women, sustainable livelihoods and micro-enterprise

Strengthening a human rights-based approach in the implementation of the NSP strategies will enhance the possibilities of addressing vulnerabilities articulated in table 22 above. An emerging vulnerability factor at household is food insecurity and lack of adequate nutrition. Food security has served as a household safety net that also tends to promote social protection. Combined with AIDS, poverty, food insecurity increases the probability of engaging in risk behaviours such as transactional sex for both adults and

young girls in particular. It is estimated that 15% of Basotho are malnourished and 30% are food insecure[42]. The LDHS (2009) estimated that 39% of children under five are stunted, 4% are wasted and 13% are underweight. This illustrates the urgency to improve household food security.

Gaps and Challenges

i. Delays in finalising the Social Development Policy incorporating issues of VC and address strategic issues of social protection in the context of impact mitigation.
ii. Data on social and economic impacts of HIV on vulnerable groups is limited. The challenge is compounded by the fact that definition of vulnerability varies from one stakeholder to another and from one strategy document to another i.e. vulnerability is defined differently by the Lesotho Vulnerability Assessment Committee (LVAC) and the National Strategic Development Plan (NSDP), and hence the measurement indicators are not compared.
iii. Coverage of services for vulnerable groups remains inadequate resulting in limited access and utilisation of basic services.

Strategic Priorities

i. Accelerate the finalisation of the Social Development Policy incorporating issues of VC and address strategic issues of social protection in the context of impact mitigation
ii. Design and adopt national HIV and gender sensitive social protection strategy that would help focus desired social protection and impact mitigation of the results.
iii. Review and improve NISSA to ensure comprehensive monitoring and data collection on social protection of PLHIV, their families and children.
iv. Facilitate the review and strengthening of the food security assessment tool by LVAC to ensure it is capability to collect comprehensive data on vulnerable groups affected by HIV and AIDS.

Results and indicators

The goal for Lesotho is strengthen social protection of vulnerable households and facilitate their movement from social welfare to social development. The indicator shown in table 23 below will be used to measure social protection for vulnerable households.

Table 23 - Support for vulnerable groups and households

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	Vulnerable Households	*Result 1: By 2016, at least 60% of vulnerable households are provided with social protection and facilitated their movement from social welfare to social development*			
Outcome	VH	% of the poorest households who received external** economic support in the past 3 months	181,620 (43%) (Census 2006)	50% (90,810)	60% (108,972)

*Baseline is from Census 2006 and LVAC 2012, HH=Household;

** External economic support is defined as free economic help (cash grants, assistance for school fees, material support for education, income generation support in cash or kind, food assistance provided at the household level, or material or financial support for shelter) that comes from a source other than friends, family or neighbours unless they are working for a community-based group or organization.

4.3 Systems Strengthening

4.3.1 Health Systems strengthening (HSS)

Situation Analysis

Lesotho is committed to strengthening its health systems as a strategy of ensuring effective and efficient equitable distribution and provision of health and HIV and AIDS service. Most of health systems strengthening initiatives are based on the Health Systems review report conducted by MOH in 2010. In the context of the national HIV and AIDS response, the health systems strengthening has prioritised human resources, strategic information management, procurement and supply management

Human resources remain the greatest challenge as Lesotho continues to experience shortage of skilled, and experienced human resources. The number of doctors per 1,000 populations is four times lower than the Africa regional average (0.049 versus 0.217). One Community Health Worker (CHW) is responsible for approximately 40 households or two villages, depending on the size of these villages. Distribution of existing staff is equally uneven. While primary health care provides 60% of health care, only 20% of the health workforce is attached to PHC. In The largest (46%) share of workers is employed at secondary level and 24% at tertiary level.

With the closure of NAC secretariat the M&E system has become dysfunctional. Other than programme routine data, no new population-based surveys have been conducted to generated new data since the last LDHS in 2009. This is evident as most NSP indicator baselines are still missing. Where data exists, it is fragmented and often inaccessible. Use of strategic information to inform policy and programming remains weak.

The procurement and supply of drugs and health commodities is the responsibility of NDSO. A key challenge facing NDSO is lack of adequate, qualified and experienced human resources. This affects the timely procurement and cost effectiveness of the procurement and supply chain management resulting in stock-outs, inadequate or emergency procurements of drugs and other commodities.

Lesotho spends $54 per capita on health, which is higher than the $34 per capita. Lesotho also provides 70% of the funding for ARVs. The key challenge is that the National HIV and AIDS response is unsustainable as it largely depends on external funding. Service delivery could also be improved to increase efficiency gains.

While physical access has improved, quality of services and service delivery has remained poor. Utilization rates are some of the lowest in the world. The World Bank Health Sector Expenditure Review reported a per capita outpatient visit ratio of 0.75 in 2009. This correlates to less than one visit per year, per Basotho and is well below the WHO norm of 3.5 visits per capita per year (Strachan 2007). It is estimated that 79.5% of the national population lives within two hours' walking distance of a fixed facility, where most of it is over rough terrain. This is attributed to inadequacy of trained personnel and drug stock-outs.

Lesotho is rehabilitating its health facilities to ensure equitable distribution of health care services including HIV and AIDS related services. Service delivery is also being decentralized to districts through the DHMT while some services are also being out sourced to private sector. This is likely to change the service provision landscape with improved equitable distribution, integration and increased accessibility and utilization of services. However the decentralization is occurring unevenly in the health sector in Lesotho.

At the primary level of the health system, the link between the community and the 'formal' health system remain undefined. Efforts are being to address this through community systems strengthening and consolidating linkages with the health system.

Proposed Health Systems priority Actions

The table below illustrates the strategic actions that will be taken during the implementation of the NSP to address the health systems strengthening from a HIV and AIDS perspective. However it should be noted that a strengthened health system will support both HIV and AID response in addition to ensuring equitable and comprehensive health services too.

Table 24 - Pillars of Health Systems Strengthening (HSS)

Component	Description
Human Resources	Adequate, skilled and competent human resources are a pre-requisite for the implementation of the NSP. Developing human resource capacity is a long term and continuous strategy that will take into account the current and future requirements. The NSP strategy will focus on improving the existing skills, recruiting additional human resources, strategic deployment and retention
Strategic Information	NSP will focus on strengthening the management of strategic information at all levels. M&E systems (HMIS, LOMSHA, and OVC) will be harmonised and aligned. The capacity for applied research will be further developed. Policy makers will be capacitated to use evidence-based information for decision and policymaking.
Leadership and governance	Given the complexity of the epidemic leadership and governance will be strengthened to ensure that strategic policy frameworks exist and are combined with effective oversight, coalition-building, provision of appropriate regulations and incentives, while paying attention to system-design, and accountability
Procurement and supply chain management and / commodity security	The NSP strategy is to ensure equitable access to quality essential medical products and technologies that assures safety, efficacy and cost-effectiveness. This will entail strengthening procurement and supply chain management systems by developing staff capacity in forecasting, quantification, procurement, warehousing and distribution of commodities.
Sustainable Financing	The NSP will support development and implementation of sustainable health financing systems.

Gaps and challenges

i. Inadequate human resources capacity (adequacy, skills and competencies) necessary to delivery comprehensive HIV and AIDS services.
ii. Lack of a human resources retention strategy targeting skilled and experienced personnel.
iii. Strategic information management systems are fragmented, poorly coordinated and under-resourced.
iv. Lack of sustainable funding strategies for the national HIV and AIDS response.
v. A weak and inefficient procurement and supply chain management systems.

Priority strategies

i. Undertake a comprehensive capacity assessment with a focus on capacity required for the implementation of the national response during and beyond the current NSP time frame.
ii. Develop a human resource capacity development strategy for the non-health sector institutions.
iii. Advocate for the implementation of the Health sector Human Resources Strategic Plan 2005 - 2025. This would also address issues of skilled and experienced human resources retention.

iv. Strengthen the M&E and HIV research capacity to generate new data necessary for measuring progress and providing indicator baselines.
v. Strengthen procurement supply chain management system, including condom management.

Results and indicators
The goal for Lesotho is to ensure equitable distribution, access and utilisation of comprehensive and quality HIV and AIDS services through a strengthened health system.

Table 15 - Health systems strengthening (HSS)

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	Health System Strengthened	*Result 1: By 2016, the health system is strengthened to ensure equitable distribution, access and utilisation of HIV services*			
Outcome	HSS	Health systems strengthened	5 (NCPI, 2007)	6	8
Outcome	HSS	% of health facilities reporting no stock out of ARVs, test kits, reagents	ARVs= TBD Test kits=TBD Reagents = TBD		ARVs=0% Test kits=0% Reagents =0%

Note: The NCPI is a composite indicator measurement that enables measurement of different variables that add to a common result.

4.3.2 Community Systems Strengthening

Situation analysis
Community involvement and participation in the national response has been the cornerstone for the success of the multisectoral response within the context of community mobilisation, demand creation, reduction of stigma and discrimination, retention in key services and in strengthening an enabling social environment for key populations. Available evidence indicates that effective participation is dependent on the existence of strong and effective community structures and community driven strategies.

It is for these reasons that community systems strengthening (CSS) have been prioritised in the NSP. It is anticipated that CCS will facilitate development of critical synergies between the community-based programmes with development sectors including civil society sector.

The NSP strategy for CSS is to empower communities to take leadership and control of community-based interventions. CSS will be modelled around the six blocks of systems strengthening discussed under health systems strengthening above. Operational linkages will be established between health, community and social protection systems. Developing linkages will enhance maximising the three systems collective efficiencies, effectiveness and development synergies, with other Government sectors. Such synergies will strengthen community capacity to address issues of livelihoods that are not the core business of the HIV, but have significant implications on the success of prevention and treatment programmes.

It is anticipated that strong community systems will accelerate the implementation and service delivery in key programmes including HTC, VMMC, ART and TB outreach refills, These services are essential in alleviating the burden of care in health facilities. In the case of community based care of PLHIV, communities must gear themselves to new functions given the impact of ART on PLHIV.

Gaps and Challenges

i. Weak community systems. The systems are largely understaffed and under resourced. Lack of a systematic plan for community systems strengthening has compromised their effectiveness and efficiency.
ii. Most communities don't know what HIV services are available, who is providing them and for whom. Communities don't have the resources and expertise to conduct a community mapping. The government does not have a common vulnerability assessment framework.
iii. Weak community leadership on issues of HIV, gender and human rights

Priority strategies

i. Accelerate community systems strengthening based on the six blocks of health systems strengthening.
ii. Strengthen community leadership and advocacy skills, including advocacy, HIV planning and budgeting, communication, especially given their role in facilitating community dialogue and conversations.
iii. Strengthen capacity of vulnerable households and communities to identify and implement sustainable livelihoods as coping strategies.
iv. Strength the welfare support system.

Results and indicators

The goal for Lesotho is to ensure effective community participation, access and utilisation of HIV services. The indicators shown in Table 16 will be used to measure sustainability and cost efficiency of the response

Table 16 Community Systems Strengthening (CSS)

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	Health System Strengthened	*Result 1: By 2016, the community system is strengthened to ensure effective community participation, access and utilisation of HIV services*			
Outcome	HSS	Community systems strengthened	5 (NCPI, 2007)	6	8

Note: The NCPI is a composite indicator measurement that enables measurement of different variables that add to a common result.

Section 5: National Strategic Plan Costing and Investment Returns

This section presents an analysis of the financial gap of the costing of the NSP for the period 2013-2016 (Resources Needed), Resources available to fund the plan (Resource Envelope), and Resource gap to be mobilised in order to implement at full scale the HIV and AIDS interventions. The financial gap analysis and distribution by intervention is shown below. It is worth noting that the available resources between 2014 and 2016 are assumed to remain constant. The estimates were based on the current unit cost of providing a particular HIV intervention at a targeted coverage level per year in the same reference period. The Resource Needs Model was the primary tool used to derive the estimates and the CHAI Resources Tracking Tool was used to determine the available resource envelope between 2013 and 2016. The rapid-scale up under the Investment Framework scenario will require large increases in expenditures as shown in table 27.

Table 27 - Financial Gap Analysis in Millions of US Dollars, Years 2013-2016

Programme Area	Resources Needed (USD Millions)					Resource Envelope Available (USD Millions)					Resource Gap to be Mobilised (USD Millions)				
	2013	2014	2015	2016	Total	2013	2014	2015	2016	Total	2013	2014	2015	2016	Total
Prevention															
PMTCT	$1	$2	$3	$3	$10	$4	$8	$8	$8	$27	$2	$6	$5	$4	$17
VMMC	$4	$13	$14	$6	$37	$4	$5	$5	$5	$20	$0	-$8	-$9	-$1	-$17
HTC	$3	$11	$14	$2	$30	$2	$3	$3	$3	$11	-$1	-$8	-$11	$1	-$19
Other Prevention	$5	$8	$10	$13	$36	$4	$10	$10	$10	$33	-$2	$2	$0	-$3	-$3
Total Prevention	**$14**	**$34**	**$41**	**$24**	**$113**	**$14**	**$26**	**$26**	**$26**	**$91**	**$0**	**-$8**	**-$15**	**$2**	**-$21**
Care and Treatment Services															
Care and Treatment	$34	$55	$79	$85	$253	$43	$44	$44	$44	$176	$8	-$11	-$34	-$40	-$77
Paediatric ART	$1	$2	$4	$5	$13	$1	$2	$2	$2	$7	$0	-$1	-$2	-$4	-$7
TB HIV	$1	$1	$1	$1	$2	$3	$4	$4	$4	$15	$3	$3	$3	$3	$12
Total Care and Treatment	**$36**	**$58**	**$83**	**$91**	**$269**	**$47**	**$50**	**$50**	**$50**	**$197**	**$11**	**-$8**	**-$33**	**-$41**	**-$72**
Impact Mitigation Vulnerable Children & Household Economic Security	$20	$26	$32	$39	$117	$15	$17	$17	$17	$66	-$5	-$9	-$15	-$22	-$50
Total Impact Mitigation	**$20**	**$26**	**$32**	**$39**	**$117**	**$15**	**$17**	**$17**	**$17**	**$66**	**-$5**	**-$9**	**-$15**	**-$22**	**-$50**
Programme Coordination & Management															
Programme Coordination & Management	$24	$47	$61	$44	$176	$11	$24	$24	$24	$82	-$13	-$23	-$37	-$20	-$93
Total Programme Coordination & Management	**$24**	**$47**	**$61**	**$44**	**$176**	**$11**	**$24**	**$24**	**$24**	**$82**	**-$13**	**-$23**	**-$37**	**-$20**	**-$93**
GRAND TOTAL	**$94**	**$165**	**$217**	**$198**	**$674**	**$87**	**$116**	**$116**	**$116**	**$437**	**-$7**	**-$48**	**-$100**	**-$82**	**-$237**

5.1 Resources Needed to Fully Implement the HIV and AIDS Response

According to table 27, HIV resources required to implement HIV programmes that will yield impactful results in the short term is USD674 million between 2013 and 2016. Of the total HIV resource needs, Care and Treatment services accounts for 40% (USD269 million); Programme Management and Coordination – 26% (USD USD176 million); followed by Impact Mitigation – 17% (USD117 million) and Prevention – 17% (USD113 million). Annual expenditures would double, from around US$94 million in 2013 to around US$ 198 million by 2016.

5.2 Resources Available to Fully Fund the HIV and AIDS Response

Findings in table 27 show that the total resources available to fund the HIV and AIDS in Lesotho between 2013 and 2016 is USD437 million. About 45% (USD197 million) is earmarked to support care and treatment HIV services; 21% (USD91 million) to support HIV prevention services; 19% (US82 million) Programme management and coordination costs; and 15% (USD66 million) Impact Mitigation interventions, mainly household economic security. The committed funds is assumed to increase from USD87 million in 2013 to a constant USD116 million between 2014 and 2016.

5.3 Financial Resource Gap Required to Mobilized to Fully Fund the HIV and AIDS Response

According to table 27, a total of USD237 million financial resource gap is required to be mobilised to fully fund the HIV and AIDS response in Lesotho between 2013 and 2016. Programme management and coordination accounts for the largest shortfall at 39% (USD93 million); followed by care and treatment HIV services at 30% (USD72 million); then Impact mitigation at 21% (USD50 million) and lastly, HIV Prevention services at 9% (USD21 million). The financial gap increases from a meagre USD7million in 2013 to a whooping USD100 million in 2015 and USD82 million in 2016.

5.4 Returns for Investments

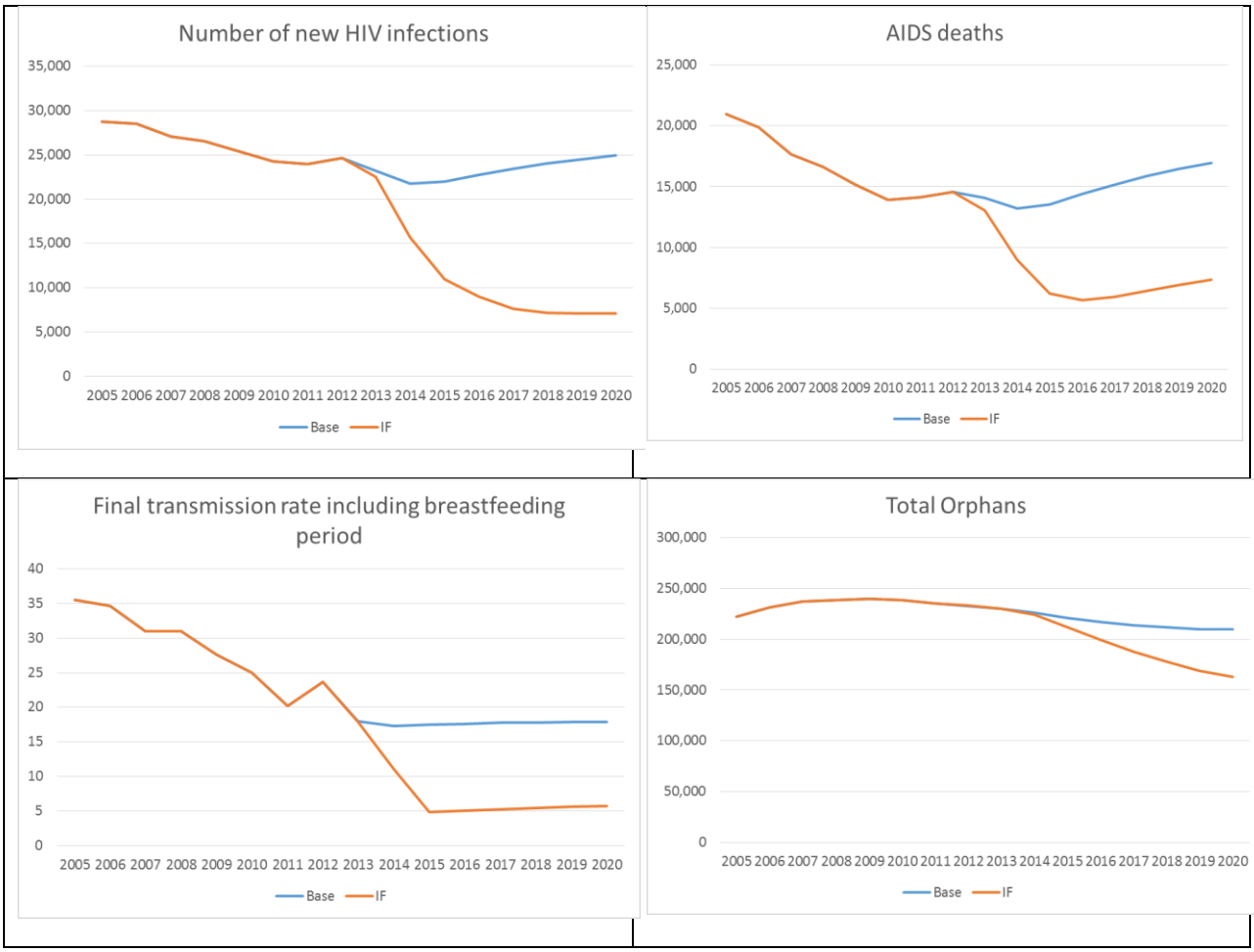
Scaling up programs to meet the targets of the Investment Framework would produce significant benefits including averting nearly 100,000 new HIV infections, nearly 60,000 AIDS-related deaths and close to 180,000 orphans. Table 28 provides a summary of the impacts. The trend in new infections, AIDS deaths, MTCT rates & orphans is shown in Figure 2. The incremental expenditure for the Investment Framework scenario results in a finding of $7,153 per infection averted and $11,953 per death averted. The most cost effective individual interventions are male circumcision, condom promotion, and prevention programs for sex workers and clients.

Table 28: Impact of Scaling Up Prevention and Treatment

Indicator	2013-2020	Percentage
Infections averted	99,668	-53%
Adult infections averted	87,640	-53%
Child infections averted	12,030	-61%
AIDS-related deaths averted	59,294	-50%
Adult deaths averted	51,657	-50%
Child deaths averted	7,641	-49%
Orphans averted	176,932	-10%
Cost of per infection averted	$7,153	N/A
Cost of per death averted	$11, 953	N/A

The number of new infections would be reduced by 53% by 2020 from about 29,000 in 2013 to just 7,000 in 2020. Without the rapid scale-up of intervention there would still be about 25,000 new infections in 2020. The number of AIDS deaths would drop even more sharply due to the effects of scaling up ART. Deaths would be 50% lower in 2020 with rapid scale-up. The scale-up of PMTCT coverage under the Investment Framework scenario would reduce the percentage of children of HIV+ mother who become infected from about 18% today to 6% by 2020. (Half of this transmission is due to the few women not covered by the program.) This will avert approximately 12,000 new child infections during the period 2013-2020 but it is still short of the global goal of reducing transmission to less than 5%.

Figure 2: Impact of Scaling-Up Treatment and HIV Prevention Services



With estimated investments between 2013 and 2016 of USD237 million, the returns will be as follows:

- ✓ HLM and MDG 6 targets will be met
- ✓ About 32,000 new HIV infections will be averted
- ✓ About 21,000 AIDS related deaths will be averted
- ✓ MTCT rate will reduce more than three-fold
- ✓ Will save about USD100million additional resources per year required to put patients on lifetime treatment as a result of averting new HIV infections

In the medium to long term (2013-2020),

- ✓ HLM and MDG 6 targets will be met
- ✓ About 99,700 new HIV infections will be averted, representing a 53% reduction in new HIV infections

- ✓ About 59,300 AIDS related deaths will be averted, representing a 50% reduction in AIDS related deaths
- ✓ MTCT rate will reduce more than three-fold
- ✓ Will save over USD625 million additional resources required to put patients on lifetime treatment as a result of averting new HIV infections.
    - Estimated cost of averting new HIV infection is USD7,153
    - Estimated cost of averting an AIDS related death is USD11,953

Section 6 - Annexes

Annex 1 – The NSP Results Framework –Impact and Outcome Indicators & Targets

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	Prevention	*Result 1 General Population, Key Populations and their clients adopt safer sexual behaviour , reduce sexual transmission of HIV by 50% & keep atleast 85% of PLHIVs on treatment alive by 2015/16*			
Impact	Prevention	Percentage of young women and men aged 15–24 who are HIV infected	Women 13.6% Men 4.2% LDHS, 2009	Women 10% Men 3.2%	Women 7% Men 2.1%
Impact	Treatment	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	2010-74%	72%	85%
Impact	Prevention	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	MTCT at 6 weeks – 10.02% (2010) MTCT including breastfeeding – 24.97% (2010) (2012 Spectrum)	8.4% 17.9%	1.3% 5.0%
	TREATMENT, CARE & SUPPORT				
	Treatment	*Result 1: At least 80% of eligible Adult and Child PLHIVs reached with lifesaving antiretroviral treatment and ART services scaled up by 2015/16* *Result 1: TB deaths in people living with HIV reduced by 50% by 2015/16*			
Outcome	ART	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	2010 - Adults 58.7%	70%	80%
			2010 - Children 21%	65%	80%
Outcome	TB/HIV	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	2010- 26.9% (MoH)	60%	80%

RESULT LEVEL	THEME & SUB-THEME	INDICATOR	BASELINE	2013	2015/16
	ELIMINATION OF MOTHER TO CHILD TRANSMISSION OF HIV				
	eMTCT	*Result 1: Mother-to-child transmission of HIV during pregnancy, child birth and breastfeeding reduced to less than 5% by 2015/16* *Result 2: Access to lifesaving treatment for HIV+ pregnant women increased to 90% by 2015/16 and AIDS-related maternal deaths substantially reduced*			
Outcome	eMTCT	Percentage of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission	50.3% (MoH, 2010)	80%	90%
Outcome	eMTCT	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	2010 - %	80%	100%
	MEDICAL MALE CIRCUMCISION				
	MC	*Result 1: Quality Male Medical Scaled Up and 80% of males circumcised by 2015/16*			
Outcome	MC	Percentage of men age 15-49 who report having been circumcised	15-24 = 42.1% 15-49 =51.6% LDHS, 2009	15-24 = 53% 15-49 =65%	15-24 = 70% 15-49 =80%
	CONDOM PROMOTION AND DISTRIBUTION				
	Condom Promotion	*Result 1: Condom use among general population engaged in risky sexual behaviour increased by at least 50% by 2015/16*			
Outcome	Condom Promotion	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	15-49yrs women 38.5% Men 52.3% LDHS, 2009	15-49yrs women 48% Men 65%	15-49yrs women 60% Men75%
			15-24yrs women 64.0% Men 64.4% LDHS, 2009	15-24yrs women 70% Men 70%	15-24yrs women 80% Men 80%
RESULT	**THEME &**	**INDICATOR**	**BASELINE**	**2013**	**2015/16**

LEVEL	SUB-THEME				
	HIV TESTING AND COUNSELLING				
	HTC	*Result 1: HIV testing and counselling services scaled up and at least 50% people who know their HIV status by 2015/16*			
Outcome	HCT	Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results	15-49yrs women 42.0% Men 24% LDHS, 2009	15-49yrs women 53% Men 30%	15-49yrs women 63% Men 50%
			15-24yrs women 40.4% Men 17.1% LDHS, 2009	15-24yrs women 50% Men 22%	15-24yrs women 60% Men 40%
	KEY POPULATIONS				
	Key Populations	*Result 1: Comprehensive knowledge about HIV and AIDS increased by at least 50% by 2015/16 and key populations adopt safer sexual behaviour* *Result 2: Condom use among key populations engaged in risky sexual behaviour increased by at least 50% by 2015/16* *Result 1: HIV testing and counselling services scaled up and at least 80% key populations who know their HIV status by 2015/16*			
Outcome	SBCC	Percentage of key populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	CSW 15-24 yrs 15-49 yrs	CSW 15-24 yrs 15-49 yrs	CSW 15-24 yrs 15-49 yrs
			MSM 15-24 yrs 15-49 yrs	MSM 15-24 yrs 15-49 yrs	MSM 15-24 yrs 15-49 yrs
Outcome	Condom Promotion	Percentage of CSW and MSM reporting use of a condom with their most recent partner	CSW -TBD MSM - TBD	CSW = % MSM = %	CSW =80% MSM=80%
Outcome	HTC	Percentage of CSW and MSM aged 15–49 who received an HIV test in the last 12 months and who know the results	CSW -TBD MSM - TBD	CSW = % MSM = %	CSW =80% MSM=80%
RESULT	**THEME &**	**INDICATOR**	**BASELINE**	**2013**	**2015/16**

LEVEL	SUB-THEME				
	SOCIAL AND BEHAVIOUR CHANGE COMMUNICATION				
	SBCC	*Result 1: Comprehensive knowledge about HIV and AIDS increased by at least 50% by 2015/16 and general population adopt safer sexual behaviour*			
Outcome	SBCC	Percentage of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by age and sex)	15-24yrs: women 23.7% Men 32.9% LDHS, 2009	15-24yrs: women 30% Men 41%	15-24yrs: women 36% Men50%
			15-49yrs: women 42.3% Men 32.2% LDHS, 2009	15-49yrs: women 53% Men 40%	15-49yrs: women 63% Men 48%
Outcome	SBCC	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (disaggregated by age and sex)	15-24yrs women 7.8% Men 22.1% LDHS, 2009	15-24yrs women 6% Men 16%	15-24yrs women 4% Men 11%
			15-19yrs women 8.5% Men 25.5% LDHS, 2009	15-19yrs women 6.5% Men 19%	15-19yrs women 5% Men 13%
			20-24yrs women 6.9% Men 17.6% LDHS, 2009	20-24yrs Women 5.2% Men 13.2%	20-24yrs women 3.5% Men 9%
Outcome	SBCC	Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months (disaggregated by age and sex)	15-49yrs women 8.8% Men 29.2% LDHS, 2009	15-49yrs women 6.6% Men 22%	15-49yrs women 4.5% Men 15%
			15-24yrs women 7% Men 33.5% LDHS, 2009	15-24yrs women 5% Men 25%	15-24yrs women 3% Men 17%

Annex 2 – The NSP Results Framework –Output Indicators & Targets

Programme Area	Baselines			Targets			
ART	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Adults (15+ years) In need of ART	117,000	132,500	142,300	160,200	240,200	252,500	262,700
Adults (15+ years) Receiving ART	74,563	77,622	87,352	96,300	148,500	208,900	223,100
Coverage	64%	59%	61%	60%	62%	83%	85%
Adults on 2nd line ARV drugs			880	960	1,700	2,100	2,230
Children(0-14 years) Receiving ART	21,000	20,500	20,600	20,000	21,900	20,100	19,700
Children(0-14 years) Receiving ART	4,443	5,014	5,279	5,400	7,900	13,200	16,700
Coverage	21%	24%	26%	27%	36%	66%	85%
Children on 2nd line ARV	270	300	320	330	480	800	1000
Programme Area	**Baselines**			**Targets**			
TB/HIV	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
TB Incidence	13,900	14,000	14,100	14,200	14,200	14,200	14,200
HIV+ TB Incidence	10,600	10,500	10,300	10,000	9,600	9,000	8,400
Number Not Receiving ART	8,200	7,600	7,100	6,400	5,800	5,200	4,500
Coverage receiving ART (%)	27%	40%	60%	60%	70%	75%	80%
Coverage receiving ART (No.)	2,214	3,040	4,260	3,840	4,060	3,900	3,600
Programme Area	**Baselines**			**Targets**			
PMTCT	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
HIV+ Pregnant Women In-need of PMTCT	16,000	16,000	16,000	16,000	16,000	15,000	15,000
Receiving PMTCT according to eMTCT plan	8,047	12,090	11,389	12,611	13,417	14,077	15,000
Coverage	50%	76%	71%	79%	84%	94%	100%
Programme Area	**Baselines**			**Targets**			
VMMC	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
No of MMC 15-49			3886	37469	113191	118652	44018
% progression (cumulative)			16%	24%	48%	72%	79%
No of neonatal MMC			0	745	3140	5569	6261
% progression (cumulative)			0	10%	40%	71%	79%
Total MMC			3886	38214	116331	124221	50279
Programme Area	**Baselines**			**Targets**			
Condom Promotion & Distribution	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Male Condoms				23,007,169	23,237,241	23,469,613	23,704,310
Female Condoms				5,751,792	5,809,310	5,867,403	5,926,077
Total				28,758,961	29,046,551	29,337,016	29,630,387

Programme Area	Baselines			Targets			
HIV Testing & Counselling	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Number testing & receiving results	256,526		310,059	427,500	537,180	626,500	731,680
Coverage (%)	32%	34%	37%	50%	60%	70%	80%
Programme Area	**Baselines**			**Targets**			
SBCC - 15-49 Years	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Number Reached with SBCC	-		156,292	319,843	416,617	501,827	555,441
Coverage (%)		15%	20%	40%	50%	60%	65%
SBCC - 15-24 Years							
Number Reached with SBCC	-	58,251	78,241	158,203	199,188	240,746	262,673
Coverage (%)		15%	20%	40%	50%	60%	65%
Programme Area	**Baselines**			**Targets**			
Vulnerable Children	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Number of Vulnerable Children			105,000	105,000	105,000	105,000	105,000
Number of Vulnerable Children Reached			76,226	84,000	94,500	105,000	105,000
Coverage (%)			73%	80%	90%	100%	100%
Number of Vulnerable Households			182,000	182,000	182,000	182,000	182,000
Number of Vulnerable Households Reached			76,226	91,000	100,100	109,200	118,300
Coverage (%)			43%	50%	55%	60%	65%
Programme Area	**Baselines**			**Targets**			
Key Populations			**2012**	**2013**	**2014**	**2015**	**2016**
Estimated Number of Sex Workers			10,779	10,946	11,115	11,288	11,463
Coverage number			1,078	1,824	2,594	3,386	4,203
Coverage (%)			10%	17%	23%	30%	37%
Estimated Number of MSM			6,356	6,454	6,554	6,656	6,759
Number			127	645	1,180	1,730	2,298
Coverage %			2%	10%	18%	26%	34%
Estimated Number of Prisoners			2,500	2,539	2,578	2,618	2,659
Number			1,825	1,925	2,028	2,134	2,242
Coverage %			73%	76%	79%	82%	84%
Estimated Number of Mobile and Migrant Populations			57,202	58,089	58,989	59,903	60,831
Number			1,144	5,809	10,618	15,575	20,683
Coverage %			2%	10%	18%	26%	34%

Annex 3 Glossary of Terms Used

Term	Definition
Baseline	A quantity, value or fact used as a standard for measuring other quantities and values. Represents the current status.
Critical enablers	These are activities that are necessary to support the effectiveness and efficiency of core programme activities in HIV and their primary purpose is to contribute to HIV related outcomes as they are more HIV-specific. Enablers help overcome major barriers to service uptake such as, stigma and inequity, etc. and they are presented as social and programme enablers.
Culture	Refers to people's inherited way of life. It is manifested through cultural practices and is defined by cultural norms and attitudes.
Development synergies	These are investments in other sectors that can have a positive effect on HIV results and they have limited HIV specificity since their existence is normally not for HIV. Synergies have a broader range of impact across health and other development sectors and hence present opportunities for collaboration and complementarity in multiple contexts.
Discordant couples	A case where one member of a couple is HIV positive and the other is not.
Duty bearer	The person or institution with a legal mandate to provide certain services to another person in need.
Effectiveness	The extent to which an intervention objective was achieved or is expected to be achieved
Efficiency	A measure of how economically resources / inputs are converted to results
Empowerment	Action taken to overcome obstacles arising from inequality between people and between gender – male and female.
Family	A social unit by blood, marriage, and or adoption, defined by common line relationship of a paternal, maternal or parental nature. This can be biological or adoptive, It can be described as nuclear (parents and children) or extended (the conjugal family as well as other relatives or ascendants of the husband or wife)
Gender	Refers to the social conceptualization of males and female based on social differences and relations between them that are learnt, changeable over time, and have wide variations across cultures. They are context specific and can be modified.
Gender empowerment	A composite index measuring gender inequality in three basic dimensions of socio-economic and political participation in decision-making and power over economic resources. Empowerment of women means development of their ability, collectively and individually to take control of their lives, to identify their needs, to determine interests that suit them.
Gender equality	Entails the concept that all human beings, both men and women are free to develop their personal abilities or make choices without limitations set by stereotypes, rigid gender roles and prejudices; so that their rights, responsibilities, and opportunities do not depend on whether they are born male or female.
Gender equity	It is fairness of treatment (distribution) of females and males according to their respective needs, rights, benefits, obligations and opportunities. Equity is the means to reach equality.
Gender-based violence	Gender-based violence is a form of violence derived from the unequal power relationship between men and women. It is the type of violence where either a man or a woman exerts his or her power over the other with the intention to harm, intimidate, and control the other person.
Human Rights Based Approach[1]:	Entails consciously and systematically paying attention to human rights in all aspects of programme development. A HRBA is conceptual framework for the process of development that is normatively based on international standards and

[1] UNFPA, a Human Rights Based Programming: Practical Implementation Manual and Materials

	operationally directed to promoting and protecting human rights.
Multiple and concurrent sexual partners:	Multiple partnerships is a situation where a man or woman has more than one sexual partner and overlapping, or a situation where the partners actively engaged the same time. Concurrent sexual partnerships refer to when a person has "overlapping sexual partnerships where sexual intercourse with one partner occurs between two acts of intercourse with another partner" (UNAIDS Reference Group on Estimates, Modelling, and Projections, 2009). The prevalence of the population with concurrent sexual partners is referred to as 'concurrency prevalence', and this can be measured in two ways – point prevalence of concurrency, and cumulative prevalence of concurrency
Outcome:	A change in behaviour (values, attitudes, practices etc.) of, or the use of new capacities (laws, policies etc.) by target group (people and institutions).
Output:	Operational changes or new capacities (knowledge, skills and equipment, products and services), which result from the completion of activities within a specified intervention in a given time.
Poverty	Poverty is multi-dimensional including shortage of income and deprivation in access to basic social services (education, health and water), food security, shelter, credit and employment. It can be defined in absolute and relative terms. Absolute poverty refers to inability to attain a minimum standard of living measured by a range of economic and social indicators such as household incomes, expenditure per capita, health status, life expectancy, access to basic social services, infant mortality rate, nutritional status and literacy.
Result:	A measurable or describable change in the lives of people or organizations resulting from a cause and effect relationship or programme intervention.
Results chain	The causal sequence for an intervention to achieve impacts, moving from inputs and activities to outputs outcomes and impacts
Rights Holder	A person who has a human and or legal right to claim for services from another person or institution with the mandate to provide such services
Risks	The probability that a person may be affected negatively by a condition or behaviour i.e. acquiring HIV infection
Sex	A biological construct defining the physical differences that males and females are born with
Social protection	A set of interventions whose objective is to reduce social and economic risks and vulnerabilities with vulnerable children and households.
Vulnerability	Results from a range of external factors[2] that are often beyond the ability of a person to control that increases the possibilities of their exposure to HIV infection
Vulnerable groups/households	These are the disproportionately vulnerable to the socio-economic impacts of HIV and AIDS and are those at the lowest quintile

[2] This may include personal factors such as lack of knowledge and skills required to protect oneself, and others; factors pertaining to the quality and coverage of services such as inaccessibility of services due to distance, cost etc., and societal factors such as social and cultural norms, practices beliefs and laws that stigmatize and disempower certain populations such as women and girls.

End-notes

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[28] Modes of Transmission report (2009).
[29] WHO (June, 2013) Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV prevention
[30] WHO Three "I's meeting, Intensified Case Finding, Isoniazid Preventative Therapy and TB Infection Control for people living with HIV, April 2008
[31] In 2008 the NTCP reported that 66.9% of TB patients had been tested for HIV
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