The Government of Lesotho

National HIV and AIDS Strategic Plan 2006 - 2011

(Revised April 2009)

National AIDS Commission

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Preface

The National Strategic Plan (NSP) 2006-2011 which was launched in 2006 has just been revised through a comprehensively consultative process. The design of the Revised NSP provides enough room for communities, civil society, private sector, development partners (bilateral and Multi-lateral agencies) and Government institutions to actively participate in the national response based on their comparative advantage. The NSP has articulated specific interventions for implementation at national, district and community levels.

The Revised NSP provides a shared vision and articulates the roles and responsibilities of various players towards the ultimate reduction of the rate of infection in Lesotho and provision of necessary services for the infected and affected.

The Revised Strategic Plan highlights the importance of strengthening the current policy and operational framework to guide the implementation of the national multi-sectoral response based on the 3 Ones Principle. It also emphasises the importance of using available evidence to set priorities and identify specific interventions while focusing on clearly set impact and outcome level results.

Stakeholders are expected to formulate and implement innovative sector plans that are aligned to the Revised National Strategic Plan. They are further encouraged to adopt the "Results Based Management (RBM)" approach in developing and managing their institutional or sector plans.

The country has also taken note of the lack of empirical data in certain areas of the national response to objectively inform evidence-based-planning. In this regard it is anticipated that stakeholders will work together during the remaining period to generate the necessary data to fill in the gaps in preparation for the next planning cycle.
It is our sincere hope that all stakeholders shall join the fight against the HIV and AIDS epidemic, through concrete interventions and achieve the desired results.

Board Chairperson
National AIDS Commission, Lesotho

Acknowledgements

The National AIDS Commission wishes to acknowledge with gratitude the valuable contribution of a large number of individuals and organisations who made it possible for the Mid Term Review (MTR) of the NSP to be a success. We wish to express special thanks and appreciation to the members of the NSP Review Forum and the NAC NSP Review Task Team for their invaluable contribution in providing policy guidance and administrative oversight during the review process.

We further wish to thank the various stakeholders, Government Ministries and Departments in particular the Ministry of Health and Social Welfare, civil society organisations, PLWHAs, District AIDS Committees (DAC), Community Councils AIDS Committees (CCACs), development partners for their participation in different ways during the review of the NSP. Your participation has helped to improve the quality and comprehensiveness of the review process.

We would also like to express special thanks to the Joint United Nations Programme on HIV and AIDS (UNAIDS), UNDP and Technical Support Facility (TSF) for Southern African for their support in providing technical and financial assistance to support the review process. We further want to acknowledge the assistance provided by the Consultants who facilitated the compilation of the Mid-term Review Report, the Revised NSP, the Two-Year National Operational Plan and the comprehensive report on the possible Scenarios for Financing the National Response.

Finally, we want to express our gratitude to the staff of the National AIDS Commission for their dedication and effective coordination and facilitation of the entire process. Without their support this MTR and the development of the NSP and NOP would not have been possible.

Chief Executive a.i.
National AIDS Commission, Lesotho

Acronyms

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

Section 1: Executive Summary

1.1 Executive Summary

Introduction

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

The Revised NSP has used Results Based Management (RBM) approach and has mainstreamed gender and human rights considerations. The Revised NSP has therefore, focused on specific impact, outcome and output level results. Impact level results have been articulated at national and thematic levels. Outcome and output level results have been articulated at programme level. A summary of the results framework is part of the executive summary. The framework provides a clearly defined chain link between outputs, outcomes and impact level results. The specific outcome and output results are also included in the relevant sections of the NSP for ease of reference.

Justification of the NSP review and introduction of Results Based Management Approach

The HIV prevalence in Lesotho is the third highest in the world currently standing at 23.2%[1]. The epidemic in Lesotho is characterised by a mature pattern, with a high case–fatality ratio, large numbers of orphans and vulnerable children, increasing mother-to-child transmission, decreasing life expectancy, declining productivity, affecting the national economy and very high demands on the health care system. It is also evident that the epidemic has a gender bias with women being more affected. The disease burden has compromised health care services. The Ministry of Health and Social Welfare has noted that 50% of outpatients attendances are AIDS related ailments and that more than 60% of inpatients are due to AIDS related illnesses. The number of orphans and vulnerable children, and vulnerable households has rapidly increased since the advent of the epidemic. The level of vulnerability has increased due to the inability of the traditional healthcare infrastructure to cope with the increasing demands to take care of individuals and families affected and infected with HIV and AIDS.

It is evident that the prevalence pattern has not changed much since 2004 when the first Demographic and Health Survey was conducted. In particular the drivers of the epidemic have not changed as confirmed by recent studies that include the Modes of Transmission Study (MOT) and the study on Multiple and Concurrent Partnerships among others. The identified epidemic drivers include the following:

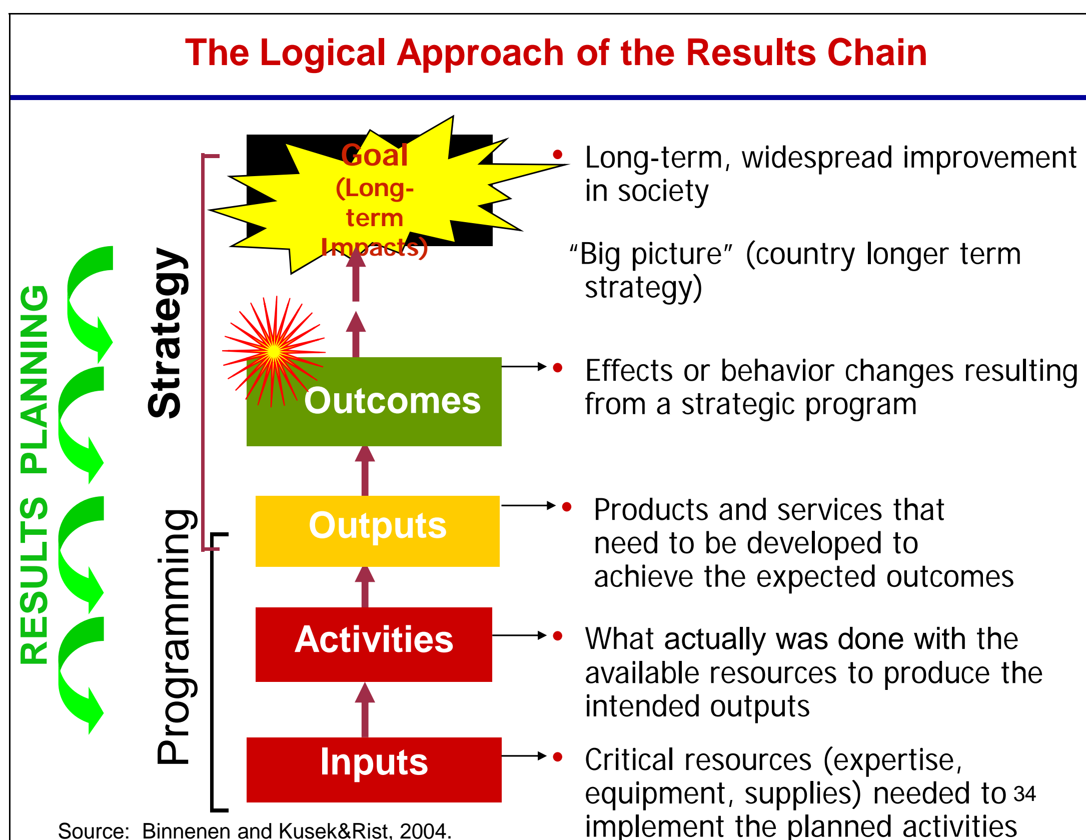
- Multiple and concurrent sexual relationships;
- Inter-generational sex;
- Early sexual debut;
- Mother to Child Transmission;
- Income inequality compounded by poverty and food insecurity;
- Migration and mobility;
- Alcohol and drug abuse;
- Gender based violence; and
- Some cultural practices that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

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

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

The NSP was developed to provide a coordinated and strategic approach to HIV and AIDS response, with the aim of halting the epidemic and providing comprehensive care and support to those already infected and affected. Lesotho was also cognisant of the need to move away from business as usual in the planning and implementation of HIV and AIDS interventions by adopting strategies that will contribute to specific and measurable results in prevention, treatment, care and support, impact mitigation and in coordination and management of the response. It is on this premise that the country adopted Results Based Management (RBM) approach that also incorporated gender and human rights mainstreaming.

The adoption of the RBM was necessary given the high HIV prevalence levels and in most cases low levels of service coverage and uptake. The use of evidence and the application of RBM have facilitated the selection of effective interventions that have the likelihood to contribute to the specific and measurable results. Based on the RBM planning framework, the revised NSP has also adopted results language which is articulated in terms of impact, outcome and output level results, with specific targets that are measurable within a period of time. The diagram below illustrates the RBM results framework that has been used.



National Response

The national response to the HIV and AIDS epidemic in Lesotho has three main aims. First, is to stop the epidemic from growing by reducing the incidence rates to below 2% threshold. Second, is to provide comprehensive treatment, care and support to PLWHA and those with the co-infection of TB and HIV. Third, is to mitigate the socio-economic impact of the epidemic on society and in particular, OVC, PLWHA and vulnerable households.

In this regard Lesotho is committed and working towards ensuring universal access to HIV and AIDS services. Services are being scaled-up and service delivery systems are being strengthened and decentralised in order to

achieve this. New interventions such as male circumcision are also being introduced as part of the national response strategies. While existing partnerships are being consolidated, expanded and new ones are being forged.

Challenges in the Response

A key challenge of the national response is the impact of social behaviours that continue to fuel the spread of HIV. Of particular concern are multiple and concurrent partnerships and migrant workers in addition to low level of comprehensive knowledge and people's inability to translate knowledge to behaviour change. The uptake of services also remains low, with stigma being a key barrier to utilisation of HIV and AIDS services.

Efforts are being made to generate empirical data and evidence on the state of the epidemic, but the use of available evidence is still inadequate. The response in some cases lacks the requisite sense of urgency. These have been compounded by the fact that in most cases, the design of HIV and AIDs programmes has encountered key challenges in monitoring and measuring results.

Strategic Focus Areas Addressed by the Revised NSP

The Revised NSP has prioritised interventions based on available evidence moving the response from a "want" situation to a "need" based response. The strategic focus areas on Prevention, Treatment, Care and Support, Impact Mitigation and Management and coordination are discussed below.

Strategic Focus on Prevention

The focus for prevention interventions is to reduce the HIV incidence rate to a level where the epidemic would not sustain itself. The focus therefore, will be to reduce the rates of new infections (incidence rate, usually measured as new infection rate over one year) rather than focusing on prevalence rates which are the total number of infections at a particular time. Based on this premise, the Revised NSP has provided two priority levels i.e. priority one are interventions that are backed by strong evidence for their impact and that have the potential, in combination with measures at different levels to halt the epidemic. These interventions include social and behaviour change communication, male circumcision, prevention of mother to child transmission and condom use in certain populations.

Priority two interventions are those interventions that have to continue given the benefits accrued over time and their complementary nature to HIV prevention and in particular public health. They include prevention of STI, provision of ART, workplace programmes, and ensuring blood safety. Priority two will also focus on some other key populations such as MSM and mobile populations.

Strategic Focus on Treatment Care and Support

The focus on treatment care and support is to reduce mortality and morbidity among PLWHA, and consequently improve their quality of life. In this context the NSP has prioritised ART, TB/HIV co-infection and Home Based Care, including Palliative Care.

Strategic Focus on Impact Mitigation

In the context of Impact Mitigation, the NSP will focus on reducing the negative impact on vulnerable households, individuals and groups of people such as OVC and PLWHA among others. While priority interventions are those that reduce the level of impact, the focus will shift from short term mitigation to long term interventions including developing appropriate policies and legislation and alternative livelihoods.

Strategic Focus on Management and Coordination Mechanisms

The focus of the NSP in management and coordination will be:

- To strengthen institutional capacities for coordination at all levels;

- Create and strengthen an enabling policy and legal environment that provides space for a multi-sectoral participation by all stakeholders, and in particular communities; and
- Strengthen leadership to address critical issues such as key drivers of the epidemic and policy formulation.

Advocacy, Public Policy and legislation

The NSP will promote and support advocacy work that will ensure that HIV and AIDS issues remain on the national, social, economic, and political and development agenda. This will not only influence decision making but will also accelerate the adoption of policies to support the national response.

A key focus will be to initiate policies that will help to prevent or reduce vulnerability of HIV and AIDS among key population groups, improve the quality of life of people affected by HIV and AIDS, and in particular for women and the girl child. In this context issues of human rights and gender mainstreaming are priority areas of action.

Monitoring and Evaluation

It is evident from the mid-term review that significant progress has been made in monitoring and evaluation of the national response, the system has not adequately been able to collect empirical data in all areas of the response. Most of the available data is based on selected behavioural studies conducted between 2006 and 2008. Among the major concerns is lack of adequate information on key populations on both the impact of HIV and AIDS on such populations and their role in spreading HIV. In other areas most data is based on the first Lesotho Demographic and Health Survey conducted in 2004 which is too old given the dynamic nature of the response.

The revised NSP has taken cognisance of this challenge. Consequently it is anticipated that the M&E Framework and data collection systems will be revised and aligned to the NSP, to facilitate sufficient data and other strategic information collection, management and utilisation. This will be necessary to inform the formulation of the next generation strategic plan in 2011.

1.2 The Results Framework

Results Framework for the Lesotho National Strategic Plan (NSP)

National Level	Impact Level	Outcome Level Result	Output Level Results
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011	<u>Behaviour Change Communication</u> The % of men and women who have correct knowledge of HIV prevention increased from 23% in 2005 to 80% by 2011	Men and women aged 15-49 years access a comprehensive social and behaviour change package including MCP, MC, intergenerational and age-disparate sex, condom use
		The % of people aged 15-49 with multiple and concurrent sexual partners are reduced from 40% in 2008 to 30% in 2011.	# of Villages hold at least 4 community conversations a year on multiple and concurrent sexual partners
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011	The % of young men and women aged 15-24 years who commence sexual intercourse before the age of 15 reduced from 27% for men and 15% for women in 2004 to 15% for men and 10% for women by 2011	% of in and out of school youth aged 6 -24 years have had capacity building through life skills HIV and AIDS Education
		<u>Male Circumcision</u> The % of men who undergo facility based circumcision is rapidly increased	The capacity of 50% of the health facilities is strengthened to provide safe MC procedures by 2011 according to national guidelines
			# of doctors trained on MC by 2011
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011	By 2011, 50% of new born boys are circumcised at health facilities within 8 days after birth	# of nurses trained on MC by 2011
		<u>PMTCT:</u> The % of HIV positive pregnant women and infants who receive a complete course of ART prophylaxis to reduce the risk of MTCT is increased from 56% (2008) to 80% by 2011	% of health facilities at designated levels that have adequate capacity to provide PMTCT (minimum package) is increased from 63.3% in 2007 to 100% in 2011
		% of HIV positive infants born to HIV+ mothers has reduced from 16.5% in 2007 to 10% by 2011	Proportion of women attending ANC offered quality testing and counselling for HIV is increased from 91% in 2007 to 100% in 2011
		<u>Condom Use, Distribution and management</u> Strengthened procurement and distribution systems that ensure no stock-outs of	The number of available female and male condoms is increased by 50% from 17 million for male condoms 25,372 for female condoms and available

		condoms at all distribution points	
			Increased usage of condoms in high risk sexual intercourse among young men and women to 80% by 2011[2]
		100% of distribution points reporting no stock-outs	All villages have at least 2 distribution points by 2011
		The % of people aged 15-49 who use condoms during sex with multiple partners is increased from 48.6% for men and 41.9% for women in 2004 to 80% for both men and women by 2011.	# of condom awareness sessions held
		The % of people aged 15-49 who use condoms correctly and consistently during sex with non regular partners	# of people who attended the awareness sessions
		100% of distribution points reporting no stock-outs	All villages have at least 2 distribution points by 2011
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011	The % of people aged 15-49 who use condoms correctly and consistently during commercial sex	# of condoms distributed at commercial sex selling points
		The % of discordant couples who use condoms correctly and consistently	# of discordant couples who are found positive with STIs in the last 12 months
		<u>HTC</u> The % of Basotho 12 years and above who have tested and know their negative HIV status in the past 12 months and accessed HIV Prevention services	HTC counsellors who provide quality assured services that meet the minimum standards are increased from x in 2008 to x in 2009 in the country
		The % of Basotho 12 years and above who have tested and know their positive HIV status and accessed treatment, care and support	90% of HTC service providers provide referral to treatment services by 2011
National Level	**Impact Level**	**Outcome Level Result**	**Output Level Results**
The Lesotho Human Development index is improved from 0.55 in 2005	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011		% of HTC service providers ensure continued access to prevention services by 2011
			Routine HTC services are provided in all health facilities to those in need including STI, TB and ANC clients.
			% of clients in long-term relationships access HTC

[2] High risk sex is associated with Sex Workers, MSM, long distance Heavy Duty Vehicle Drivers, Cross-border Farm Workers

to 0.60 in 2011			together as a couple
			% of discordant couples access prevention services[3]
		Prevention of HIV in the workplace The number of employees in the formal sector who have access to HIV and AIDS workplace minimum package is increased from x to 50% to X by 2011	The number of medium and large scale public and private sector institutions that have established HIV and AIDS workplace programmes is increased to 50%
		HIV prevention among key populations[4] % of key populations at risk who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission is increased from X in 2009 to 50% in 2011	% of most at risk populations reached with HIV prevention programmes is increased from X in 2009 to 50% by 2011
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011	Key populations at risk have knowledge and skills for effective HIV prevention.	Approved policies and strategies to address issues of all key populations in place by 2011
			% of most at risk populations that have tested for HIV and know their status and have been provided access to ongoing prevention and treatment services as required is increased from X in 2009 to 50% in 2011
		Blood safety Prevalence of HIV in donated blood units is less than 1%	100% of donated blood is screened in a quality assured manner for HIV
		Post Exposure prophylaxis Health workers identified and in need of PEP receive PEP within 72 hours	All health facilities providing ART and PMTCT are providing PEP services by 2011.
		Identified survivors of rape access PEP within 72 hours	Mobilisation, education and empowerment for rape survivors
		Sexually Transmitted Infections 100% of people attending health facilities are appropriately diagnosed, treated and counselled for STIs	100% of all health facilities providing comprehensive diagnosis and treatment of STIs

[3] This entails MC, consistent condom use

[4] Key populations in the context of Lesotho are Prisoners, Herd boys, Sex workers, Men who have sex with other men and Mobile Populations. There is very little information available on the impact of HIV and AIDS on these key populations or empirical data on their contribution to the spread of HIV.

			% of communities reached with STI educational materials.
		Treatment Care and Support	
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	Mortality due to HIV and AIDS is reduced from 26% for men, 31% for women and 18% for children (<12) in 2007 to 16% for men, 21% for women and 8% for children in 2011	Increased quality of life for HIV infected people in Lesotho by 2011	# of adults and children with advanced HIV infection **newly** enrolled on ART (by sex, by age group, pregnant women)
		Increased proportion of women and men with advanced HIV infection receiving ART from 25% in 2007 to 80% in 2011. (disaggregated by adults and children by gender)	# of adults and children with advanced HIV infection receiving ART (current) (by sex, by age group)
		Improved survival rates of people on ART (adults on ART - 36 months and children on ART- 5 years)	# of PLWHA trained on adherence counselling
			# of adherence support groups
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	Mortality due to HIV and AIDS is reduced from 26% for men, 31% for women and 18% for children (<12) in 2007 to 16% for men, 21% for women and 8% for children in 2011	Strengthened capacity of the Health system's ability to provide quality ART care	# of HIV+ mothers counselled on prevention of transmission to their unborn infants
			# of HIV positive clinically malnourished clients who received therapeutic or supplementary food
			# of health care facilities that offer comprehensive and quality ART services (by type; public, private, NGO)
			Decreased number of health care facilities providing ART that experienced stock-outs of ARVs in the last 12 months
			% of health care facilities providing ART in accordance with ART national guidelines/policies on site or through referral
		Increased proportion of children under 15 in	

		need of ART receiving ART	
National Level	**Impact level**	**Outcome Level Result**	**Output Level Results**
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	Mortality due to HIV and AIDS is reduced from 26% for men, 31% for women and 18% for children (<12) in 2007 to 16% for men, 21% for women and 8% for children in 2011	**TB/HIV co-infection** Increased proportion of health facilities that provide integrated TB/ HIV services from X to Y by 2011	Proportion of patients diagnosed with TB/HIV co-infection enrolled on treatment by 2011
			# of TB patients who had an HIV test result recorded in the TB register
			% of estimated HIV positive clients & TB cases that received treatment for TB and HIV by 2011
			# of HIV positive patients in HIV care and treatment screened for TB infection
			HIV positive people receiving prophylaxis as a prevention for TB

National Level	Impact level	Outcome Level Result	Output Level Results
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	Mortality due to HIV and AIDS is reduced from 26% for men, 31% for women and 18% for children (<12) in 2007 to 16% for men, 21% for women and 8% for children in 2011	**CHBC and Palliative Care:** # of people in need of home-based care receiving comprehensive care and support by 2011.	# of households with chronically ill persons receiving standard package for external basic support[5] to care for them by 2011
			Number of people on HBC who are adhering to treatment
			Functional referral system in place (from home-based care givers to Facilities and vice versa)
		Increased number of Home Based Carers providing HBC and palliative care (PC) according to national guidelines	Guidelines for HBC and PC developed, disseminated and implemented
			Increased number of HBC givers that have had comprehensive training.

[5] This may include shelter, food, psychological support, basic care, etc.

National Level	Impact level	Outcome Level Result	Output Level Results
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	% of vulnerability due to HIV and AIDS among households in Lesotho is reduced from x% in 2008 to 15% by 2011	**Orphans & Vulnerable Children** % of OVC aged 0-17 whose households received support[6] in caring for child increased from 25% in 2005 to 75% in 2011.	% of OVC aged 0-17 who received psychosocial care & support increased from x to x%
			# of eligible OVCs who received support (disaggregated by type of support)
			Policies & Legislation for care & support for OVC developed and adopted & enacted e.g. Child protection and Welfare Bill
			# children provided with Protection and Legal aid services (by age group)
			# children provided with Protection and Legal aid services (by age group)
			# of eligible children provided with health care referral
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	% of vulnerability due to HIV and AIDS among households in Lesotho is reduced from x% in 2008 to 15% by 2011		# of eligible children provided with education and/or vocational training support (disaggregated by sex)
			A national survey on the socio-economic impact of HIV and AIDS on OVCs conducted
			# of HIV and AIDS impact mitigation programmes implemented and benefiting Orphans and vulnerable Children
		Vulnerable Groups % of members of vulnerable groups	A national survey on the socio-economic impact of HIV and AIDS on vulnerable groups conducted and the report disseminated.

[6] Basic Support denotes 3 or more services (Psycho- social services, Medical care, Financial help, Education, Food packages, clothing/household, shelter, legal services)

		experiencing negative socio-economic impacts of HIV and AIDS decreased from X% in 2008 to 50% by 2011	Proportion of vulnerable groups supported with activities aimed at improving livelihoods
			# of vulnerable groups reached with comprehensive sustainable livelihood support by 2011
			Number of vulnerable groups identified and registered in accordance with the selection criteria
			Policies & Legislation for care & support for vulnerable groups developed and adopted
			Psycho-socially empowered vulnerable groups (disaggregated by type of vulnerability)
			Reduced stigma and discrimination against PLWHA and those with disabilities
			# of HIV and AIDS impact mitigation programs implemented and benefiting Vulnerable populations

National Level	Impact level	Outcome Level Result	Output Level Results
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	An effective, well managed national HIV/AIDS response which prevents infection , mitigates the impact of the epidemic, and enhances the care of Basotho through a multi sectoral approach	<u>Advocacy, Public Policy and Legislation</u> A policy, cultural and legal enabling environment created and enabling the effective implementation of HIV and AIDS interventions country wide by 2011	Number of policies and laws developed and adopted that empower women and protect children and or address social economic inequalities that affect them
			All Policies and Legislation are aligned to evidence based HIV criteria
			Increased commitment by Government, Implementing and development partners in implementing policy frameworks by 2011
			The capacity of legislators to utilise evidence based HIV information for policy formulation and strategic plan is

			strengthened
			Increased commitment of leadership and participation by community, religious and political leaders in HIV and AIDS
			The Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) is domesticated by statutory legislation in Lesotho
			Attitudes of gender equality improved among men and women (Disaggregated by Gender)
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	An effective, well managed national HIV/AIDS response which prevents infection , mitigates the impact of the epidemic, and enhances the care of Basotho through a multi sectoral approach	<u>Coordination and Management</u> The capacity for coordination and management of the decentralized national response is strengthened by 2011	Strengthened capacity of NAC, umbrella bodies and decentralised coordinating structures for improved service delivery
		An effective joint multi-sectoral stakeholders response to HIV and AIDS based on the NSP	Increased alignment and implementation of plans for Public, private, civil society and development partners in line with the NSP
			Decentralized coordination and management structures strengthened in all 10 districts by 2011
		Sufficient resources mobilized and efficiently managed for the implementation of the NSP activities by 2011	Fully developed and adequately institutionalised resource tracking mechanisms
		<u>Community Strengthening</u>: Community based interventions effectively monitored, implemented and well coordinated	At least 50% of HIV interventions targeting community council level or lower that are aligned to NSP are implemented by 2011
			DACs and CCAC's constituted and operating according to their TOR's
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	An effective, well managed national HIV/AIDS response which prevents infection , mitigates the impact of the epidemic, and enhances the care of Basotho through a multi sectoral approach		Number of community leaders able to impart accurate HIV information is increased by 50% by 2011
			At least 50% of data collected through the community based monitoring system meets the quality data standards and criteria

		<u>Evidence Based Decision Making</u> The capacity for the national M&E system is strengthened at all levels to generate evidence to inform policy, planning and programming for HIV and AIDS in Lesotho by 2011	National M&E system strengthened and operationalised at all levels
			Accredited M&E training Institutionalised
			Improved advocacy and harmonization of all M&E systems in the country by 2011
		The national capacity for HIV research is strengthened at all levels to generate empirical data to inform policy, planning and programming for HIV and AIDS in Lesotho by 2011	National capacity for HIV research developed and strengthened by 2011
			Strengthened and updated HIV and AIDS database

Note: the performance of the NSP in management and coordination will be measured using the National composite Policy Index (NCPI). Comparisons will be made over the period between 2006 and 2011 using the assessment especially Lesotho UNGASS reports.

Section 2: Background Information

2.1 The Rationale for the Strategic Plan Framework

The National Strategic plan was developed in 2006, to facilitate the scaling up of universal access to prevention, treatment, care and support, and impact mitigation. The NSP covered a period of five years from 2006 to 2011. The development of the NSP was influenced by a number of national and international factors related to HIV and AIDS response and the lessons learnt during the implementation of the previous plan.

In March 2009, the NAC in collaboration with other stakeholders commissioned the mid-term review of the NSP. The review adopted a participatory consultative strategy to ensure involvement and participation of all stakeholders. Consultations took place at national and district level with diverse stakeholders. The review also benefited from an in-depth literature review.

This document constitutes the revised NSP. The review process has taken cognisance of on-going interventions such as those supported by the Government of Lesotho and development Partners such as Global fund, PEPFAR and EU. The revision of the document has also used Results Based Management approach and attempted to mainstream gender and human rights considerations in the revised framework. As a result, the NSP has been revised to focus on specific results. Impact level results have been articulated at national and thematic levels. Outcome and output level results have been articulated at programme level. A results framework has been included in the executive summary, while specific outcome and output level results are provided for in the relevant sections of the report (see section 4).

2.2 Key Environmental Influences

The development of the revised National HIV and AIDS Strategic Plan takes place in the context of global, regional and national developments in the HIV and AIDS landscape that influence the country's response. The following are the main initiatives that have a bearing on the national response and development of the NSP.

2.2.1 National Environment

The status of the national environment determines the capacity and ability of the organisations to effectively deal with the identified challenges, and optimise organisational systems, policies and procedures to fit requirements for higher chance of success.

2.2.1.1 National Coordination Structure

The establishment of the NAC, an organisation made up of public and private sector representation provides for potentially enhanced coordination of the national response. Participation of stakeholders in the institutional arrangements for coordination of activities is guaranteed through this arrangement.

2.2.1.2 Policy Framework

The policy framework that was established in 2000 and further enhanced in 2006 together with the NAC Act of 2005 and other policies and legislation provide appropriate framework for effective coordination of HIV and AIDS activities. The framework enables the optimisation of planning functions and resource mobilisation and utilisation for effective management of HIV and AIDS in Lesotho

2.2.1.3 The "Three Ones" Principle

The Government of Lesotho, in an effort to facilitate synergy of action among all players in the multi-sector HIV and AIDS response, has adopted the "Three Ones" principle that stresses the need for one overall national authority with a broad-based multi-sector mandate to lead and coordinate the entire response; one agreed HIV and AIDS Action Framework that drives alignment of all partners and; one agreed country level Monitoring and

Evaluation System. This is also intended to enhance effective use of international support. The "Three Ones" principle is currently being implemented with the establishment of NAC, the development of the NSP and the establishment of the national M&E framework.

2.2.1.4 Enhancement in Technical and Management Capacity

Current efforts to strengthen operational and management capacities of institutions involved in the implementation management of HIV and AIDS interventions will lead to improved planning and operational efficiency.

2.2.1.5 The NSP and M&E Framework

The revised National Policy and National Strategic Plan as well as the development of M&E framework has provided the basis for effective coordination of the national HIV and AIDS response.

2.2.2 The External Environment

External environmental factors can promote or constrain the effectiveness of interventions, and the influences of these factors need to be factored in the strategic options of the plan.

2.2.2.1 Alignment and Harmonisation of International Support

Efforts to improve the harmonisation of multilateral institutions and international partners, and their alignment with national approaches have been made in Lesotho and were further supported by international consultations, which culminated in the 2005 Report of the Global Task Team (GTT). The report of the task team has made far-reaching recommendations on empowering inclusive national leadership and ownership of the national response, alignment and harmonisation, reform for a more effective multilateral response, and accountability and oversight. The recommendations have a significant bearing on the Lesotho national response to HIV and AIDS.

2.2.2.2 Improved Funding for HIV and AIDS

Donor support to Lesotho for HIV and AIDS prevention, treatment, care and support, and impact mitigation activities have increased considerably in the past decade. The available resource bases include bilateral and multilateral development partners, private foundations and international NGOs. The Government of Lesotho also supported their commitment to universal access by providing resources to support the interventions.

2.2.2.3 National Commitment to International Conventions

Lesotho has been signatory to several international declarations and is dedicated to the fight against HIV and AIDS. These declarations of commitment have guided the country towards internationally sanctioned approaches to global handling of HIV and AIDS. These are listed below:

- Millennium Development Goals (MDGs), 2000;
- United Nations General Assembly Declaration of Commitment on HIV and AIDS (UNGASS), 2001;
- African Union (AU) Abuja Declaration on AIDS, TB and Malaria and Other Related Infectious Diseases, 2001;
- Maseru Declaration on combating of HIV and AIDS in the SADC region, 2003;
- African Union Maputo Declaration on AIDS, TB and Malaria and Other Related Infectious Diseases, 2003;
- The 2005 World Summit at which international leaders reaffirmed their commitment to intensify global and national HIV and AIDS responses;
- The Abuja Call to Action: Elimination of HIV infection in infants and children, December 2005;
- Brazzaville Commitment on Scaling up Universal Access to HIV and AIDS Prevention, Treatment, Care and Support, March 2006.
- Abuja Call for Accelerated Action towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa, May 2006

The commitments impose further obligation and impetus on Lesotho to act effectively against the HIV and AIDS epidemic.

2.2.2.4 Regional Context

Lesotho is a member of the Southern African Development Community (SADC), which is guided in its response by the SADC HIV and AIDS Strategic Framework and Programme of Action for 2003-2007 and the SADC Five-Year Business Plan for HIV and AIDS for 2004 – 2008. The two documents focus on six strategic areas of Policy Development and Harmonization, Mainstreaming HIV and AIDS; Capacity Building; Facilitating a Technical Response; Facilitating Resource Network and; Facilitating the Monitoring of Regional and Global Commitments. All these have significantly influenced the country's strategic directions on the management and coordination of HIV and AIDS.

2.2.2.5 National Initiatives

Lesotho has led the way in its commitment to fight HIV and AIDS by his Majesty King Letsie III declaring HIV and AIDS as an emergency in 2000, the adoption of the scaling up strategy "Turning a Crisis into an Opportunity" in 2003 and the launch of the "Know Your Status" campaign operational plan which is a gateway to treatment, care and support for universal access to HTC in December 2005. The Health Sector Mid-term Strategic plan 2008/11 maps out the Strategic interventions for the achievement of Universal Access to HIV and AIDS Care and Treatment for Lesotho. These actions have galvanized the country and its development partners to clearly articulate what needs to be done to reduce the spread of HIV and mitigate against the negative impact of AIDS.

2.3 Guiding Principles

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

a) **Evidence Based Planning**: The planning of the response at all levels will be informed by available empirical evidence on the efficacy of interventions.
b) **Results Based Management**: The implementation will focus on identified impact, outcome and output level results. These results are articulated in the Results Framework in the executive summary.
c) **3-Ones principle**: Lesotho has adopted and operationalised the 3-Ones Principle. During the remaining period all stakeholders will be expected to mainstream the principle in their operations.
d) **Human rights:** Human rights and dignity will be respected, irrespective of HIV status. Efforts will be made to eliminate stigma and discrimination against PLWHA and those affected by the epidemic. The NSP will continue to create awareness of the roles and responsibilities of "duty bearers" and "rights holders"
e) **Multi-sectoral approach:** The NSP forms the basis for the multi-sectoral response to HIV and AIDS. The design provides the opportunity for all stakeholders to identify their areas of response based on their mandate, resources, capacity and more importantly their comparative advantage.
f) **Gender sensitivity:** Stakeholders will mainstream gender issues or be cognisant of gender dimensions in all aspects of their response.
g) **Cultural sensitivity:** While the NSP has taken cognisance of cultural sensitivity to HIV response, the interventions will ensure that cultural norms and values that influence negative and risk behaviours such as multiple- concurrent partners and intergenerational sex among others are adequately addressed.
h) **Greater involvement of PLWHAs (GIPA):** PLWHAs are part of the solution not the problem. Their meaningful involvement is critical to the success of the national response and the NSP in general.
i) **Decentralised approach:** The implementation of the NSP will be decentralised providing greater opportunities for districts, communities and sectors to be involved in the national response in a meaningful way. The roles and responsibilities of the various stakeholders at different levels will be clearly defined and articulated in the National Coordination Framework.

2.4 Critical Success factors for the NSP implementation

The following have been identified as the critical success factors for the NSP implementation. To ensure effective and meaningful realisation of these factors stakeholders' capacity will be strengthened and on-going technical assistance will be provided as appropriate.

i. **Leadership and political commitment to the response:** Meaningful and practical involvement of political leadership coupled with greater commitment is critical to the success of the HIV and AIDS response. It is anticipated that during the remaining period of the NSP implementation, His Majesty's office, the Office of the Prime Minister, The Cabinet, Senate and Parliamentary HIV and AIDS Portfolio Committees in particular will play a greater role not only at policy level but also in influencing the general society to adopt key prevention behaviours. This is strategic given that the members are "people's representatives". Community and religious leaders will also be mobilised to be involved in the response at community level.

ii. **Harmonisation of HIV and AIDS activities:** The results based management (RBM) provides a collective focus on common impact and outcome level results, hence the need to harmonise and align sector plans and interventions with those of the NSP. The collateral benefit of this approach is improved effectiveness and efficiency of the response, increased collaboration among stakeholders, improved synergy and partnership.

iii. **Human resources development:** Successful implementation of the response will largely depend on availability of adequate, skilled and competent human resources. While the NSP will endeavour to strengthen available skills and expertise, it will also pursue other options such as having staff that are multi-skilled, and even task shifting.

iv. **Stakeholder commitment:** The NSP will promote and support strengthening of greater stakeholders' commitment in ensuring effective and efficient implementation of quality and comprehensive interventions that are compliant with the guiding principles.

v. **Sustainable Financing of HIV and AIDS response:** The NSP will pursue opportunities for sustainable financing of HIV and AIDS interventions from a number of fronts. First, stakeholders will advocate for increased funding from the Government of Lesotho beyond the current sector funding (including the 2% budget allocation), and the funding through the NAC. The NAC together with other stakeholders will advocate for programme funding rather than project funding with development partners and donors.

vi. **Effective communication:** Effective communication is a pre-requisite for the achievement of the response results. The NSP implementation strategy will ensure efficient communication between NAC and stakeholders on policy issues, dissemination of M&E data for purposes of planning and on emerging issues.

Section 3: Epidemiology and Impact of HIV and AIDS

3.1 HIV prevalence Levels and Trends

HIV prevalence among people aged 15-49 is estimated at 23.2% (women -26.4% and men – 19.3%)[7]. By 2007 the daily HIV infection rate was estimated at 62[8]. According to the Lesotho Demographic and Health Survey (LDHS 2004), infection among people aged 15-19 was 5.3% and among 20-24 year olds was 19.2%. The LDHS noted that infection increased significantly 25 – 39 with a low rate of 33.2% increasing to a high rate of 41.6%. The LDHS found that HIV prevalence was higher (39.2%) in women than men under 30 years. This finding reversed among people aged 40-49 where men had higher prevalence rates of 31% compared to women with 23%. Prevalence among divorced or separated men and women was highest (women =51%, men=37%) compared to the never married persons (women=15%, men =9%). Prevalence in married or co-habiting persons was 27% for women and 33% for men. Available data shows lower prevalence rates in rural (29.1%) compared urban areas with 21.9%.

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

The recent Lesotho Analysis of Prevention Response and Modes of Transmission (2009) indicate that the annual incidence rates has stabilised at approximately 1.7%. This is significant progress compared to 2.3% in 2007.

Annual incidence rates among children has halved in the last 8 years to 0.17%. The sentinel HIV/Syphilis survey showed that the prevalence of HIV among STI patients was high at 56.2%. Among young people aged 15-19 and 20-24, HIV prevalence among STI clients was around 20% and 40% respectively compared to the prevalence among young people surveyed in Lesotho Demographic and Health Survey (LDHS) 2004 which was at 7.72%.

The Sentinel HIV Surveillance (2007) showed that 1.4% of ANC clients and 2.3% of STI clients were infected with syphilis. STIs were among the top ten causes of frequent Out Patient Department (OPD) consultations at health facilities in 2006.

By the end of 2007, approximately 270,273 people were living with HIV and AIDS. 11,801 were children[9]. The epidemic has had a gender bias with 153,581 (56%) of PLWHA being females compared to 116,692 (44%) males[10]. Of the 46,116 young people aged 15-24 living with HIV 33,174 (71.9%) are women. Eighty percent (80%) of people with TB are said to be infected with HIV[11].

The number of people who died of HIV in 2007 was estimated at 18,244[12]. As more people die so do the increase in the number of OVC. The total number of children orphaned due to AIDS has increased from 88,500 in 2005 to 108,700 in 2008.

By 2008, ART coverage increased to 45% (38,586)[13]. In 2007, the number of pregnant HIV positive women who received anti-retroviral treatment to prevent mother to child transmission (PMTCT) was estimated to be 3966. Available data indicate that PMTCT coverage increased from an estimated 5% in 2005 to 56% in 2009. Antenatal care, post natal care (PNC) and PMTCT were being offered in 19 hospitals and 116 health centres out of 167 public health facilities.

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[7] Lesotho Demographic and Health Survey 2004)
[8] MOHSW, Review of the Health Sector Response to HIV and AIDS 2004-2007, report
[9] Ibid (2)
[10] Ibid (3)
[11]Ibid (2)
[12] Ibid (2)
[13] Lesotho Analysis of Prevention Response and Modes of Transmission (MOT) Study,2009

Although life expectancy has improved slightly from 36.81 years (2006) to 42 years in 2007, overall population growth has drastically slowed down to about 0.1% in 2009[14]

By the end of 2007, the cumulative number of people who had tested and received results was 229,092 out of a population of 1.88 million people. Although there has been significant progress, HIV testing still remains low at only 12% of the total population. Lesotho offers both provider and client initiated HTC from 161 health facilities.

The Mid-term review of the NSP noted that approximately 376,318 out of school youth were trained in life skills based HIV and AIDS education in 2006. This number increased to 388,741 by June 2007. According to the LDHS 2004, the school attendance among orphans and non-orphans aged 10-14 in Lesotho was 1:1. This has been achieved by making primary education free, providing bursaries and supporting OVC with education needs such as books and uniforms. By 2008, 32% of OVC were receiving free basic support.

Recent studies such as the Modes of Transmission (MOT) have identified key populations such as sex workers, inmates (prisoners) and migrant labour in Lesotho. They have also alluded to the presence of men who have sex with men (MSM) and injecting drug users. A review of available data during the NSP mid-term review, established that there isn't sufficient empirical data to help determine the extent of the epidemic (i.e. prevalence, level of knowledge, access to services) or the magnitude of the socio-economic impacts of the epidemic on such groups.

With regard to vulnerable groups the studies have identified women and girls, people with disability, herd boys and PLWHA as vulnerable groups. With the exception of women and PLWHA, there is no data on the other groups. However the LDHS (2004) reported that approximately 1.7% of men had paid for sex in the last twelve months. Fifty eight percent (58%) of them reported having used a condom in their most recent sexual intercourse.

3.2 Drivers of the Epidemic

HIV and AIDS related studies conducted in Lesotho including the Lesotho Demographic and Health Survey (LDHS 2004)), the Modes of Transmission, the Multiple Concurrent Partnerships, the CIET study on HIV and AIDS related Knowledge, Attitudes and Practices have identified the following as the key epidemic drivers in Lesotho. The drivers of HIV are those conditions that increase the risk of transmission of the virus to a large number of people and would continue to do so if no appropriate measures are taken.

- **Multiple and concurrent sexual partners (MCP)**: Sexual concurrency is exceptionally high in Lesotho with an overall prevalence of multiple concurrent partners of 24% in 2007[15]. The culture tolerates multiple sexual partnerships. Available evidence indicates that labour migration which separates couples and steady partners coupled with multiple basic needs perpetuate MCP.
- **Early Sexual debut**: The age of sexual debut in Lesotho is low around 15 years. With the average marriage of 25 years, there is a ten year period of pre-marital sex, often with multiple partners.
- **Poverty (income inequality)**: available evidence indicates that it is not poverty that necessarily drives the epidemic but rather income inequalities. Income inequality causes people to engage in transactional sex more often.
- **Migrant labour:** Migrant labourers to South African mines, and textile industries internally and employment seekers, are major concern for fuelling the epidemic, due to long term periods of separation from spouses.. The sexual networks among mobile populations involve relationships of both transactional and commercial nature.
- **Gender inequality and gender based violence**: Promoted by low social economic status, legal positions for women, cultural norms and values. Women are not empowered enough to make decisions on their lives. The Government of Lesotho has recently adopted the "Legal Capacity of Married Persons Act" 2006. That is likely to change the status quo.
- **Inter-generational sex**: in 2004, the LDHS showed that 7% of women aged 15-19 had sex with a man 10

[14] Ibid (8)
[15] Survey of HIV and AIDS Related Knowledge, Attitudes and Practice, CIET 2008

years older. The LDHS further notes the increasing relationship between wealth, urban residence with inter-generational sex. This is corroborated by the findings of the Multiple and Concurrent Sexual Partnership Study findings undertaken in Lesotho.

- **Alcohol and drug abuse**: HIV and AIDS is linked to alcohol and drug abuse problems which contribute to increased spread of HIV transmission due to inhibition of behaviour resulting from alcohol consumption. High alcohol consumption decreases the individual's judgement and increases its likelihood for sexually risky behaviour including sexual violence.
- **Low condom use:** The LDHS indicates a low condom use. 51.4% of men and 58.1% women 15-49 years with multiple sexual partners do not use condoms during high risk sex.
- **Low levels of HIV and AIDS knowledge:** comprehensive knowledge of HIV and AIDS remains low. This has a direct impact on peoples' ability to make informed decisions and choices on their lifestyles and in particular sexuality.
- **High levels of unprotected sexual practices** exposing individuals to risk of STIs and HIV transmission.
- **Inadequate access to HIV and AIDS** information and services

Section 4: National Strategic Plan Programme Interventions

4.1 Criteria for prioritisation of NSP programme Interventions

The review of the NSP adopted evidence and results based management approach to HIV and AIDS planning. Consequently the prioritisation of interventions for the remaining period of the NSP 2009/10 to 2010/2011 are based on the need to clearly identify interventions that have the potential to achieve specific results, and their efficacy is supported by evidence. The following criteria have been used to prioritise the NSP interventions.

a) **Results Based Management**: The objectives and targets or the NSP have been revised to reflect specific outcome and output results to be achieved. The revision has provided the basis for assessing change being made.
b) **Evidence based Planning:** The interventions have been selected based on available evidence of their efficacy in achieving the desired results.
c) **Feasibility of interventions:** Considerations have been given to the current institutional capacity supportive systems, human and financial resources at national, district and community levels to effectively support implementation.
d) **Focus on the epidemic drivers.** The review noted that the epidemic drivers were not adequately addressed due to lack of sufficient focus and linkage of interventions to them. The revised NSP has strategically linked interventions with the drivers.
e) **Sustainability of interventions**: The potential for sustainability has been considered from different perspectives including continued availability of financial resources, community ownership and eventually having interventions community driven and efficiency in service delivery

The NSP has provided two priority levels. Priority one interventions are those that have a strong evidence base for the potential to halt and reverse the epidemic at national level in combination with other strategic interventions at different levels. Priority two interventions are also important, but unlikely to contribute as much to HIV prevention in the population. Blood safety is an essential proven strategy to prevent transmission through blood and blood products, and PEP is an essential proven intervention when implemented within 72 hours of exposure as well as Universal Precautions for infection control to protect health workers, home-based carers and other personnel to come into accidental contact with HIV-infected blood and blood products, although neither reaches the number of people that would be needed to impact significantly on the epidemic. Likewise, reaching key populations at high risk for infection, such as sex workers and men having sex with men, is important for human rights reasons, although they contribute relatively small numbers of new infections compared with infections in the general sexually active population. Other priority two interventions have a less clear evidence base for impact than Priority One interventions (syndromic management of STIs, workplace interventions) but they have the potential to reach large numbers of the population. HIV testing and counselling is listed as a priority one intervention, though in fact its main contribution to HIV prevention is in reaching HIV-positive individuals and discordant couples, and as an entry point for treatment, particularly through provider initiated services. On its own there is limited evidence that it contributes significantly to change behaviour in those who test negative. Table-1 below indicates the programme interventions classified as priority one or two.
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Table 1: NSP prioritisation of Interventions

Priority level	Prevention	Treatment Care and Support	Impact Mitigation	Management and Coordination,
Priority 1	i. Social and Behaviour Change Communication ii. Male circumcision iii. Prevention of Mother to Child Transmission iv. Condoms use, and management v. HIV Testing and Counselling vi. HIV prevention in the work place	i. Antiretroviral Therapy ii. TB/HIV co-infection iii. Community Home Based Care and Palliative Care	i. Orphans and Vulnerable Children, ii. Vulnerable Households iii. Support to vulnerable groups iv. Community systems strengthening	i. Coordination and partnership ii. Capacity building iii. Monitoring and Evaluation, and HIV research iv. Mainstreaming of HIV and AIDS v. Policy and advocacy vi. Resource mobilisation
Priority 2	i. Blood safety ii. Post Exposure Prophylaxis & Universal Precautions iii. STI iv. HIV prevention in Key populations[16]			

The NSP takes cognisance of the critical role of communities in the implementation of community based interventions in all the thematic areas and in particular impact mitigation. Consequently the NSP will strengthen the capacity of community groups, community based coordination and leadership institutions and in particular Community Councils AIDS Committees (CCACs). The role of civil society organisations in accelerating capacity development will be critical.

4.2 Prevention

4.2.1 Introduction

Lesotho has prioritised prevention in its efforts to address the challenges of HIV and AIDS. The strategy around prevention is multi-pronged. First the strategy is to reduce exposure to HIV, the probability of transmission and change social norms, values and practices that prevent adoption of key prevention behaviours. Second, the prevention strategy intends to strengthen comprehensive knowledge of HIV and AIDS among the general population to enable individuals to make informed choices and decision on their sexuality.

To reduce exposure to HIV, the NSP will support interventions that address issues of sexual debut, multiple and concurrent partners, intergenerational and age-disparate sex, male circumcision, and correct and consistent use of condoms among others. In addition, the NSP includes proven interventions such as PMTCT and ART.

The NSP approach has considered primary and secondary prevention strategies. ART is mentioned here as a secondary prevention strategy. In the first instance the NSP will support activities for scaling up provision of ART for PMTCT and for post-exposure prophylaxis. Lesotho will also continue providing ART to PLWHA for treatment, with the added prevention benefit of reducing viral load and hence contributing to HIV prevention.

The NSP will focus on strengthening social and behaviour change communication, including comprehensive knowledge as a strategy to empower people to address social norms, values and practices that negatively impact on prevention. The interventions will also encompass broader issues of stigma and discrimination associated with HIV

[16] Key populations include sex workers, migrant labour, and inmates. Women and girls, youth, people with disability, herd boys and PLWHA are treated as vulnerable groups.

and AIDS as this will have collateral benefits in treatment, care and support and impact mitigation. Consequently the "positive prevention" becomes imperative.

Lesotho is committed to halving the number of new infections from over 22,000 in 2007 (incidence of 2.3%) to under 11,000 in 2011. Efforts must be guided by evidence of best practices and informed by consumer acceptability surveys among others. Implementation will require increased coverage and intensity, reduction of fragmentation, and improved targeting. Improved quality and comprehensiveness of key interventions is an absolute pre-requisite.

The NSP has prioritised prevention interventions into categories. The first priority interventions, as explained in Section 4.1, are those that have the best evidence of their effectiveness to halt and potentially stop the spread of HIV at population level. Priority two interventions are those that are important for other reasons as outlined in the 4.1.

Priority 1:

- Social and Behaviour Change Communication
- Male Circumcision
- Prevention of Mother to Child Transmission
- Condoms (correct and consistent use)
- Linked HIV testing and Counselling
- (HTC) HIV prevention in the workplace

Priority 2:

- Blood safety
- Post exposure prophylaxis (PEP) & Universal Precautions
- HIV prevention in key populations
- Treatment of Sexually Transmitted Infections (STIs)

The results of the services provided under each of these interventions will contribute to the overall prevention impact level results stated below.

In the revised NSP, the age group that is monitored is 15-49, but it is recognised that people older than 49 still need to be reached with HIV prevention and treatment and mitigation efforts, and in the next NSP it is recommended to widen the age range to at least 60. This will require changes in baseline data obtained in the DHS and other surveys.

Impact Level Result	Baseline	2011 Target
The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011	22000	11000

Specific outcomes for each intervention are listed in the relevant sections below.

4.2.2 Social and Behaviour Change Communication

4.2.2.1 Introduction

Social and behaviour change is considered a strategic entry point for HIV prevention. While change in most cases takes place at a personal level, society influence has significant impact on one's behaviour. The inclusion of social change interventions in behaviour change communication strategies is therefore critical in achieving desired results. The NSP priority will be to strengthen and expand comprehensive knowledge of HIV and AIDS as part of the strategy to empower people to make informed choices.

The NSP has identified interventions that will address social norms, beliefs and values and individual behaviours and attitudes that expose a person to HIV infection, including interventions that will promote reduction of multiple and concurrent sexual partners, alcohol and drug abuse, and inter-generational sex. The NSP will further support implementation of interventions that promote safe sex through condom use, abstinence, and quality life skills based HIV and AIDS education for in and out of school youth to reach minimum standards.

4.2.2.2 The Challenges to be Addressed

The key challenges to be addressed include the following

i. Inability to translate HIV and AIDS knowledge and awareness to desired social norm and behaviour change
ii. lack of sufficient information on key population groups
iii. Insufficient service delivery, by addressing issues of quality, coordination, fragmentation, coverage and intensity among others
iv. Societal tolerance of MCP and inter-generational/age disparate sex
v. Accurate measurement of incidence, and of concurrent sexual relationships
vi. Lack of adequate training and sufficient quality and intensity in life skills education, and of effective social and communication strategies for in and out of school youth to make a significant difference to sexual behaviour
vii. Inadequate focus on women and girls in the context of their sexual and reproductive health and gender based violence, and lack of male involvement.

4.2.2.3 Outcome Level Results

The implementation of the social and behaviour change communication interventions will focus on attaining the following outcome level results.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
The % of men and women who have correct knowledge of HIV prevention increased from 23% in 2005 to 80% by 2011	23% (2005)	To be established	80%
The % of people aged 15-49 with multiple and concurrent sexual partners are reduced from 40% in 2008 to 30% in 2011.	40%	As above	30%
The % of men with multiple and concurrent sexual partners is reduced from x in 2008 to y in 2011		TBD	
The % of women with multiple and concurrent sexual partners is reduced from x in 2008 to y in 2011		TBD	
The % of young men and women aged 15-24 years who commence sexual intercourse before the age of 15 reduced from 27% for men and 15% for women in 2004 to 15% for men and 10% for women by 2011	Men=27% W= 15%	As above	M=15% W=10%

4.2.2.4 Output Level Results

The implementation of priority actions will result in the following output results that will lead to the achievement of the outcome level results stated above.

Output	Baseline	Targets	
		2009/2010	2010/2011
Men and women aged 15-49 years access a comprehensive social and behaviour change package including MCP, MC, intergenerational and age-disparate sex, condom use	To be established	To be established	To be established
Villages hold at least 4 community conversations a year on multiple and concurrent sexual partners	To be established	To be established	80%
X number of facilitators are trained and holding at least 4 village conversations according to minimum standards per year	TBD	TBD	TBD
% of in and out of school youth aged 6 -24 years have had capacity building through life skills HIV and AIDS Education	408,526 (Sept 2008)	To be established	To be established

4.2.2.5 Priority strategies

To achieve the above outcome and output level results the following strategic actions will be taken:

i. Strengthen the capacity of the Communication Technical Working Group to oversee the implementation of selected activities and in particular quality control
ii. Translate and disseminate the National HIV Behaviour Change Strategy to all stakeholders
iii. Develop and disseminate materials on key epidemic drivers, stigma and discrimination. Such materials should be culturally sensitive and incorporate gender and human rights dimensions
iv. Develop social and behaviour change materials that specifically target key populations (vulnerable groups) such as MSM, Sex workers, herd boys, people with disability, women and girls, and migrant workers
v. Support implementation of Life Skills HIV and AIDS based education for in and out of school youth; and
vi. Develop an outreach HIV and AIDS Peer Education Programme for implementation at community level. The programme will also include training of community based Peer educators. Partnerships with civil society and CCACs will be crucial.

4.2.3 Male Circumcision

4.2.3.1 Introduction

Facility based male circumcision has been adopted as a prevention strategy in Lesotho. This follows a situation analysis to establish the effectiveness of the strategy in helping to reduce HIV infection in the country. Randomised controlled trials and other studies in many countries and regions have proven that complete male circumcision has the potential to reduce the probability of HIV infection from HIV positive females to HIV negative males by over 60%. However research into HIV prevalence in circumcised males in Lesotho (LDHS, 2004) indicates that MC practice to date, including traditional and facility based MC and the rites of passage in Lesotho, appear not to have conferred this protection.

In Lesotho, the LDHS (2004), indicated that approximately 48% of Basotho men have been circumcised, including traditional and facility based circumcisions. Approximately 15,000 circumcisions occur every year. It is estimated that nearly one-third of circumcision procedures are conducted at public health facilities and nearly two-thirds of circumcisions are offered as part of the traditional initiation process known as *"lebollo"*. Circumcision of most men takes place between 16 and 20 years of age. Circumcision procedures are also done by private doctors. (Sept 2007)

Majority of patients coming for male circumcision are adults (60%) followed by adolescents (24%) and children (16%). According to the survey of health facilities, very few parents bring their infants (0-2 years) for facility based male circumcision despite the fact that at this age the procedure is much simpler and safer for the child.

4.2.3.2 The Challenges to be Addressed

The following challenges have been identified

i. Only 1/3 of health centres currently have the facilities, equipment, and staff to conduct safe male circumcisions
ii. Only doctors are authorised to perform MC. Doctors are confined to district hospitals, filter clinics and private surgeries. To scale up MC, there is need to consider task shifting to allow qualified nurses to offer MC and lower health facilities that are closer to the people. Task shifting would require skills training for qualified registered nurses
iii. Doctors also require training on MC procedures
iv. Currently there is insufficient community demand for MC. Most people are not aware of the benefits of MC for reducing HIV and STI infections.
v. MC is an extremely sensitive issue in Lesotho that requires appropriate engagement and dialogue with traditional practitioners and communities

vi. There are emerging myths around MC, that some men assume MC as an alternative to using condoms. Accurate information and risk perception must be widely shared as part of the minimum package of integrated MC roll out.
vii. Neonatal MC is not a common current practice and to achieve rapid roll out will require its integration into PMTCT with training of health staff and community outreach to mobilise demand, as well as technical training to perform safe neonatal MC.

4.2.3.3 Outcome Level Results

The implementation of the male circumcision interventions will focus on attaining the following outcome result.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
The % of men who undergo facility based circumcision is rapidly increased	20% 2008	To be established	40%
By 2011, 50% of new born boys are circumcised at health facilities within 8 days after birth	Not available	To be established	50%

The implementation of the strategic male circumcision programme interventions that address the above challenges is intended to result in the following output results.

4.2.3.4 Output Level Results

The implementation of the above strategic actions will result in the following output results that will lead to the achievement of the outcome level result stated above

Output	Baseline	Targets	
		2009/2010	2010/2011
The capacity of 50% of the health facilities is strengthened to provide safe MC procedures by 2011 according to national guidelines	To be established by 2011	To be established by 2011	50%
# of doctors trained on MC by 2011	TBD	TBD	TBD
# of nurses trained on MC by 2011	TBD	TBD	TBD

4.2.3.5 Priority strategies

To achieve the above outcome and output level results the following strategic actions will be undertaken to ensure scaling up and expanding MC in Lesotho

- Development of policy guidelines on MC in Lesotho and implementation of the MC policy;
- Undertake community mobilisation and education on MC;
- Train doctors and qualified nurses on MC procedures;
- Roll out MC to 50% of health facilities in the country;
- Procure and distribute MC kits and equipment to all health facilities providing MC in the public sector. Ensure no stock-outs of MC supplies; and
- Identify and register all private practitioners offering MC.
- Engage actively with traditional circumcisers regarding roll out of facility based MC and the requirements for safe sexual behaviours after circumcision
- Integration of MC into ANC.

4.2.4 Prevention of Mother To Child Transmission

4.2.4.1 Introduction

HIV transmission during pregnancy and delivery is the most common mode of HIV transmission to children in Lesotho. This can be sharply reduced to less than 2% by providing antiretroviral (ART) prophylaxis, safe delivery in approved health facilities, and safe infant feeding practices. The ART prophylaxis is given to mothers during pregnancy and to infants during the first weeks of life.

PMTCT uptake in Lesotho has increased from 5.9% in 2005 to 56% in 2009, with over 90% of mothers offered HTC in ANC settings. Services are available in 166 health facilities including 19 hospitals and 117 health centres. The PMTCT programme is integrated into routine maternal and child health care services. Lesotho has developed a PMTCT policy and technical guidelines.

4.2.4.2 The Challenges to be Addressed

The following challenges will be addressed

i. The uptake for PMTCT remains low with a coverage of 56%
ii. Inadequate capacity at health facilities to provide PMTCT
iii. Stock out of ARV drugs for PMTCT
iv. Lack of male involvement in PMTCT
v. Stigma associated with HIV and AIDS
vi. A weak referral system between PMTCT and ARV for infants; and
vii. Private sector is inadequately involved in the provision of PMTCT. Reporting by private practitioners is considered inconsistent.

4.2.4.3 Outcome Level Results

The implementation of the strategic PMTCT programme interventions that address the above challenges is intended to result in the following outcome results

Outcome	Baseline	Targets	
		2009/2010	2010/2011
The % of HIV positive pregnant women and infants who receive a complete course of ART prophylaxis to reduce the risk of MTCT is increased from 56% (2009) to 80% by 2011	56 % (2007)	To be established	80%
% of HIV positive infants born to HIV+ mothers has reduced from 16.5% in 2007 to 10% by 2011	16.5% (2007)	As above	10%

4.2.4.4 Output Level Results

Output	Baseline	Targets	
		2009/2010	2010/2011
% of health facilities at designated levels that have adequate capacity to provide PMTCT (minimum package) is increased from 63.3% in 2007 to 100% in 2011	63.3%	To be established	100%
Proportion of women attending ANC offered quality testing and counselling for HIV is increased from 91% in 2007 to 100% in 2011	91%	As above	100%

4.2.4.5 Priority Strategies

The following strategic actions will be taken to achieve the above outcome and output results

- Strengthen PMTCT uptake
- Strengthen the resource capacity – human, infrastructure, financial - at the antenatal clinics to be able to deliver PMTCT services efficiently in all health facilities to meet minimum standards
- Strengthen monitoring / tracking of PMTCT clients
- Strengthening of referral systems between HTC, PMTCT and ART services
- Strengthening of community education and active promotion of the concept and services for PMTCT
- Promote male involvement in reproductive health services including PMTCT-plus; and
- Strengthen the provision of services to help pregnant mothers to stay HIV negative and to increase access to family planning to prevent unwanted pregnancies, especially for HIV positive women and men

4.2.5 Condom Use, Distribution and Management

4.2.5.1 Introduction

Condoms constitute an important barrier to HIV infection when correctly and consistently used, hence their potential to reduce the risk of exposure to HIV. In spite of this understanding and 90% of adult Basotho having been taught the use of condoms, condom acceptance and use in Lesotho remains low. The LDHS in 2004 noted that 51.4% of men and 58.1% of women aged 15-49 years were not using condoms during high risk sexual intercourse and with multiple partners.

Efforts have been made to increase condom usage including increasing the number of available condoms. In 2006 alone 17 million male condoms and 25,372 female condoms were made available. Lesotho has also developed a National Condom Management Strategy and a policy is being developed by Ministry of Health and Social Welfare. Condoms are made available for free by government and through social marketing by PSI. Additional condoms are available through commercial outlets including retail shops and pharmacies. Because the KYE study indicated that a high proportion of new infections are occurring between long-term discordant couples, it is essential to find effective ways to increase condom use in this cohort.

4.2.5.2 The Challenges to be Addressed

The following challenges will be addressed

i. Availability of female condoms is still low compared to male condoms, and comparative cost-benefits need to be considered.
ii. The use of condoms during high risk sex and with multiple partners is equally low.
iii. Community education and awareness of condoms has not reached a critical level to spell out myths associated with condoms
iv. Stock out of condoms at district and community level
v. In-adequate access (not user friendly) to condoms by young people.
vi. The implementation of the condom strategy has taken a slow pace.

4.2.5.3 Outcome Level Results

The implementation of the strategic condom related activities will result in the following outcome results

Outcome	Baseline	Targets	
		2009/2010	2010/2011
Strengthened procurement and distribution systems that ensure no stock-outs of condoms at all distribution points			
100% of distribution points reporting no stock-outs			
The % of people aged 15-49 who use condoms during sex with multiple partners is increased from 48.6% for men and 41.9% for women in 2004 to 80% for both men and women by 2011.	M=48.6% F= 41.9%	To be established	80%
The % of people aged 15-49 who use condoms correctly and consistently during sex with non regular partners	TBD	TBD	TBD
The % of people aged 15-49 who use condoms correctly and consistently during commercial sex	TBD	TBD	TBD
The % of discordant couples who use condoms correctly and consistently	TBD	TBD	TBD

4.2.5.4 Output Level Results

The implementation of the above actions will result in the following output results

Output	Baseline	Targets	
		2009/2010	2010/2011
The number of available female and male condoms is increased by 50% from 17 million for male condoms 25,372 for female condoms and available	M=17 million F= 25,372	M=25 million F=38,000	M=34 million F=5,744
Increased usage of condoms in high risk sexual intercourse among young men and women to 80% by 2011[17]			80%
All villages have at least 2 distribution points by 2011	TBD	TBD	TBD
# of condom awareness sessions held	TBD	TBD	TBD
# of people who attended the awareness sessions	TBD	TBD	TBD
# of discordant couples who are found positive with STIs in the last 12 months	TBD	TBD	TBD

4.2.5.5 Priority Strategies

The following strategic actions will be taken to achieve the outcome (above) and output results (below)

i. Strengthen condom procurement and distribution strategies.
ii. Develop advocacy material around correct and consistent use of condoms
iii. Intensify condom awareness education especially among young people and key populations (sex workers ,migrant and mobile populations, MSM, discordant couples and herd boys

4.2.6 HIV Testing and Counselling (HTC)

[17] High risk sex is associated with Sex Workers, MSM, long distance Heavy Duty Vehicle Drivers, Cross-border Farm Workers

4.2.6.1 Introduction

HTC is offered as provider initiated at health facilities and client initiated in either health facilities or at Voluntary Counselling and Testing (VCT) centres. Provider initiated HTC is provided as part of clinical care and disease prevention. Client initiated is offered basically in response to individual basic rights to know their HIV status. Among the key services being offered is counselling and testing for PMTCT, and survivors of sexual abuse and violence. Evidence shows the impact of knowing one's status in helping discordant couples and HIV positive clients to adopt safer sexual behaviour. However, there is little evidence to date that clients who test negative adopt safer sexual behaviour. HTC services need to be strongly linked with treatment services and with ongoing prevention services including condom counselling and provision, male circumcision, and raising risk perception and support to reduce multiple and concurrent sexual partnerships One-off counselling at the VCT site is not sufficient to change sexual behaviour in the long term, and hence the need for on-going post test services provided on site and through referral as appropriate.

Stigma and discrimination are major barriers to people knowing their status, therefore efforts towards the elimination of stigma and discrimination should be intensified.

4.2.6.2 The Challenges to be Addressed

The following are the critical challenges to be addressed to achieve universal access to HTC

- The current HTC policy and guidelines do not include provider initiated HTC, although this is an optimal strategy for increasing earlier entry into treatment
- Implementation of quality assurance standards (based on the MOHSW guidelines) of HTC services given the multiple stakeholders involved
- Stigma associated with HIV and AIDS
- Inadequate funding
- Poor motivation of community health workers in promoting HTC
- Lack of integration of the Know Your HIV Status (KYS) campaign into the health system and isolation of KYS events from ongoing prevention support services and from treatment access
- Inadequate management of supplies. Some facilities have reported stock-outs of test kits
- Challenges in the quality control of services

4.2.6.3 Outcome Level Results

By addressing the above challenges, HTC interventions will result in the following outcome results.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
The % of Basotho 12 years and above who have tested and know their HIV status in the past 12 months	28%	32%	65%
The % of Basotho 12 years and above who have tested and know their negative or positive HIV status and accessed prevention services	TBD	TBD	TBD
The % of Basotho 12 years and above who have tested and know their positive HIV status and accessed treatment, care and support	TBD	TBD	TBD

4.2.6.4 Output Level Results

The implementation of the above actions will result in the following output results

Output level Results	Baseline	Targets	
		2009/2010	2010/2011
HTC counsellors who provide quality assured services that meet the minimum standards are increased from x in 2008 to x in 2009. in the country	TBD	TBD	TBD

90% of HTC service providers provide referral to treatment services by 2011	TBD	TBD	TBD
% of HTC services providers ensure continued access to prevention services by 2011	TBD	TBD	TBD
Routine HTC services are provided in all health facilities to those in need including STI, TB and ANC clients.	As above	As above	As above
% of clients in long-term relationships access HTC together as a couple	TBD	TBD	TBD
% of discordant couples access prevention services[18]	TBD	TBD	TBD

4.2.6.5 Priority Strategies

The following strategic actions will be undertaken to achieve the desired output results

i. Revise the HTC guidelines to include "provider initiated" HTC at all health facilities to all clients, with priority to STI, TB and ANC clients
ii. Strengthen procurement and supply management of HTC test kits to avoid stockouts
iii. Promote and support expansion of "Know Your Status" campaign at community level linked with access to prevention and treatment services
iv. Involve PLWHA in promoting HTC and in particular in stigma reduction
v. Promotion of the reduction of stigma and discrimination
vi. Expand HTC services in the community, by way of decentralising services to qualified and competent organisations including civil society
vii. Advocate for HTC as a core component of HIV and AIDS workplace programmes, and support public private partnerships to scale HTC linked with ongoing prevention services and treatment access
viii. To provide routine testing to all those attending health facilities, and as a priority to STI, TB and Ante-natal Clinics (ANC) clients & under 5 clinics, linked with access to prevention and treatment services
ix. Mobilise men to take HIV tests; and
x. Strengthen the referral systems from HTC to other post test services.
xi. Promote counselling for couples and support to discordant couples for prevention and for treatment access.

4.2.7 Prevention of HIV in the Workplace

4.2.7.1 Introduction

HIV and AIDS Workplace programmes usually constitute an internal response to the epidemic primarily helping employees prevent infection and cope with the impacts. They serve to expand availability of services and increase access and utilisation, and can help dispel stigma and discrimination and uphold workers and their families' rights. Available information indicates that some private sector companies and government ministries in Lesotho have established some workplace programmes. The primary focus has been the basic services related to prevention (i.e. condom distribution, peer education and counselling and referral services to other service providers. However a few larger and well resourced companies are providing HTC and treatment). What is possible in larger workplaces is more extensive than in small and informal workplaces.

In attempts to strengthen capacity for workplace programmes, Lesotho has developed national guidelines. A situation analysis (survey) was conducted to establish the extent of the workplace programmes. As a result, advocacy for workplace initiatives is ongoing to support the establishment of quality programmes.

4.2.7.2 The Challenges to be Addressed

[18] This entails MC, consistent condom use

The following are some of the key challenges identified with the workplace programmes in Lesotho

i. Delays in finalising the HIV and AIDS workplace policy for the public sector
ii. Reluctance of many public and private sector institutions to establish workplace programmes
iii. Despite the existence of the national guidelines services vary from one service provider to another. The guidelines are not explicit on the minimum package for the workplace programmes
iv. Inadequate capacity to manage the workplace programmes
v. Mainstreaming of HIV in the corporate functions has been slow and limited to basic functions. With the exception of a few companies, mainstreaming HIV and AIDS in corporate policies, financial and human resources systems have remained inadequate
vi. Existing programmes are mainly located within large and well resourced companies, medium and small companies have not attempted to establish work programmes and it is more challenging for them to do so; and
vii. Coordination of the private sector remains weak.

4.2.7.3 Outcome Level Results

The effective response to the above challenges will result in the following outcomes.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
The number of employees in the formal sector who have access to HIV and AIDS workplace minimum package is increased from x to 50% to X by 2011	To be established in year 1	20%	50%

4.2.7.4 Priority Strategies

The following strategic actions will be implemented

i. Scaling up the workplace response to HIV and AIDS through sensitization of employers
ii. Develop and implement effective social and behaviour change communication strategy for Management and Workers in both private and public sectors
iii. Expand other HIV prevention services at the workplace including access to male and female condoms
iv. Support and promote "HIV and AIDS at the workplace
v. Involvement of workers' organisations in the workplace response to HIV and AIDS
vi. Promote and support of capacity building of workers and employers organisations to respond to the epidemic
vii. Develop workplace programmes in the informal sector
viii. Ensure enforcement of SADC policy on employment and HIV and AIDS.

4.2.7.5 Output Level Results

The implementation of the above strategic actions will result in the following output results

Output	Baseline	Targets	
		2009/2010	2010/2011
The number of medium and large scale public and private sector institutions who have established HIV and AIDS workplace programmes is increased to 50%	To be established	To be established	50%

4.2.8 HIV Prevention in Key Population Groups

4.2.8.1 Introduction

Key populations in the context of Lesotho are groups within the larger society who display social behaviours that tend to put them at a higher risk of HIV infection. In most cases these are groups that are often marginalised and have limited access to HIV and AIDS related services. They are often discriminated against, stigmatised, open to exploitation and their behaviours may be criminalised (e.g. sex work, men having sex with men).

The NSP will focus on key priority population groups that will include sex workers, men having sex with men, migrant labour, and inmates (prisoners). Strategic information on the extent of some of these population groups and their HIV prevalence is inadequate and will be generated through a series of studies to inform the prevention and care and treatment responses. Injecting drug use is believed to be extremely low, but this will also be investigated.

Available epidemiological evidence indicates that in a generalised epidemic such as the case for Lesotho, controlling HIV infection amongst the key populations at risk will not necessarily reduce the overall number of new infections significantly at population level, or prevent the epidemic from sustaining itself. However, it is important to provide services based on a human rights approach and the obligations of the duty bearers.

4.2.8.2 The Challenges to be Addressed

The following challenges will be addressed

i. There is no empirical data on the extent and impact of HIV and AIDS among the key populations
ii. There are no targeted interventions. Some programmes had started for sex workers but have since stopped.
iii. Stigma has negatively impacted on access and utilisation of services by the key population groups

4.2.8.3 Outcome Level Results

The effective response to the above challenges will result in the following outcomes

Outcome	Baseline	Targets	
		2009/2010	2010/2011
% of key populations at risk who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission is increased from X in 2009 to 50% in 2011	Not available	To be established	50%
Key populations at risk have knowledge and skills for effective HIV prevention.	TBD	TBD	TBD

4.2.8.4 Output Level Results

The implementation of the above actions will lead to the following output results.

Output	Baseline	Targets	
		2009/2010	2010/2011
% of most at risk populations reached with HIV prevention programmes is increased from X in 2009 to 50% by 2011	To be established	To be established	50%
Approved policies and strategies to address issues of all key populations in place by 2011	HIV & AIDS policy & Strategy address		

	these issues		
% of most at risk populations that have tested for HIV and know their status and have been provided access to ongoing prevention and treatment services as required is increased from X in 2009 to 50% in 2011	As above	As above	50%

4.2.8.5 Priority Strategies

The following strategic actions will be undertaken

Conduct surveys on the key populations (sex workers, MSM, prison inmates, drug users)

i. Establish a National Technical Working Group to spearhead development and coordination of services for vulnerable groups.
ii. Conduct surveys to establish the extent of HIV and its impact on the identified key population groups.
iii. Based on the survey results develop policy guidelines and programmes targeting each of the key populations
iv. Accelerate the finalisation of the policy and strategic plan for Correctional Services in order to initiate services and interventions with inmates.
v. Strengthen the capacity of service providers and in particular civil society organisations to reach out and serve key populations establishment of special services to cater for vulnerable populations

4.2.9 Blood Safety

4.2.9.1 Introduction

There is a high risk of transmission of HIV through donated blood or blood products if appropriate measures are not taken to screen all donated blood and blood products for HIV and other infections. Blood donation has also been used as a reinforcement mechanism to encourage regular blood donors to stay negative. It is critical for all blood donated for transfusion to be screened for HIV and Hepatitis B and syphilis viruses. Currently only the Central Laboratory at Queen II screens blood for HIV and hepatitis B and syphilis to maintain high standards

4.2.9.2 The Challenges to be Addressed

The following challenges will be addressed

i. Blood transfusion services are centralised
ii. Declining blood donors
iii. Inadequate capacity for the National Blood Transfusion Services

4.2.9.3 Outcome Level Results

Addressing the above challenges will lead to realising the following outcome.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
Prevalence of HIV in donated blood units is less than 1%	4.2% 2008		Below 1%

4.2.9.4 Output Level Results

Output	Baseline	Targets	
		2009/2010	2010/2011
100% of donated blood is screened in a quality assured manner for HIV	100%	100%	100%
100% of donors are voluntary and non-remunerated	97.5% (2008)	100%	100%

4.2.9.5 Priority Strategies

The following strategic actions will be undertaken to achieve the output results.

i. Decentralise and strengthen laboratory capacity or blood transfusion and screening
ii. Improve quality control in blood screening to reduce the risk of HIV or Hepatitis B and syphilis transmission through blood transfusion or use of blood products to 0% by end of 2007.
iii. Support the establishment of blood donor clubs in 100% of primary and high schools.
iv. Mobilise communities to donate blood.

4.2.10 Post Exposure Prophylaxis (PEP) & Universal Precautions

4.2.10.1 Introduction

Post-exposure prophylaxis (PEP) is a necessary secondary prevention measure in health care settings, occupational exposure in other workplace environments and for victims of sexual violence as well as Universal precautions for infection control to protect health workers, home-based carers and other personnel to come into accidental contact with HIV-infected blood and blood products. Incidents of occupational exposure to blood borne pathogens, including HIV, often occur in health care settings compared to other settings. PEP for HIV consists of a comprehensive set of services to prevent infection developing in an exposed person, including: first aid care; counselling and risk assessment; HIV testing and counselling; and, depending on the risk assessment, the short term (28-day) provision of antiretroviral drugs, with support and follow up. Antiretroviral treatment if initiated within 2 hours or maximum of 72 hours of suspected exposure to HIV can reduce the risk of HIV infection.
Further the universal precautionary measures which include the use of gloves, appropriate cleaning techniques when dealing with open wounds and blood spills; and the safe disposal of needles and medical waste; and use of properly sterilised and injecting and other skin-piercing instruments as well as their none-reuse, safe disposal should be provided to minimise the risk of acquiring HIV from work –related situations through use of protective materials.

4.2.10.2 The Challenges to be Addressed

The following challenges will be addressed

i. Low levels of awareness of PEP services outside of health facilities, especially among community members and in particular victims of rape
ii. Many survivors of rape, domestic and other gender violence do not report to the authorities, and stigma is high
iii. Insufficient availability of protective materials in the workplace where relevant,
iv. Weak referral system between law enforcement agents and health facilities in cases of survivors of rape or other domestic violence that expose survivors to HIV infection

4.2.10.3 Outcome Level Results

Effectively addressing the above challenges will contribute to the realisation of the following outcome result.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
Workers in need of PEP receive PEP within 72 hours as well as Universal precautions	TBD	TBD	TBD
Identified survivors of rape access PEP within 72 hours	TBD	TBD	TBD

4.2.10.4 Output Level Results

The implementation of the above actions will contribute to the realisation of the following output level results

Output	Baseline	Targets	
		2009/2010	2010/2011
All health facilities providing ART and PMTCT are providing PEP and Universal Precautions services by 2011.	10%	To be established	To be established
Mobilisation, education and empowerment for rape survivors	TBD	TBD	TBD

4.2.10.5 Priority Strategies

The following strategic actions will be addressed

i. Education of health workers, police who handle rape and accidents and other sectors involved on PEP and infection control at all levels.
ii. Strengthening community education on PEP and infection control procedures.
iii. Sensitise law enforcement officers and the community on PEP
iv. Expanding the PEP services to all health facilities.
v. Ensuring availability of protective materials at all times and PEP at all health facilities and the community.
vi. Provide psychosocial support for victims of rape

4.2.11 Sexually Transmitted Infections

4.2.11.1 Introduction

Available epidemiological and scientific data indicates that the presence of STI, especially ulcerative conditions, in an HIV-negative person increases the risk of acquiring HIV infection. Additionally, HIV-infected persons with STI, both ulcerative and inflammatory ones, are at increased probability of transmitting HIV to their sexual partners due to increased genital shedding of HIV. Furthermore, there is evidence that HIV-infected women are at a higher risk of developing cervical cancer, which in 99% of the time is caused by the sexually transmitted human papilomavirus. In 2007, the prevalence of HIV in Lesotho among STI patients was high at 56.2%.

Although STIs are an important co-factor for HIV transmission and acquisition, some research seems to show that treating the STIs does not seem to reverse the impact on HIV transmission and acquisition, except under specific conditions and in certain populations at high risk. (Sangani et al, 2004; Gray and Waver, 2008; Watson-Jones et al. 2008; Celum et al., 2008). A recently-completed study amongst sex workers in Zimbabwe (Cowan et al., 2008), for example, showed that amongst HIV-1 positive and HSV-2 positive female sex workers, HSV-2 treatment suppressed HSV-2 viral shedding, but not HIV. This evidence should not detract from the fact that STIs enhance HIV transmission and acquision. Treatment of STIs is, therefore, an important public health intervention in that, together with prevention interventions, will reduce the prevalence of STIs in the population, and thus reduce the HIV infections attributable to STIs. Additionally, STIs are important in their own right because they cause considerable burden of disease and expenditure, particularly in women. Therefore, STI prevention and control for the general population should be a priority intervention as a component of sexual and reproductive health services.

4.2.11.2 The Challenges to be Addressed

The following challenges will be addressed

i. Strengthen the capacity of health facilities to provide treatment of both bactrial and viral STIs
ii. Low levels of knowledge of STI and their relationship to HIV. This has a negative impact on people in seeking early diagnosis and treatment

iii. In most rural settings, people seek care and support from traditional health practitioners before attending a health clinic.
iv. There is no sufficient empirical data that supports STI as an effective HIV prevention strategy.
v. Not all STI survey sites are functional

4.2.11.3 Outcome Level Results

By addressing these challenges will contribute to the achievement of the following outcome result.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
100% of people attending health facilities are appropriately diagnosed, treated and counselled for STIs	56%[19]	To be established	100%

4.2.11.4 Output Level Results

The implementation of the above activities will contribute to the achievement of the following output level results.

Output	Baseline	Targets	
		2009/2010	2010/2011
100% of all health facilities providing comprehensive diagnosis and treatment of STIs	To be established	To be established	100%
% of communities reached with STI educational materials.	To be established	To be established	To be established

4.2.11.5 Priority Strategies

The following strategic actions will be implemented.

i. Strengthen the capacity of STI surveillance sites to effectively generate quality and comprehensive data on prevailing STIs and populations commonly affected, including monitoring of antimicrobial resistance, particularly in *Neisseria gonorrhoeae*, to guide prevention interventions and the management of STIs using syndromic approach.
ii. Establish services for STI care in all hospitals and strengthen their capacity to provide counselling for STI / HIV testing and to serve as referral centres
iii. Strengthen the referral systems to STIs services by establishing services with better equipment and adequately trained staff at key sentinel sites.
iv. Intensify community education on STIs to emphasize prevention of STIs.
v. Integrate routine HIV testing as part of STI diagnosis.
vi. Review the STI policy and guidelines.
vii. Engage the appropriate private sector with clear guidelines on how to enhance their response to management of STIs within the context of the national framework and policies on STI control.
viii. develop a working relationship with Traditional Health practitioners especially in the areas of education and adherence to treatment

[19] Were tested and treated

4.3 Treatment, Care and Support

4.3.1 Introduction

The core objective of treatment, care and support is to improve the quality of life of PLWHA. A starting point is implementing interventions that delay progression to AIDS. Such interventions include provision of nutrition, treatment of opportunistic infections, and reduction of TB prevalence among PLWHA through treatment. The ultimate target is to reduce mortality and morbidity among PLWHA.

Impact level Result	Baseline	Targets	
		2009/2010	2010/2011
Mortality due to HIV and AIDS is reduced from 26% for men, 31% for women and 18% for children (<12) in 2007 to 16% for men, 21% for women and 8% for children in 2011	Men = 26% W= 31% Children = 18%	To be determined	Men = 16% W= 21% Children = 8%

4.3.2 Antiretroviral Therapy (ART)

4.3.2.1 Introduction

By 2007, ART coverage was estimated at 25% for adults and 26% for children. The provision of ART has improved the quality of life of PLWHA by reducing mortality and morbidity. As part f of the package PLWHA also get nutritional and psychosocial support. Complementary programmes include treatment literacy, care and support of vulnerable children, home based and palliative care.

4.3.2.2 The Challenges to be Addressed

The introduction of ART has come with its own challenges. Among them are the following.

i. ART services were not available in all health facilities
ii. Inadequate capacity to provide ART
 Quality assurance and supervision
iii. 75% of people in need of ART are not receiving ART
iv. The uptake for paediatric ART is still very low. Current coverage is estimated at 26%
v. The TB/HIV co-infection is very high. In 2007, 80% of all TB patients were also HIV positive
vi. Erratic supply of ART drugs in some health facilities. There are also challenges associated with drug forecasting. Stigma remains a key barrier in access and utilisation of ART service.
vii. Accelerate the accreditation of ARV sites.

4.3.2.3 Outcome Level Results

The implementation of the antiretroviral Therapy (ART) interventions will focus on attaining the following outcome results by 2011.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
Increased proportion of women and men with advanced HIV infection receiving ART from 25% in 2007 to 80% in 2011. (disaggregated by adults and children by gender)	25%	TBD	80%
Improved survival rates of people on ART (adults surviving for more than 36 months and Children on ART surviving for more than 5 years	74% Adults		
Increased propotion of children under 18 in need of ART receiving ART	26%	TBD	100%
Strengthened capacity of the health system's ability to provide			

quality ART care			
Increased quality of life for HIV infected people in Lesotho by 2011	TBD	TBD	TBD

4.3.2.4 Output Level Results

The implementation of the above strategic actions will contribute to the realisation of the output results below.

Output	Baseline	Targets	
		2009/2010	2010/2011
# of adults and children with advanced HIV infection **newly** enrolled on ART (by sex, by age group, pregnant women)	TBD	TBD	TBD
# of adults and children with advanced HIV infection receiving ART (current) (by sex, by age group)	TBD	TBD	TBD
# of adults and children with advanced HIV infection who **ever started** on ART (by sex, by age group)	TBD	TBD	TBD
Decreased number of health care facilities providing ART that experienced stock-outs of ARVs in the last 12 months	TBD	TBD	TBD
% of health care facilities providing ART in line with national guidelines/policies on site or through referral	TBD	TBD	TBD
# of health care facilities that offer comprehensive and quality ART services (by type; public, private, NGO)	TBD	TBD	TBD
# of HIV positive clinically malnourished clients who received therapeutic or supplementary food	TBD	TBD	TBD
# of PLWHA trained on adherence counseling	TBD	TBD	TBD
# of adherence support groups	TBD	TBD	TBD

4.3.2.5 Priority Strategies

The following strategic actions will be taken in order to attain the output level results and the outcome level results.

i. Strengthen national capacity to provide ART services at all health facilities. Such capacity will include strengthening laboratory capacity, human resources, referral system, provision of drugs and other diagnostics, and infrastructure
ii. Review ART guidelines and technical guidelines aligned to the most recent WHO standards.
iii. Decentralise ART services down to most peripheral health facilities and the community.
iv. Strengthen the M&E system for ART services including quality of care, tracking to lost to follow patients, treatment adherence, monitoring of HIV drug resistance and children on paediatric ART.
v. Strengthen procurement, supply and management systems for ART drugs and other supplies.
vi. Strengthen capacity for paediatric ART services
vii. Accelerate the approval of the policy for TB prophylaxis for PLWHA.
viii. Strengthen the capacity of home based care givers to provide quality and comprehensive care including palliative care/ and pain management.
ix. Strengthen the Monitoring of ART services, including patients adherence to treatment, provision and access to nutrition and micronutrients for PLWHA including children
x. Establish comprehensive services for health workers within the health centres
xi. Introduce patient tracking system
xii. Introduce HIV drug resistance prevention program

4.3.3 TB/HIV co-infection

4.3.3.1 Introduction

The key concern for the national HIV and AIDS response is the increasing burden of TB on PLWHA. By the end of 2007, 80% of all TB patients had the co-infection of TB and HIV. TB remains the major cause of mortality among PLWHA. Lesotho is 5th in the world among the 15 countries with the highest rates per capital incidence. In 2006, there were 635 incident TB cases per 100,000 population. By the end of 2007, 12201 cases of all forms of TB were reported. Of these, 5767 (47%) took an HIV test. Eighty-eight (88%) of those who took the test turned to be HIV positive. The TB resurgence poses even greater challenges in managing the HIV epidemic. In 2007, eighty-seven (87) MDR-TB cases were enrolled. MDR-TB/HIV co-infection rate was estimated at 65%. Eight (8) MDR-TB related deaths were recorded in 2007. In MDR-TB, two cases of XDR-TB were also detected in 2007.

Effective treatment of TB is therefore a strategic component of the management of HIV and AIDS in Lesotho. *Recent studies have shown that* "the combination of antiretroviral treatment (ART) and tuberculosis (TB) treatment could more than halve the mortality rate among patients with TB/HIV co-*infection*".

4.3.3.2 The Challenges to be Addressed

The NSP will focus on addressing the following challenges

i. Inadequate integration and roll out of TB/HIV services at health facilities
ii. Lack of capacity to scale up TB/HIV co-infection treatment
iii. Lack of comprehensive data on the extent of MDR and XDR-TB in the country.
iv. Low rates of treatment. Currently the curative rate is 73%.
v. Insufficient community awareness of TB/HIV interactions

4.3.3.3 Outcome Level Results

Outcome	Baseline	Targets	
		2009/2010	2010/2011
Increased proportion of health facilities that provide integrated TB/HIV services from X to Y by 2011	73%	To be determined	100%

4.3.3.4 Output Level Results

The implementation of the above strategic actions will contribute to the realisation of the following output result and the outcome result stated above

Output	Baseline	Targets	
		2009/2010	2010/2011
Proportion of patients diagnosed with TB/HIV co-infection enrolled on TB and AIDS treatment by 2011	TBD	TBD	TBD
# of TB patients who had an HIV test result recorded in the TB register	TBD	TBD	TBD
# of HIV positive patients in HIV care and treatment screened for TB infection	TBD	TBD	TBD
HIV+ people receiving prophylaxis as a prevention for TB	TBD	TBD	TBD

4.3.3.5 Priority Strategies

The following strategic actions will be implemented

i. Develop and disseminate TB/HIV collaborative activities guidelines
ii. Accelerate the process for approving the policy guidelines for TB prophylaxis.

iii. Roll out TB/HIV services in all health facilities.
iv. Strengthen the capacity of health facilities to provide TB/HIV services including diagnosis, testing, counselling, and referral services among others
v. Conduct community mobilisation to create awareness of the interactions between TB and HIV. The campaigns should also target TB and PLWHA to encourage them to access services on time.
vi. Capacity building of community home-based Care Givers to encourage adherence to treatment.
vii. To establish treatment adherence programme for TB/HIV patients to safeguard against early development of drug resistance with greater community involvement. This will require community capacity strengthening

4.3.4 Community Home Based Care (CHBC) and Palliative Care (PC)

4.3.4.1 Introduction

The increased patient load faced by hospitals as a result of chronic illnesses including the HIV and AIDS related conditions has necessitated the provision of comprehensive home based care services including palliative care. Home based care services are being provided by a variety of stakeholders including nurses, HBC volunteers and community based organisations. To a large extent home based care services have been supported by family members. It is only until recently that the concept of "family caregivers" has emerged and is increasingly being recognised as the cornerstone for HBC services.

By the end of 2008, the number of people on home based care had increased to 35,090. Of these 15,360 were men and 19,730 were women.

4.3.4.2 The Challenges to be Addressed

The NSP will focus on the following strategic challenges

i. Inadequate and fragmented coordination of home based care services. There is need to develop guidelines for coordination
ii. Due to lack of standards based on a minimum package for HBC, the quality of services is often compromised.
iii. Inadequate skills and experience among HBC service providers. This is particularly the case for palliative care.
iv. Inadequate human resources coupled with increasing attrition of caregivers
v. Weak referral system and patient discharge planning.
vi. Inadequate guidelines for waste management.
vii. Limited access to HBC materials and supplies
viii. Non-remuneration of HBC givers

4.3.4.3 Outcome Level Results

The NSP will focus on strategic interventions that will contribute to the achievement of the outcome level result stated below.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
% of people in need of home based care receiving comprehensive care and support by 2011.	35,090 people (2008)	To be determined	100%
Increased number of Home Based Carers providing HBC according to national guidelines	TBD	TBD	TBD

4.3.4.4 Output Level Results

Output	Baseline	Targets	
		2009/2010	2010/2011
# of households with chronically ill persons receiving external basic support[20] to care for them by 2011	TBD	To be determined	100%
# of CHBC service providers trained on CHBC skills including Palliative Care(PC)	TBD	25%	50%
# of HBC materials distributed (by type)	TBD	TBD	TBD
CHBC and PC givers mapped	TBD	TBD	TBD
# of people on HBC who are adhering to treatment	TBD	TBD	TBD
Functional referral systems in place(from Home-based Care Givers to Facilities and Vice Versa	TBD	TBD	TBD

4.3.4.5 Priority Strategies

The following strategic actions will be implemented.

- Develop and disseminate CHBC coordination guidelines.
- Define a minimum package for CHBC coupled with quality standards for provision of services
- Train service providers on CHBC services. The training should also focus on quality standards and client (customer) care strategies.
- Train care givers including family caregivers on "palliative care" skills
- Strengthen referral system between CHBC and other service providers.
- Train service providers on "patient discharge" procedures
- Develop and disseminate guidelines for waste management. This should be coupled with training of caregivers in waste management procedures.
- Decentralise the management (distribution) of CHBC materials and supplies
- Increased supervision of people who have been trained on HBC
- Advocacy for HBC policy development
- Strengthened M&E system and reporting of community and home based care services

4.4 Impact Mitigation

4.4.1 Introduction

Impact mitigation services are intended to reduce the negative impacts resulting from the HIV epidemic on individuals, vulnerable households and communities. The interventions focus on addressing the root causes of vulnerability. In most cases, the relationship between vulnerability and HIV infection is reciprocal as the factors that contribute to either vulnerability or HIV infection also increases the susceptibility to the other. For example poverty, violence and ignorance (i.e. pre-existing vulnerability before HIV infection) increases a persons' susceptibility to HIV infection and hence becomes a driver of the epidemic. Being HIV positive re-enforces vulnerability that enables the epidemic to thrive and worsens the quality of life.

The NSP goal is to mitigate the social and economic impacts being experienced by identified vulnerable groups. These vulnerable groups have been identified as, OVC, PLWHA, women and girls, prisoners (inmates), sex workers, migrant workers, people with disabilities and herd boys. This section will focus on impact mitigation, while issues of prevention, treatment, care and support as they related to these groups are integrated in the appropriate sections above.

[20] this may include shelter, food, psychological support, access to protection, etc.

Impact level result

Impact	Baseline	Targets	
		2009/2010	2010/2011
% of vulnerability due to HIV and AIDS among households in Lesotho is reduced from x% in 2008 to 15% by 2011	Contact (DMA)	5%	15%

4.4.2 Support to Orphans and Vulnerable children (OVC)

4.4.2.1 Overview

Orphans and Vulnerable children (OVC) are the most visible negative social impacts associated with HIV and AIDS epidemic. In Lesotho, the number of OVC has increased rapidly from 88,500 in 2005 to 108,000 in 2008. Some of the OVC are infected with HIV while many others experience trauma and emotional distress as they continue to live with parents who are very sick. The greatest challenge for OVC is living in an environment, at home, school or in the community where stigma and discrimination associated with HIV is prevalent.

More often OVC (especially girls) have assumed the roles of caregivers and heads of households. This has compromised their rights to attend school and even make them more vulnerable to abuse, neglect and rejection. Property left behind by parents is often grabbed by relatives under the pretence of traditional customs. In the absence of adequate and effectively enforced legislation and policies, the rights of OVC to a decent life are violated by the very duty bearers supposed to defend them.

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

4.4.2.2 The Challenges to be Addressed

i. Inadequate legislation and policies that protect the rights of the OVC. Lesotho has ratified the UN Convention of the Rights of the Child (CRC), however the CRC has not yet been domesticated.
ii. Delays in enacting the Child Protection and Welfare Bill has had a negative impact on the overall welfare of the OVC
iii. The coordination of OVC support is fragmented. The management of registration of OVC data needs to be standardized and a standard basic package of support defined.
iv. Inadequate provision of external support services to OVC.
v. Stigma and discrimination against HIV and AIDS orphans

4.4.2.3 Outcome Level Results

The NSP will focus on interventions that will contribute to the achievement of the following outcome level result

Outcome	Baseline	Targets	
		2009/2010	2010/2011
% of OVC aged 0-17 whose households received support[21] in caring for child increased from 25% in 2005 to 75% in 2011.	25% (2005)	50%	75%

4.4.2.4 Output Level Results

[21] Basic Support denotes 3 or more services (Psycho- social services, Medical care, Financial help, Education, Food packages, clothing/household, shelter, legal services)

The above strategic actions will be implemented to ensure the achievement of the following output level results

Output	Baseline	Targets	
		2009/2010	2010/2011
Child protection and Welfare bill enacted	The bill is ready to be tabled to Parliament	TBD	TBD
# of eligible OVCs who received support (disaggregated by type of support)	TBD	TBD	TBD
# children provided with Protection and Legal aid services (by age group)	TBD	TBD	TBD
# of eligible children provided with health care referral	TBD	TBD	TBD
# of eligible children provided with education and/or vocational training support (disaggregated by sex)	TBD	TBD	TBD
# of eligible children provided with economic strengthening services (disaggregated by age and sex)	TBD	TBD	TBD
A national survey on the socio-economic impact of HIV and AIDS on orphans & vulnerable children conducted	TBD	TBD	TBD
# of HIV and AIDS impact mitigation programmes implemented and benefiting orphans & vulnerable children	TBD	TBD	TBD

4.4.2.5 Priority Strategies

The following strategic actions will be implemented

i. Advocate for the enactment and adoption of the Child Protection Welfare Bill and the Domestication of the CRC
ii. Effective implementation of the National OVC Strategic Plan
iii. Develop guidelines for a minimum package of support for OVC. The package will also consider issues around psychosocial support, socialisation of OVC, and care.
iv. Provide basic support to OVC households.
v. Strengthen community capacity to provide care and support to OVC.
vi. To develop an integrated and functional data management system which addresses the OVC program needs at community, district and national level
vii. Develop programmes that keep OVC and in particular members of child-headed households in schools
viii. Establish mechanisms for early identification of OVC needing care and support by mid 2011

4.4.3 Support for Vulnerable Households

4.4.3.1 Introduction

The advent of HIV and AIDS in a family and community has imposed severe socio-economic and psychological stress that negatively impacts on the household's capacity to cope due to stigmatisation and discrimination. In addition, the accompanying chronic illness drain the family's financial and physical resources and quite often leading to a reversal of roles where the children become the care givers interrupting their opportunity to attend school. At the death of the parents or head of family, the remaining members of the family may be subjected to loss of the estate to greedy relatives using the pretext of traditional inheritance rules. HIV and AIDS affected families and households turn to experience economic hardships including lack of basic human needs such as food, shelter, proper sanitation and clothing. Provision of these basic necessities has been identified as strategic to reducing the hardships imposed by the epidemic that may in turn make the households even more vulnerable to HIV infection.

4.4.3.2 The Challenges to be Addressed

i. Lesotho does not have a clearly articulated multi-sectoral strategy to guide and inform the development of interventions targeting vulnerable households.
ii. In the absence of empirical data the extent of vulnerable households is not known. This may compromise a strategic approach in developing a response strategy. The Lesotho Demographic and Health Survey (2004) did not include data collection around vulnerable households.

4.4.3.3 Outcome Level Results

The NSP will support the implementation of interventions that have the potential to mitigate the social and economic impacts of HIV and AIDS, and contribute to the achievement of the following outcome level result.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
% of vulnerable households that have achieved minimum food security, and economic and psycho social needs	Not available	TBD	TBD

4.4.3.4 Output Level Results

The implementation of the above strategic interventions will contribute to the output level results stated below, and eventually contribute to the achievement of the outcome level results stated above.

Output	Baseline	Targets	
		2009/2010	2010/2011
# of vulnerable households identified and registered in accordance with the selection criteria agreed upon	TBD	TBD	TBD
# of vulnerable households reached with comprehensive sustainable livelihood support by 2011	To be established	To be established	50%
# of households initiated and implemented a livelihoods intervention	TBD	TBD	TBD

4.4.3.5 Priority Strategies

i. Conduct Quality of Impact Mitigation survey. The survey will also determine extent of vulnerability, the number of vulnerable households, and key challenges being encountered by vulnerable households.
ii. Develop a comprehensive data management system for vulnerable households.

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

4.4.4 Support to Other Vulnerable groups

The NSP has identified vulnerable groups as, OVC, PLWHA, women and girls, prisoners (inmates), sex workers, migrant workers, people with disabilities and herd boys. The nature and degree of vulnerability vary from one group to another. In most cases vulnerability has been influenced by socioeconomic or biological status. Majority of the vulnerable community groups are those at the lowest quintile levels. The focus for the NSP is to reduce the degree of vulnerability and consequently the socioeconomic impact of HIV and AIDS among these groups.

4.4.4.1 Women and girls

4.4.4.1.1 Introduction

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

4.4.4.1.2 The Challenges to be Addressed

The following challenges will be addressed

i. Inadequate implementation and enforcement of laws and policies that protect women and girls from social and economic exploitation, including sexual abuse and gender based violence.
ii. Inadequate awareness and implementation of the appropriate legal instruments including the Legal Capacity of Married Persons Act, to protect property inheritance for women after the death of their spouses.
iii. The lack of harmony between the law and social cultural practices

4.4.4.1.3 Outcome Level Results

Outcome	Baseline	Targets	
		2009/2010	2010/2011
An enabling policy and cultural environment that would improve the quality of life of women and girls socially and economically.	Information not available	To be determined	To be[22] determined

4.4.4.1.4 Output Level Results

The implementation of the above strategic actions will contribute to the following output and outcome level results stated above

Output	Baseline	Targets	
		2009/2010	2010/2011
Number of policies and laws developed and adopted that empower women and or address social economic inequalities that affect them	1 Law adopted[23]	TBD	TBD
The Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) is domesticated by statutory legislation in Lesotho	Lesotho has ratified the convention	TBD	TBD
Attitudes of gender equality improved among men and women (Disaggregated by Gender)	KAP survey	TBD	TBD

4.4.4.1.5 Priority Strategies

The following strategic actions will be implemented

i. Implement and enforce the Legal Capacity of Married Persons Act.

[22] While new initiatives will be undertaken, emphasis will be on completion of draft policies and legislation.

[23] this refer to the " Legal Capacity of Married Persons Act"

ii. Empower women in decision making over their sexuality and economic development issues, especially where cultural practices constitute a barrier.
iii. Encourage behaviour change of men and boys around women's rights and changing roles in society
iv. Develop policies and programmes that keep girls in school,
v. Domesticate the Convention on the Elimination of All forms of Domestic Violence Against Women (CEDAW)

4.4.4.2 Vulnerable Groups: (PLHIV, people with disability and herd boys)

4.4.4.2.1 Introduction

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

4.4.4.2.2 The Challenges to be addressed

i. No reliable data to inform programming or policy development for the vulnerable groups. The extent of the problem and the impact of HIV and AIDS on the identified vulnerable groups are not known.
ii. Existing interventions tend to be ad hoc, one-time event without a systematic follow up.

4.4.4.2.3 Outcome Level Results

Outcome	Baseline	Targets	
		2009/2010	2010/2011
% of members of vulnerable groups experiencing negative socio-economic impacts of HIV and AIDS decreased from X% in 2008 to 50% by 2011.	TBD	To be determined	50%

4.4.4.2.4 Output Level Results

Output	Baseline	Targets	
		2009/2010	2010/2011
A national survey on the socio-economic impact of HIV and AIDS on vulnerable groups conducted and the report disseminated.	Not applicable	Survey conducted	Baseline information established
# of HIV and AIDS impact mitigation programs implemented and benefiting Vulnerable populations	Information not available	TBD	TBD
Psycho-socially empowered vulnerable groups (disaggregated by type of vulnerability)	TBD	TBD	TBD
Reduced stigma and discrimination against PLWHA and those with disabilities	TBD	TBD	TBD

4.4.4.2.5 Priority Strategies

The following strategic actions will be implemented to achieve the outcome and output results.

i. Undertake a comprehensive survey of the extent (prevalence rates, number of people infected and affected disaggregated by gender) of HIV and AIDS impact on the vulnerable groups.
ii. Develop appropriate programs and action plans to inform and guide the HIV and AIDS response to vulnerable groups
iii. Improve access to services specific targeting vulnerable groups.

4.5 Management, Coordination and Support Mechanisms

4.5.1 Introduction

The effectiveness of the national response to the HIV epidemic requires sound management and coordination mechanisms, effective systems and structures. In Lesotho, The NAC is responsible for coordinating the national multi-sectoral response while the Ministry of Health and Social Welfare is responsible for coordinating the health sector response. The Ministry of Public Service has been identified to coordinate the response in the public sector outside of the Ministry of Health and Social Welfare. Civil society sectors are coordinated through umbrella organisations, while the UN is coordinated through UNAIDS. Bilateral development partners work directly with NAC or the appropriate technical line ministry. At district level coordination is through the District AIDS Committees and the Community Councils AIDS Committees.

Lesotho has adopted a multi-sectoral coordination approach, 3-Ones principles and has developed a National Coordination Framework. The existing mechanism has improved stakeholder coordination resource tracking, harmonisation of stakeholders' programmes with national priorities.

4.5.1.1 Impact Level Result

Impact	Baseline	Targets	
		2009/2010	2010/2011
An effective, well managed national HIV and AIDS response which prevents infection, mitigates the impact of the epidemic, and enhances the care of Basotho through a multi sectoral approach	NCPI - 2007 UNGASS		

4.5.2 Advocacy Policy and Legislation

4.5.2.1 Introduction

Advocacy work: Advocacy work is necessary to place and maintain HIV and AIDS issues on the national socioeconomic development and political agenda. The focus is to ensure that community, religious and political leadership is aware and support the implementation of the national response. The key areas for advocacy are to influence policy decisions, resource allocation, and the communities in general in terms of community accessing and utilising HIV and AIDS services.

The NSP will also target communities with advocacy work around key issues including advocacy work around multiple and concurrent partnerships, inter-generational sex, alcohol and drug abuse all of which are key epidemic drivers.

Policy and Legislation: The NSP recognises the importance of strengthening the existing policies and legislative guidelines to direct the development of programme interventions, and offer protection to those made vulnerable by HIV and AIDS from discrimination and exploitation. The policy environment also provides for authority for national institutions to allocate resources for HIV and AIDS programmes. In addition, the creation of effective mechanisms to coordinate the national response would provide and ensure equity in the allocation of resources to national priority areas

4.5.2.2 The Challenges to be Addressed

The following challenges were identified during the mid-term review of the NSP and will be addressed during the remaining period.

i. Delays in initiating new policies and legislation, and the adoption of existing drafts.

ii. Inadequate monitoring the implementation of adopted policies and legislation
iii. Inadequate meaningful involvement of political, community and religious leaders [24] in influencing decision and policies around HIV and AIDS. The involvement of the Cabinet, Senate and Parliamentary portfolio committees in a meaningful manner has been ad hoc.
iv. Stakeholders' compliance with the National AIDS Commission's Act and National HIV and AIDS Policy among others has been limited. The authority and legal mandate of NAC has not been fully accepted by all stakeholders

4.5.2.3 Outcome Level Results

The NSP will support the implementation of interventions that facilitate the creation and sustenance of an enabling policy and legal environment for HIV and AIDS programmes. The interventions will contribute to the realisation of the following outcome level result.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
A policy, cultural and legal enabling environment created and enabling the effective implementation of HIV and AIDS interventions country wide by 2011	NCPI -2007 (UNGASS)		

4.5.2.4 Output Level Results

The implementation of the above strategic actions will result in the following output level results

Output	Baseline	Targets	
		2009/2010	2010/2011
All policies and legislation are aligned to evidence based HIV criteria	x[25]	TBD	TBD
Increased commitment by Government, Implementing and Development Partners to implement policy frameworks		NCPI measure	NCPI measure
Strengthened capacity of legislators to utilise evidence based HIV information for policy formulation and programmes	Portfolio Committees on HIV are operational	NCPI measure	NCPI measure
Increased commitment of leadership and participation by community, religious and political leaders in HIV and AIDS	No available	NCPI measure	NCPI measure

4.5.2.5 Priority Strategies

The following strategic actions will be carried out.

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

[24] Leadership includes leaders in all sectors

[25] no target number was set by the NSP II

ii. Intensify and expand coverage of advocacy work among leaders to support strategic interventions, especially around multiple concurrent partnerships, inter-generational sex, and alcohol and drug abuse.
iii. Enhance capacity of Legislators and policy makers to critically evaluate policies and legislation from an evidence based HIV and AIDS approach
iv. Develop new policies and operational frameworks to guide interventions targeting vulnerable groups (covered in impact mitigation)
v. Disseminated existing (relevant to HIV and AIDS response) policies and legal instruments to all stakeholders
vi. Carry out advocacy with stakeholders for compliance (reporting, use of national indicators etc) with requirements for the National Monitoring and Evaluation System.

4.5.3 Coordination and Management of the Multi-sectoral Response

4.5.3.1 Introduction

The success of the national response is dependent on effective management and coordination of stakeholders and development partners, resource coordination and tracking, M&E, and HIV research. The efficiency of the coordination and management processes depend on the existence of strong and effective institutions, policies and legislation and more importantly on clarity of roles and responsibilities of partner organisations at national, district and community levels.

A key focus of the NSP will be to consolidate the operationalisation of the National Coordination Framework and the 3-Ones principles at national, district and community levels, and within individual sectors. Advocacy work will be carried out to ensure that stakeholders understand and appreciate the legal mandate of NAC to coordinate and manage the national response.

Efforts will be made to ensure that effective coordination of the national M&E framework and the implementation of the national HIV research agenda.

The decentralised coordination structures at sector, district and community levels are functional but lack the necessary capacity to realise their potential. Key areas of concern for coordination are the public sector outside the ministry of health and the private sector.

4.5.3.2 The Challenges to be Addressed

The following challenges will be addressed

- The capacity of existing coordinating structures at different levels remains weak and in some cases the infrastructure is underdeveloped including PLWHA network.
- The interventions of the private sector are fragmented and largely un-coordinated.
- Although the National Coordination Framework has been developed and adopted, there is still lack of clarity of stakeholders' roles and responsibilities.
- Resource coordination remains fragmented. Some of the funds are channelled through NAC, the two principal recipients for Global Fund, and some development partners provide funding directly to implementing partners. In the case of government the 2% of the ministerial budgets is given directly to the ministries. Tracking of funds remains a great challenge for NAC.
- HIV and AIDS is not adequately mainstreamed in the sector policies and programmes

4.5.3.3 Outcome Level Results

Outcome	Baseline	Targets	
		2009/2010	2010/2011
The capacity for coordination and management of the national response is strengthened by 2011	TBD	NCPI Measure	NCPI measure

An effective joint multi-sectoral stakeholders response to HIV and AIDS based on the NSP	Not available	NCPI measure	NCPI measure
Sufficient resources mobilized and efficiently managed for the implementation of the NSP activities by 2011	Not available	NCPI measure	NCPI measure

4.5.3.4 Output Level Results

Output	Baseline	Targets	
		2009/2010	2010/2011
Strengthened capacity of NAC, umbrella bodies and decentralised coordinating structures for improved service delivery	Not available	Refer to the WB assessment	
Increased alignment and implementation of plans for Public, private, civil society and development partners in line with the NSP	Not available	75%	85%
Fully developed and adequately institutionalised resource tracking mechanisms	NASA done every two years	Refer to NASA- Number / % of organisations	

4.5.3.5 Priority Strategies

The implementation of the following strategic actions will contribute to the achievement of the following output and outcome level results

i. Operationalise direct contact and regular sessions between NAC and strategic offices
ii. Guide sectors and development partners to harmonise and align their action plans with NSP
iii. Strengthening the capacity for coordination structures and implementing partners at national, district and community levels including thematic networks such as the network of people living with HIV/AIDS.
iv. Disseminate the translated versions of the National Coordination Framework and other key national documents to all key stakeholders.
v. Enhance capacity of public, private, and civil society sectors to mainstream HIV and AIDS in planning and implementation.
vi. Establish the National AIDS Resource Mobilisation and Management Systems including an effective resource tracking system capable of tracking resources from the supply and demand sides.

4.5.4 Community Strengthening

4.5.4.1 Introduction

Communities continue to play a critical role in the national multi-sectoral response to HIV and AIDS, not only as beneficiaries but also as implementers of HIV and AIDS interventions. Community ownership of community based interventions is critical for sustainability and service uptake. Communities in all the districts are mobilising and organising themselves in community action groups, support groups of people living with HIV and AIDS, and in other forms of community based organisations (CBOs). The government realises the potential for community participation in scaling up the national response to HIV and AIDS. A number of initiatives have been started to support and strengthen communities. Community groups continue to receive financial and technical support. District AIDS Committees have been established in all the districts. Not all communities have established Community Councils AIDS Committees. The government and civil society organisations in collaboration with development partners continue to strengthen the

capacity of community groups. Capacity building of local leadership and sub-national coordination structures as well as existence of a strong coordination and monitoring mechanism are vital for sustained interventions.

4.5.4.2 Challenges to be addressed

It is evident from the mid-term review of the NSP that communities are struggling to respond to the impact of HIV and AIDS due to inadequate capacity for management, quality, service delivery, inadequate financial and human resources. While community systems exist they are found to be weak and often fragmented. Communities have also tended to respond to mitigating impacts rather than addressing the root causes. There has been a tendency to adopt easily provided solutions which may not address the root causes of the epidemic. The leaderships' ability to devise effective programs that address the key drivers of the epidemic has been limited. Coordination of community response to HIV and AIDS remains fragmented

4.5.4.3 Outcome Level Results

The NSP will support the implementation of interventions that strengthen community leadership, service delivery systems and build capacity for community based planning. Communities will be trained on the concepts of evidence and results based management to help them initiate effective community based planning. The initiatives will result in the following outcome level results.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
Community based interventions effectively monitored, implemented and well coordinated	Not available	TBD	NCPI measure

4.5.4.4 Output level results

The implementation of the above strategic interventions will contribute to the output level results stated below, and eventually contribute to the achievement of the outcome level results stated above.

Output	Baseline	Targets	
		2009/2010	2010/2011
At least 50% of HIV interventions targeting community council level or lower that are aligned to NSP are implemented by 2011	TBD	25%	50%
DACs and CCACs constituted and operating according to their TOR's	TBD	20%	30%
Number of community leaders able to impart accurate HIV information is increased by 50% by 2011	TBD	25%	50%
At least 50% of data collected through the community based monitoring system meets the quality data standards and criteria	TBD	TBD	TBD

4.5.4.5 Priority strategies

The following are priority strategies:

i. Strengthen community monitoring systems and utilisation of information to improve program development
ii. Strengthen the capacity of community based HIV and AIDS structures and in particular the CCAC's
iii. Strengthen community leadership around evidence based responses to the epidemic
iv. Support community-based service providers (CBOs, local NGOs) in implementing strategies that are aligned to the NSP
v. Sustained implementation of Community Council AIDS plans, (ESP)

4.5.5 Evidence Based Planning

4.5.5.1 Introduction

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

4.5.5.2 Outcome Level Results

The NSP will focus on achieving the following outcome level results.

Outcome	Baseline	Targets	
		2009/2010	2010/2011
The capacity for the national M&E and research system is strengthened at all levels to generate empirical evidence to inform policy, planning and programming for HIV and AIDS in Lesotho by 2011	TBD	TBD	TBD
The national capacity for HIV research is strengthened at all levels to generate empirical evidence to inform policy, planning and programming for HIV and AIDS in Lesotho by 2011	TBD	TBD	TBD

4.5.5.3 The Challenges to be Addressed

The capacity of the national M&E system has increased over time and this has resulted in consistent production of information products for the country. However M&E has not been fully mainstreamed across sectors and at the district level. The current M&E road map needs to be reviewed and aligned to the NSP results framework. The effective operationalisation of HIV research initiatives has been compromised by inadequate human resources.

The existing M & E framework is a combination of framework and plan and therefore, not clearly defined and consequently has not adequately identified and defined the data sources, linkages, SOP's and coordination. Integration of the different structures that produce, manage and utilise data remains a challenge. Similarly information management systems remain fragmented. Lesotho has a central HIV and AIDS database, but data quality assurance remains a challenge.

Consequently there is a general lack of empirical data that can be used to inform decision and HIV programme planning. Most information is available only in hard copies that are held by various organisations. Lesotho profiled all research studies that have been done in and on the country. There is need to update it regularly so that it can serve as a national depository for research reports. Lesotho has a Research Coordination Unit and has developed the research agenda. However, there is no clear and systematic linkage between the unit and the key sectors.

4.5.5.4 Output Level Results

The implementation of the above activities will contribute to the achievement of the following outcome level results.

Output	Baseline	Targets	
		2009/2010	2010/2011
National capacity for HIV research developed	Not available		
National M&E system strengthened and operationalised at all levels	Not available		
Accredited M&E training Institutionalised	Not available		
Strengthened and updated HIV and AIDS database			

4.5.5.5 Priority Strategies

The following actions will be undertaken

i. Strengthen the capacity of the national M&E system to collect and analyse data, and produce reports.
ii. Develop an M&E framework that outlines the countries HIV and AIDS information systems requirements and data management processes
iii. Development of an M&E strategy that addresses the data gaps in all priority programme areas of the NSP
iv. Update the existing National database's ability to achieve an integrated and comprehensive national database for M&E HIV and AIDS data.
v. Identify and support a training institution that would provide M&E training.
vi. Facilitate HIV research in critical areas especially on vulnerable groups and disseminate findings
vii. Develop capacity building programmes for biomedical and social research.
viii. Develop an M&E system that monitors the integration of HIV/TB and STIs

Section 5: Financial Implications

5.1 Resources required for full coverage

The resources required to achieve the coverage targets of the revised NSP will increase from M249 million in 2006 to M918 million by 2011. The annual scale up of resources required and the distribution by intervention are shown below:

Financial requirements in Millions of Maloti

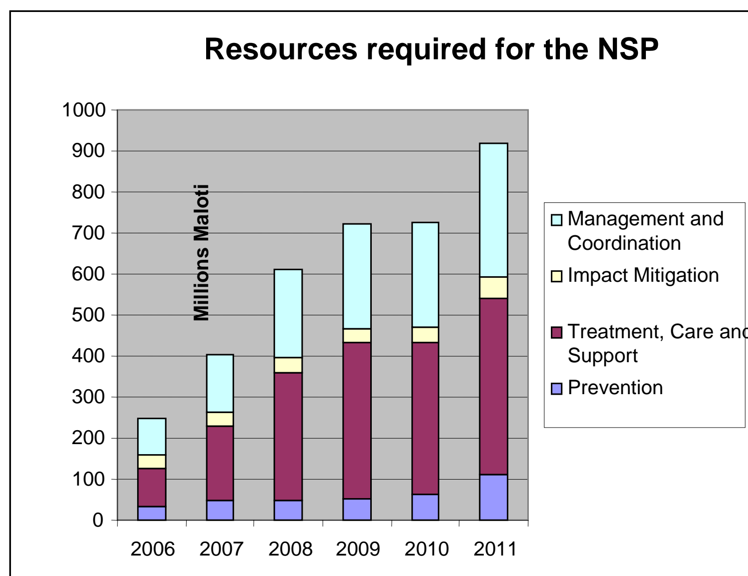
Focus Area	2006	2007	2008	2009	2010	2011
Prevention	35	49	49	53	63	111
Treatment, Care and Support	92	179	312	380	369	428
Impact Mitigation	34	34	34	35	38	54
Management and Coordination	88	143	217	256	257	325
Total (Millions of Maloti)	249	405	612	724	727	918
Total (Millions of USD)	35	57	87	103	103	131

5.2 Methods and Assumptions for Estimating Resources Required

For most interventions that provide services or information to the population the resources required are estimated by multiplying the population in need of the service by the coverage (the percent of the population in need getting the service) to determine the number of people utilizing each service and, then, multiplying this number by the unit cost (the cost to provide the service to one person).Resources required = population in need x coverage x unit cost.

The 'Population in need' is the population for which each intervention is targeted. Information on the size of the population need comes from demographic estimates and projections, behavioural surveys, health statistics and estimates based on epidemiological trends. The number of people reached with each service is estimated from the coverage; that is the percentage of the population in need of the service that receives it in that year. Resources required are estimated by multiplying number of people served by the cost per unit of service, the unit cost. Ideally the unit cost would include all costs associated with providing a service including personnel time, drugs, supplies, training, equipment and facilities.

Some activities, such as management and coordination, policy and advocacy, research, monitoring and evaluation, cannot be represented in this way and are costed with different approaches. Two approaches have been used to estimate the resources required for these activities. They are detailed costing based on the number and type of people required and their salaries plus other direct costs as a percentage of direct service costs.



The total resources needed grow rapidly and are 100% larger in 2011 than in 2008. Most of the increase is caused by scaling-up coverage to the target levels by the end of the NSP. In 2011, 11% of the resources are needed for prevention, 49% for treatment, care and support, 5% for Impact mitigation, and 35% for management and coordination.

Two-thirds of the resources needed for prevention are for four interventions, namely male circumcision, HIV counseling and testing, condom provision, and PMTCT. Antiretroviral drugs account for 72% of the resources required for treatment, care and support in 2011. Within programme support, management, administration and coordination account for 47%, human capacity building accounts for 33% of requirements.

5.3 Resources available and sources of funding

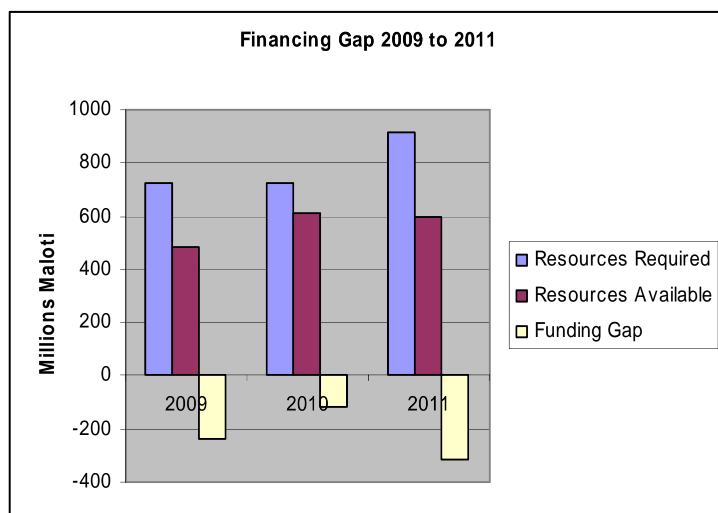
The main development partners supporting HIV and AIDS response in Lesotho are Irish Aid, The United States Government-PEPFAR, The European Union, GTZ, DFID, and The Global Fund for AIDS, TB and Malaria, The Millennium Challenge Corporation, The World Bank and The UN Family. The table below shows the estimated resources available through 2011 based on the Resource Needs Model. It indicates that resources available are likely to increase to nearly M 600 million by 2011.

Estimated resources available in Millions of Maloti

	2006	2007	2008	2009	2010	2011
Domestic Public	40.2	41.3	41.5	41.5	41.5	49.0
Private Sector	0.0	0.0	0.0	0.4	0.4	0.4
PEPFAR	2.3	3.4	89.1	35.0	196.0	196.0
MCC	0.0	0.0	85.9	147.0	168.0	140.0
Irish Aid	4.8	34.1	56.5	50.0	55.0	60.5

GTZ	1.5	2.4	0.8	1.1	1.7	0.9
EU	0.0	4.7	24.0	24.0	24.0	25.2
Int. Private Sector	0.0	0.0	0.0	7.5	7.5	7.5
GFATM	13.6	24.9	116.2	179.4	115.8	120.4
Total	62.3	110.7	414.0	485.8	609.9	599.9

Financing Gap 2009-2011



The graph above summarizes the resources gaps for HIV and AIDS in Lesotho for the remaining years of the NSP. It indicates that resources required will increase over time while resources available will increase from 2009 but will remain almost constant from 2010 to 2011. The resources gap amounts to M238 million in 2009, M117 million in 2010 and M318 million in 2011. These gaps are subject to change depending on finalisation of some resources mobilisation initiatives that are currently underway.

Section 6: Implementation Arrangements

6.1 Ensuring Implementation

Implementation of this Revised National Strategic Plan will take place at three major levels. The first is the management and coordination level, while the second is the level at which various role-players will have specific areas to coordinate and implement depending on their mandate and comparative advantage. The third Level is at policy decision making and leadership level where the accomplishment of the efficacy and efficiency of the results in scaling-up the national response to the HIV epidemic are enhanced through the establishment of National Response Results Assurance Task Team.

Coordination will be guided by the National Coordination Framework which that has been developed in close consultation with all stakeholders. All sectors are obliged to align their strategic and annual action-plans to the Revised National Strategic Plan where strategic priorities are further articulated through the annual development of the National Operational Plan in consultation with all stakeholders. The roles and responsibilities of various stakeholders are discussed below.

6.2 Roles and Responsibilities of National Coordination

6.2.1 The National Results Assurance Committee

There is need to establish a high level HIV and AIDS Results Assurance Committee whose mandate will be to ensure that the results in scaling-up the national response to the HIV epidemic are achieved through a multi-sectoral and participatory approach at the policy decision making level in the country. This committee should comprise decision makers from various sectors, namely Principal Secretaries, Country Representatives, Ambassadors, Executive Directors of Civil Society Organizations, Managing Directors of Private Sector organisations. Government Ministries to be represented include MOHSW, MOPS, MOLGC, MOET, MOLE, MOAFS and MOYGSR. The HIV and AIDS Results Assurance Committee will generally be the apex of all formal coordination structures. It will receive reports from the already established four (4) Thematic Teams and the Technical Working Groups as shown in Annex 1 of the document.

6.2.2 The National AIDS Commission

The Commission is focussing on the management and coordination of efforts towards scaling-up the response to avoid duplication of efforts and, thereby improve efficiency and better utilisation of resources. It will effect coordination through the national HIV and AIDS Policy and this strategic plan. National interventions will be coordinated at both national and sector-specific levels, while all district local and community-based interventions will be coordinated at the district level.

6.2.3 Roles and Responsibilities of Implementers

6.2.4 Ministry of Health and Social Welfare (MOHSW)

The MOHSW and the health sector in general, will focus on prevention, treatment, care and support and impact mitigation programmes. Prevention programmes include HTC, STI management, PMTCT and PEP services, and Blood and Tissue Safety, while treatment includes ART services, management of opportunistic infections including TB, and standardisation of home-based care programmes. In addition, MOHSW deals with Impact mitigation programming through the Department of Social Welfare.

6.2.5 Government Ministries

The Ministry of the Public Service is the entry point for the implementation and coordination of HIV and AIDS interventions in the Public Sector. Various Government Ministries and their constituencies are expected to focus on external mainstreaming of HIV and AIDS and on developing and implementing workplace programmes for their employees.

6.2.6 Operationalisation of the Plan at the District Level

The Ministry of Local Government and Chieftainship (MOLGC) is the entry point for the decentralized HIV and AIDS Response. All the ten districts have District AIDS Committees (DACs) which are charged with the responsibility of coordination at the district level. The DACs represent all key stakeholders *(public and private)* at the district level, and therefore, they are the most appropriate bodies to be the custodians of this national strategic plan at that level. In addition to the DACs, the local authorities and the office of the District Administrator will, in collaboration with NAC provide guidance in the implementation of this plan. Furthermore, all the ten districts should have Community Council AIDS Committees (CCACs) which are multi-sectorally constituted by CBOs, locally based public offices and FBOs to coordinate implementation of HIV and AIDS interventions and ensure stakeholder involvement in planning and implementation of interventions .

6.2.7 Civil Society

Civil Society Organizations (CSOs) is inclusive of NGOs, Faith-Based Organisations (FBOs), the Lesotho Network of People Living With HIV and AIDS (LENEPWHA), institutions of higher learning, and Community-Based Organizations (CBOs) with their established Umbrella Organizations and Various Constituencies. A close connection between the civil society and the community gives CSOs the edge in issues of advocacy, implementation of HIV and AIDS interventions at Community and District levels.

6.2.8 Development Partners

The UN family and other Development Partners contribute to the implementation of the National HIV and AIDS Strategic Plan through technical and financial assistance on HIV and AIDS programmes in the Country. The UN Family through the Joint UN Programme Framework of Support which is based on the principle of "Delivering as One" on AIDS is aligned to the National HIV and AIDS Strategic Plan by galvanizing the comparative advantage of the UN Agencies resources for a multi-sectoral approach to development. Other partners' plans are also aligned to the NSP. This enhances coordinated funding mechanisms and ensures effective coordination and even distribution of interventions throughout the country.

6.2.9 International NGOs

International NGOs contribute to the implementation of the National HIV and AIDS Strategic Plan by providing technical assistance, programmes and operations on HIV and AIDS interventions through relevant sectors at national, district and community levels in the country.

6.2.10 Private Sector & Parastatals

The Ministry of Labour and Employment (MOLE) is the entry point for the implementation and coordination of HIV and AIDS interventions within the workplace in the Private Sector.

All employers should have HIV and AIDS workplace policies and plans that are aligned with the Labour Code (Amendment) Act 2006 and the Guidelines of the Implementation of Labour Code Amendment Act No.5 of 2006 which are also harmonized and aligned to the national HIV and AIDS Policy and Strategic Plan documents.

In addition to standard workplace safety measures, they are guided to develop prevention, treatment, care and support programmes for their workforces.

6.2.11 Monitoring and Evaluation

Effective implementation of this Revised National HIV and AIDS Strategic Plan 2006-2011 is to be monitored and evaluated by using updated and revised versions of the monitoring and evaluation tools that will collect, process, validate, analyse and interpret a range of qualitative and quantitative HIV and AIDS data for the enhancement of the national response at national, district and community levels. A comprehensive revised M&E plan 2006-2011 with clear indicators has to be developed to monitor and evaluate the implementation of this revised strategic plan. In addition to the M&E system, implementation of the revised NSP will be done through review of progress on a Monthly, Quarterly and Annual Partnership fora at both district and national levels.

ANNEX 1

1.3 The Results Framework

Results Framework for the Lesotho National Strategic Plan (NSP)

National Level	Impact Level	Outcome Level Result	Output Level Results	Lead Agency for Output result	Collaborating Agency for Output Result
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011	**Behaviour Change Communication** The % of men and women who have correct knowledge of HIV prevention increased from 23% in 2005 to 80% by 2011	Men and women aged 15-49 years access a comprehensive social and behaviour change package including MCP, MC, intergenerational and age-disparate sex, condom use	NAC	UN Agencies, Prisons, Monna ka Khomo, Sentebale
		The % of people aged 15-49 with multiple and concurrent sexual partners are reduced from 40% in 2008 to 30% in 2011.	# of Villages hold at least 4 community conversations a year on multiple and concurrent sexual partners	Civil society organisations	Community Councils, NGOs, PSI & Private Sector
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011	The % of young men and women aged 15-24 years who commence sexual intercourse before the age of 15 reduced from 27% for men and 15% for women in 2004 to 15% for men and 10% for women by 2011	% of in and out of school youth aged 6 -24 years have had capacity building through life skills HIV and AIDS Education	MOET	Development Partners and donors
		Male Circumcision The % of men who undergo facility based circumcision is rapidly increased	The capacity of 50% of the health facilities is strengthened to provide safe MC procedures by 2011 according to national guidelines	MOHSW	Development Partners, GOL
			# of doctors trained on MC by 2011	MOHSW	Development Partners, CHAL
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less	By 2011, 50% of new born boys are circumcised at health facilities within 8 days after birth	# of nurses trained on MC by 2011	MOHSW	Development Partners, CHAL
		PMTCT: The % of HIV positive pregnant	% of health facilities at designated levels that have	MOHSW	Private Practitioners, Development Partners

	than 11000 in 2011	women and infants who receive a complete course of ART prophylaxis to reduce the risk of MTCT is increased from 56% (2008) to 80% by 2011	adequate capacity to provide PMTCT (minimum package) is increased from 63.3% in 2007 to 100% in 2011		
		% of HIV positive infants born to HIV+ mothers has reduced from 16.5% in 2007 to 10% by 2011	Proportion of women attending ANC offered quality testing and counselling for HIV is increased from 91% in 2007 to 100% in 2011	MOHSW	Private Practitioners, Traditional Healers, NAC, NGOs, Development Partners, Donors
		<u>Condom Use, Distribution and management</u> Strengthened procurement and distribution systems that ensure no stock-outs of condoms at all distribution points	The number of available female and male condoms is increased by 50% from 17 million for male condoms 25,372 for female condoms and available	MOHSW	PSI, Private Practitioners, NAC, NGOs, Development Partners
			Increased usage of condoms in high risk sexual intercourse among young men and women to 80% by 2011[26]	MOHSW, PSI, Care Lesotho	Civil society organisations, NAC, Development Partners
		100% of distribution points reporting no stock-outs	All villages have at least 2 distribution points by 2011	Community Councils	Private Practitioners, Traditional Healers, NAC, NGOs
		The % of people aged 15-49 who use condoms during sex with multiple partners is increased from 48.6% for men and 41.9% for women in 2004 to 80% for both men and women by 2011.	# of condom awareness sessions held	Civil society organisations	MOHSW, Community support groups, Agencies responsible for procurement and distribution of condoms
		The % of people aged 15-49 who use condoms correctly and consistently during sex	# of people who attended the awareness sessions	Civil society organisations	MOHSW, CBOs, Agencies responsible for procurement and distribution of condoms

[26] High risk sex is associated with Sex Workers, MSM, long distance Heavy Duty Vehicle Drivers, Cross-border Farm Workers

		with non regular partners			
		100% of distribution points reporting no stock-outs	All villages have at least 2 distribution points by 2011	Community Councils	Agencies responsible for procurement and distribution of condoms
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011	The % of people aged 15-49 who use condoms correctly and consistently during commercial sex	# of condoms distributed at commercial sex selling points	Condom distributing agencies	NAC, UNFPA, PSI, Agencies responsible for procurement and distribution of condoms
		The % of discordant couples who use condoms correctly and consistently	# of discordant couples who are found positive with STIs in the last 12 months	MOHSW	LENEPWHA, Civil Society, Agencies responsible for procurement and distribution of condoms
		<u>HTC</u> The % of Basotho 12 years and above who have tested and know their negative HIV status in the past 12 months and accessed HIV Prevention services	HTC counsellors who provide quality assured services that meet the minimum standards are increased from x in 2008 to x in 2009 in the country	MOHSW	Agencies that provide HTC services
		The % of Basotho 12 years and above who have tested and know their positive HIV status and accessed treatment, care and support	90% of HTC service providers provide referral to treatment services by 2011	MOHSW	Agencies that provide HTC services
National Level	**Impact Level**	**Outcome Level Result**	**Output Level Results**		
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011		% of HTC service providers ensure continued access to prevention services by 2011	MOHSW	MOLGC & Civil Society organisations
			Routine HTC services are provided in all health facilities to those in need including STI, TB and ANC clients.	MOHSW	Private Practitioners, NAC, NGOs Agencies responsible for providing HTC services
			% of clients in long-term relationships access HTC together as a couple	MOHSW	Agencies providing HTC services
			% of discordant couples access prevention services[27]	MOHSW	Private health facilities, NGOs, Community Councils

[27] This entails MC, consistent condom use

		Prevention of HIV in the workplace The number of employees in the formal sector who have access to HIV and AIDS workplace minimum package is increased from x to 50% to X by 2011	The number of medium and large scale public and private sector institutions that have established HIV and AIDS workplace programmes is increased to 50%	MOLE & Business Labour Coalition	NAC, Lobour and Employer Associations
		HIV prevention among key populations[28] % of key populations at risk who both correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV transmission is increased from X in 2009 to 50% in 2011	% of most at risk populations reached with HIV prevention programmes is increased from X in 2009 to 50% by 2011	NAC	Department of Correctional Services, Care Lesotho, Civil Society Organisations, UN Agencies and Donors
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	The number of new HIV infections is reduced by 50% from 22000 in 2007 to less than 11000 in 2011	Key populations at risk have knowledge and skills for effective HIV prevention.	Approved policies and strategies to address issues of all key populations in place by 2011	MOHSW, NAC	Development Partners
			% of most at risk populations that have tested for HIV and know their status and have been provided access to ongoing prevention and treatment services as required is increased from X in 2009 to 50% in 2011		
		Blood safety Prevalence of HIV in donated blood units is less than 1%	100% of donated blood is screened in a quality assured manner for HIV	MOHSW	WHO
		Post Exposure prophylaxis Health workers identified and in need of PEP receive PEP	All health facilities providing ART and PMTCT are providing PEP services by 2011.	MOHSW	WHO

[28] Key populations in the context of Lesotho are Prisoners, Herd boys, Sex workers, Men who have sex with other men and Mobile Populations. There is very little information available on the impact of HIV and AIDS on these key populations or empirical data on their contribution to the spread of HIV.

		within 72 hours			
		Identified survivors of rape access PEP within 72 hours	Mobilisation, education and empowerment for rape survivors	CGPU, Community Chiefs, Community Councils	Leaders across the board
		<u>Sexually Transmitted Infections</u> 100% of people attending health facilities are appropriately diagnosed, treated and counselled for STIs	100% of all health facilities providing comprehensive diagnosis and treatment of STIs	MOHSW	CHAL, Private Practitioners
			% of communities reached with STI educational materials.	MOHSW	CHAL, Private Practitioners
		Treatment Care and Support			
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	Mortality due to HIV and AIDS is reduced from 26% for men, 31% for women and 18% for children (<12) in 2007 to 16% for men, 21% for women and 8% for children in 2011	Increased quality of life for HIV infected people in Lesotho by 2011	# of adults and children with advanced HIV infection <u>newly</u> enrolled on ART (by sex, by age group, pregnant women)	MOHSW	CHAL, Private Practitioners
		Increased proportion of women and men with advanced HIV infection receiving ART from 25% in 2007 to 80% in 2011. (disaggregated by adults and children by gender)	# of adults and children with advanced HIV infection receiving ART (current) (by sex, by age group)	MOHSW	CHAL, Private Practitioners, Baylor College, PLWHAs, Development Partners and donors
		Improved survival rates of people on ART (adults on ART - 36 months and children on ART- 5 years)	# of PLWHA trained on adherence counselling	LENEPWHA	MOHSW
			# of adherence support groups	LENEPWHA and MOHSW	Community Councils, Chiefs,

					NGOs
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	Mortality due to HIV and AIDS is reduced from 26% for men, 31% for women and 18% for children (<12) in 2007 to 16% for men, 21% for women and 8% for children in 2011	Strengthened capacity of the Health system's ability to provide quality ART care	# of HIV+ mothers counselled on prevention of transmission to their unborn infants	MOHSW	LENEPWHA, Baylor College, Development Partners,
			# of HIV positive clinically malnourished clients who received therapeutic or supplementary food	MOHSW	NGOs
			# of health care facilities that offer comprehensive and quality ART services (by type; public, private, NGO)	MOHSW	CHAL, Private Practitioners
			Decreased number of health care facilities providing ART that experienced stock-outs of ARVs in the last 12 months	MOHSW	CHAL, Baylor College, Development partners, NAC, NDSO
			% of health care facilities providing ART in accordance with ART national guidelines/policies on site or through referral	MOHSW	CHAL, Baylor College, Development partners, NAC
		Increased proportion of children under 15 in need of ART receiving ART		MOHSW	CHAL, Baylor College, Development partners, NAC

National Level	Impact level	Outcome Level Result	Output Level Results	Lead Agency	Collaborating Agencies
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	Mortality due to HIV and AIDS is reduced from 26% for men, 31% for women and 18% for children (<12) in 2007 to 16% for men, 21% for women and 8% for children in 2011	**TB/HIV co-infection** Increased proportion of health facilities that provide integrated TB/ HIV services from X to Y by 2011	Proportion of patients diagnosed with TB/HIV co-infection enrolled on treatment by 2011	MOHSW	EGPAF, PIH, WHO
			# of TB patients who had an HIV test result recorded in the TB register	MOHSW	NDSO, ICAP, EGPAF, WHO
			% of estimated HIV positive clients & TB cases that received treatment for TB and HIV by 2011	MOHSW	NDSO, ICAP, EGPAF, WHO
			# of HIV positive patients in HIV care and treatment screened for TB infection	MOHSW	WHO
			HIV positive people receiving prophylaxis as a prevention for TB	MOHSW	WHO, NAC

National Level	Impact level	Outcome Level Result	Output Level Results	Lead Agency	Collaborating Agencies
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	Mortality due to HIV and AIDS is reduced from 26% for men, 31% for women and 18% for children (<12) in 2007 to 16% for men, 21% for women and 8% for children in 2011	<u>CHBC and Palliative Care:</u> # of people in need of home-based care receiving comprehensive care and support by 2011.	# of households with chronically ill persons receiving standard package for external basic support[29] to care for them by 2011	MOHSW	WHO, NAC
			Number of people on HBC who are adhering to treatment	Carers and Support Groups	MOHSW
			Functional referral system in place (from home-based care givers to Facilities and vice versa)	MOHSW	Community Councils, Community Support Groups, NAC, Development Partners, Civil society organisations
		Increased number of Home Based Carers providing HBC and palliative care (PC) according to national	Guidelines for HBC and PC developed, disseminated and implemented	MOHSW	Community Councils, Community Support Groups, NAC, Development Partners, civil society organisations

[29] This may include shelter, food, psychological support, basic care, etc.

		guidelines			
			Increased number of HBC givers that have had comprehensive training.	MOHSW	WHO, NAC, PEPFAR

National Level	Impact level	Outcome Level Result	Output Level Results	Lead Agency for Output result	Collaborating Agency for Output Result
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	% of vulnerability due to HIV and AIDS among households in Lesotho is reduced from x% in 2008 to 15% by 2011	<u>Orphans & Vulnerable Children</u> % of OVC aged 0-17 whose households received support[30] in caring for child increased from 25% in 2005 to 75% in 2011.	% of OVC aged 0-17 who received psychosocial care & support increased from x to x%	Department of Social Welfare (DSW),	All partners in OVC (Office of the First Lady, LSRC, CRS, World Vision)
			# of eligible OVCs who received support (disaggregated by type of support)	Department of Social Welfare (DSW)	All partners in OVC (Office of the First Lady, LRCS, CRS, World Vision, TRA)
			Policies & Legislation for care & support for OVC developed and adopted & enacted e.g. Child protection and Welfare Bill	Department of Social Welfare (DSW), NOCC	UNICEF, Parliamentary Portfolio Committees on HIV and AIDS (both Houses of Parliament).
			# children provided with Protection and Legal aid services (by age group)	Department of Social Welfare (DSW), NOCC	Legal AID
			# children provided with Protection and Legal aid services (by age group)	Department of Social Welfare (DSW)	All partners in OVC (LRCS, CRS, World Vision)
			# of eligible children provided with health care referral	Department of Social Welfare (DSW)	All partners in OVC (Office of the First Lady, LSRC, CRS, World Vision)

[30] Basic Support denotes 3 or more services (Psycho- social services, Medical care, Financial help, Education, Food packages, clothing/household, shelter, legal services)

The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	% of vulnerability due to HIV and AIDS among households in Lesotho is reduced from x% in 2008 to 15% by 2011		# of eligible children provided with education and/or vocational training support (disaggregated by sex)	Department of Social Welfare (DSW)	All partners in OVC (Office of the First Lady, LSRC, CRS, World Vision)
			A national survey on the socio-economic impact of HIV and AIDS on OVCs conducted	NAC	LENEPWHA, UNAIDS, MOHSW
			# of HIV and AIDS impact mitigation programmes implemented and benefiting Orphans and vulnerable Children	Department of Social Welfare (DSW)	All partners in OVC (Office of the First Lady, LSRC, CRS, World Vision)
		<u>**Vulnerable Groups**</u> % of members of vulnerable groups experiencing negative socio-economic impacts of HIV and AIDS decreased from X% in 2008 to 50% by 2011	A national survey on the socio-economic impact of HIV and AIDS on vulnerable groups conducted and the report disseminated.	NAC	LENEPWHA, UNAIDS, MOHSW
			Proportion of vulnerable groups supported with activities aimed at improving livelihoods	Department of Social Welfare (DSW)	All partners in OVC (Office of the First Lady, LRCS, CRS, World Vision, TRA)
			# of vulnerable groups reached with comprehensive sustainable livelihood support by 2011	Department of Social Welfare (DSW)	All partners in OVC (LRCS, CRS, World Vision)
			Number of vulnerable groups identified and registered in accordance with the selection criteria	MOLGC	DSW
			Policies & Legislation for care & support for vulnerable groups developed and adopted	Department of Social Welfare (DSW), NOCC	UNICEF, Parliamentary Portfolio Committees on HIV and AIDS (both Houses of Parliament).
			Psycho-socially empowered vulnerable groups	Department of Social Welfare (DSW)	All partners in OVC (Office of the First Lady, LRCS, CRS, World Vision, TRA)

			(disaggregated by type of vulnerability)		
			Reduced stigma and discrimination against PLWHA and those with disabilities	Department of Social Welfare (DSW) & LENEPWHA & LANFOD	All partners in OVC (Office of the First Lady, LRCS, CRS, World Vision, TRA)
			# of HIV and AIDS impact mitigation programs implemented and benefiting Vulnerable populations	LENEPWHA	NAC, NGOS, DSW
National Level	**Impact level**	**Outcome Level Result**	**Output Level Results**	**Lead Agency for Output result**	**Collaborating Agency for Output Result**
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	An effective, well managed national HIV/AIDS response which prevents infection , mitigates the impact of the epidemic, and enhances the care of Basotho through a multi sectoral approach	<u>Advocacy, Public Policy and Legislation</u> A policy, cultural and legal enabling environment created and enabling the effective implementation of HIV and AIDS interventions country wide by 2011	Number of policies and laws developed and adopted that empower women and protect children and or address social economic inequalities that affect them	GOL Ministries	NAC
			All Policies and Legislation are aligned to evidence based HIV criteria	NAC, GOL Ministries, Civil Society, Development & International Organisations	GOL Ministries, Civil Society, Development & International Organisations
			Increased commitment by Government, Implementing and development partners in implementing policy frameworks by 2011	GOL Ministries, Civil Society, Development & International Organisations	NAC
			The capacity of legislators to utilise evidence based HIV information for policy formulation and strategic plan is strengthened	Portfolio Committees on HIV and AIDS (both houses of Parliament)	NAC, MOHSW, Civil Society
			Increased commitment of leadership and participation by community, religious and political leaders in HIV and AIDS	NAC	GOL Ministries, Civil Society, Development & International Organisations and Parliarment

			The Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) is domesticated by statutory legislation in Lesotho	Ministry of Gender, Sport and Recreation	NAC, Parliament
			Attitudes of gender equality improved among men and women (Disaggregated by Gender)	NAC	GOL Ministries, Civil Society, Development & International Organisations
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	An effective, well managed national HIV/AIDS response which prevents infection , mitigates the impact of the epidemic, and enhances the care of Basotho through a multi sectoral approach	**Coordination and Management** The capacity for coordination and management of the decentralized national response is strengthened by 2011	Strengthened capacity of NAC, umbrella bodies and decentralised coordinating structures for improved service delivery	NAC	NAC, MOHSW, Civil Society and Private Sector coordinating bodies, Community Councils
		An effective joint multi-sectoral stakeholders response to HIV and AIDS based on the NSP	Increased alignment and implementation of plans for Public, private, civil society and development partners in line with the NSP	NAC	GOL Ministries, UNAIDS, Civil society, Private sector and Development Partners
			Decentralized coordination and management structures strengthened in all 10 districts by 2011		
		Sufficient resources mobilized and efficiently managed for the implementation of the NSP activities by 2011	Fully developed and adequately institutionalised resource tracking mechanisms	GOL Ministries, Civil Society, Development & International Organisations	NAC
		Community Strengthening: Community based interventions effectively monitored, implemented and well coordinated	At least 50% of HIV interventions targeting community council level or lower that are aligned to NSP are implemented by 2011	MOLGC	NAC, MOHSW, Civil Society, UNAIDS & GTZ
			DACs and CCAC's constituted and operating according to their	MOLGC	NAC and Civil Society,

			TOR's		
The Lesotho Human Development index is improved from 0.55 in 2005 to 0.60 in 2011	An effective, well managed national HIV/AIDS response which prevents infection , mitigates the impact of the epidemic, and enhances the care of Basotho through a multi sectoral approach		Number of community leaders able to impart accurate HIV information is increased by 50% by 2011	NAC	MOLG, Civil Society, DACs, CACCs, Line Ministries, UNAIDS, ESI M&E TWG
			At least 50% of data collected through the community based monitoring system meets the quality data standards and criteria		
		<u>Evidence Based Decision Making</u> The capacity for the national M&E system is strengthened at all levels to generate evidence to inform policy, planning and programming for HIV and AIDS in Lesotho by 2011	National M&E system strengthened and operationalised at all levels	NAC and MOHSW	Development partners, IDM, M&E TWG,
			Accredited M&E training Institutionalised	NAC	MOHSW, IDM, Civil Society, Development Partners, International Organizations & GOL Ministries
			Improved advocacy and harmonization of all M&E systems in the country by 2011		
		The national capacity for HIV research is strengthened at all levels to generate empirical data to inform policy, planning and programming for HIV and AIDS in Lesotho by 2011	National capacity for HIV research developed and strengthened by 2011	NAC & MOHSW	Research institutions, individual researchers
			Strengthened and updated HIV and AIDS database		

Note: the performance of the NSP in management and coordination will be measured using the National composite Policy Index (NCPI). Comparisons will be made over the period between 2006 and 2011 using the assessment especially Lesotho UNGASS reports.