GOVERNMENT OF LESOTHO

NATIONAL HIV PREVENTION STRATEGY

FOR A

MULTI-SECTORAL RESPONSE

TO THE

HIV EPIDEMIC IN LESOTHO (2011/12-2015/16)

NATIONAL AIDS COMMISSION

Powered to conquer HIV and AIDS

Preface

Since the inception of the *National HIV and AIDS Strategic Plan, 2006 – 2011,* Lesotho's national HIV prevention response has resulted in significant progress towards the goal of reducing the number of new HIV infections. Continuing this progress, Lesotho has developed this *National Multi-Sectoral HIV Prevention Strategy, 2011 – 2015*. Key elements from this strategy will inform the forthcoming generation of the *National HIV and AIDS Strategic Plan*.

The *National Multi-Sectoral HIV Prevention Strategy, 2011 -2015* sets out the overarching goals for the response to HIV prevention and reaffirms Lesotho's commitment to a comprehensive response. A wide range of analyses and consultations carried out at the national, district, and community levels throughout Lesotho have helped to ensure that the strategy is based on the most up to date understanding of the epidemic, that the activities are based on evidence of what works in Lesotho and elsewhere, and that the strengths and weaknesses of the systems and mechanisms for responding to HIV prevention are addressed.

The development of this *National Multi-Sectoral HIV Prevention Strategy*, which was carried out between July and December 2010, has been based on broad participation of all of the stakeholders involved in HIV prevention in Lesotho: communities, civil society organisations (CSOs), non-governmental organisations (NGOs), government, and development partners. In addition, the strategy incorporates recommendations and direction from a number of existing national and sectoral policies, guidelines, evaluations, and research. As a result, we are confident that the strategies identified in the plan are those that reflect the key drivers and factors of Lesotho's HIV epidemic.

The *National Multi-Sectoral HIV Prevention Strategy, 2011 - 2015* presents all stakeholders in Lesotho's HIV prevention response with major challenges. Basotho should commit to scaling-up the implementation of HIV prevention with the aim of becoming more effective, efficient, and coherent in our common efforts to reduce the number of new infections. This document provides clear direction coupled with evidence-based strategies for achieving the ambitious results to prevent the further spread of the epidemic.

It is now our responsibility to rise to the challenge and combine the necessary individual and collective resources in our drive towards reducing the number of new HIV infections. Let us get to work, or rather continue our work, with renewed energy and determination in the fight against HIV and AIDS.

The Right Honourable The Prime Minister

Dr. Pakalitha Mosisili

Acknowledgements

The Government of Lesotho (GOL) through the National AIDS Commission (NAC) wishes to acknowledge with gratitude the valuable contribution of a large number of stakeholders who made it possible to develop the *National Multi-Sectoral HIV Prevention Strategy* in a collaborative manner.

We wish to thank the public sector and in particular the Ministry of Health and Social Welfare (MOHSW), the Ministry of Local Government and Chieftainship (MOLGC), and the Ministry of Gender, Youth, Sport and Recreation (MGYSR), the Ministry of Education and Training (MOET), the Ministry of Labour and Employment (MOLE), the Ministry of Public Service (MOPS) and other ministries.

We would also like to thank the organisations that have a particular perspective on HIV prevention from the community level, which include non-governmental organisations (NGOs), civil society organisations (CSOs), faith based organisations (FBOs), people living with HIV (PLHIV), traditional leaders, District AIDS Committees (DACs), and Community Council AIDS Committees (CCACs) and the communities. They participated in consultations and review meetings, and provided valuable written and verbal feedback on the HIV prevention response in Lesotho, challenges and achievements, recommendations and objectives, and key strategies and activities. As such, not only was the quality of the final product greatly enhanced, but also the process was inclusive, and the final strategy represents the key priorities of multiple stakeholders.

We are also grateful for the financial and technical support from our development partners. Specifically, we wish to express special thanks and appreciation to the members of the Prevention Thematic Team, the Core Team, and the High-Level Forum for their invaluable contributions in providing policy and strategic guidance.

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We thank the consultants Mr. Thomas Scalway, Ms. Chrissy Carmody, and Ms. Mary Wieczynski Furnivall, who assisted in developing the strategy. This document would not have been possible without the support from NAC staff, both at the district and central levels.

Dr. 'Molotsi Monyamane

Acting NAC Board Chairperson

Executive Summary

Lesotho is currently experiencing one of the most serious HIV epidemics in the world, although there is evidence that the epidemic has somewhat stabilised in the past few years. The HIV prevalence rate in 2009 among Basotho aged 15-49 was 23% and in 2007, annual adult HIV incidence was 1.7% or approximately 21,000 new cases that year. Projections on ART needs in 2009 were such that 117, 903 people would need treatment. In the same year the survival rate of both adults and children with HIV known to be on treatment 12 months after initiation was 80% which was an increase from 74.4% in 2007. AIDS mortality on the other hand stood at 11,000 in 2009.

The *National Multi-Sectoral HIV Prevention Strategy, 2011 – 2015*, describes how the national HIV prevention response will reduce levels of HIV incidence by directly addressing the drivers of Lesotho's epidemic. The 2009 Lesotho Demographic and Health Survey (LDHS) data indicate a rapid rise in HIV prevalence among young people, particularly young women. The total number of HIV-infected females aged 15-49 is 27%, but significantly lower at 18% for men the same age. By age 20-24, approximately 24% of women are infected; prevalence increases to 35% for the age cohort 25-29 and peaks at 42% for women throughout their thirties. Male prevalence lags behind female prevalence by about five years, but similarly reaches about 40% among men aged 30-45. With such high average levels of prevalence nationally, the pool of at-risk individuals is likely at or near saturation among adult men and women aged 25-44.

For the most part, HIV prevalence levels have remained the same since the first population-based HIV testing was conducted five years ago as a component within the 2004 LDHS. Although this might be in part attributed to the growing number of HIV-infected Basotho who receive care and support services, including antiretroviral therapy (ART), HIV prevalence levels are essentially unchanged between the two surveys among young adults aged 15-24. In the absence of HIV incidence testing, examining HIV prevalence within this age group is an internationally accepted proxy for monitoring new HIV infections. As such, the complexity of the epidemic and the underlying factors require a reinvigorated multi-level approach to curtail the number of new infections.

This five-year *National Multi-Sectoral HIV Prevention Strategy* sets forth ambitious results aimed at reducing HIV incidence by 50% by 2015. It is closely aligned to Lesotho's revised *National HIV and AIDS Strategic Plan, 2006 – 2011*, the *Health Sector Policy on Comprehensive HIV Prevention*, and the *Essential HIV and AIDS Service Package (ESP)*. The strategy is supported by a strategic framework and a five-year monitoring and evaluation (M&E) plan that draws upon the most current data within the country. These tools will serve to guide and coordinate the efforts of those working at national, district and community levels. The accompanying three-year costed Operational Plan will assist stakeholders with resource allocation and programme implementation.

A number of overarching principles underpin the strategy: addressing the key epidemic drivers; creating an integrated, comprehensive response; strengthening a decentralised response; improving the use of strategic information; employing a human rights-based approach; and intensifying social and behaviour change communications (SBCC). Following current best practices, the *National Multi-Sectoral HIV Prevention Strategy,* adopts a combination prevention approach that systematically identifies and targets the behavioural, biomedical and structural drivers of the epidemic. The approach is arranged within a results-based framework that will assist with the monitoring of progress and results.

The strategy's four objectives are:

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

Within these four objectives, the *National Multi-Sectoral HIV Prevention Strategy* calls for a reinvigorated response to HIV prevention. First and foremost is the need to focus on the main drivers of Lesotho's epidemic: multiple and concurrent sexual partnerships. The strategy underscores the need to address the complexities of the motivations, behaviours, and social norms that shape these deeply rooted practices. Other priorities and key objectives build upon the significant achievements made to date in policy, research, and programme implementation. This includes building upon and expanding results in HIV testing and counselling (HTC), SBCC to address behavioural, biomedical, and structural epidemic drivers, the prevention of mother-to-child transmission (PMTCT), the prevention and management of sexually transmitted infections (STIs), condom promotion and distribution, infection control and waste management, and blood safety.

The strategy emphasises the scaling up of emerging HIV prevention initiatives within the country. These include, among others, Positive Prevention services for HIV-infected individuals, the roll out of male circumcision (MC) with a focus on engaging traditional circumcisers, and the implementation of the neonatal and the existing voluntary adult male circumcision and SBCC for HIV prevention among vulnerable groups, especially migrant populations, and the youth. The strategy reinforces the need for all HIV prevention programmes to address underlying factors that create risk and vulnerability to HIV infection. These include risky traditional, cultural, and gender norms and practices, lack of male involvement in reproductive health care, and stigma and discrimination toward those infected with HIV.

The strategy also highlights the need for innovation to address dynamics and factors that contribute to HIV incidence or affect specific populations. These include the piloting, evaluating, and rolling out of programmes related to HIV prevention and sexual and gender-based violence (SGBV), alcohol and drug abuse, and infection control within communities. Underserved at-risk populations[1] include sex workers (SWs), men who have sex with men (MSM), and orphans and vulnerable children (OVC).

The *National Multi-Sectoral HIV Prevention Strategy* recognises that the national HIV prevention response requires robust underlying systems to sustain achievements and investments. As such, the strategy calls attention to results in policy and legislation, coordination and management, strategic information, infrastructure, and human resources. Within these are opportunities to engage an expanded broad-base of Basotho stakeholders in HIV prevention.

[1] **At-Risk Populations:** these are populations most often considered to be at an elevated risk for HIV infection. These populations engage in illicit or socially stigmatized behaviours and are at disproportionately higher risk for HIV. HIV may spread rapidly in these populations due to more frequent participation in high risk behaviours such as unprotected anal and vaginal sex, sharing of injection equipment, and the overlap of risk behaviours and sexual networks (such as sex workers who use drugs or men who have sex with men (MSM) who sell sex). These at-risk populations include sex workers, clients of sex workers, substance abuse-using populations, herd boys, prisoners, people with disabilities, single, separated, or divorced adults, OVC, men and women who work away from home, MSMs who have sex with men and their male and female partners.

These include traditional, cultural, and religious leaders, the private sector, and people living with HIV (PLHIV).

The *National Multi-Sectoral HIV Prevention Strategy* must be seen as more than another planning document; it is a chance to revive HIV prevention efforts throughout the country. The strategies contained herein represent evidence-based, innovative approaches for stemming cases of new HIV infections. As such, it is a tool that will evolve and strengthen the engagement and participation of all stakeholders working in HIV prevention efforts throughout Lesotho.

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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ALE	Association of Lesotho Employers
ANC	Antenatal Clinics
ART	Antiretroviral Therapy
ARV	Antiretroviral Drug
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CBO	Community-Based Organisation
CCAC	Community Council AIDS Committee
CCSP	Community Council Support Persons
CCP	Comprehensive Condom Programme
CSSC	Community Social Service Committee
CHAL	Christian Health Association of Lesotho
CHW	Community Health Worker
CRIS	Country Response Information System
CSO	Civil Society Organisation
CSW	Commercial Sex Worker
DAC	District AIDS Committee
DC	District Council
DHMT	District Health Management Team
ESP	Essential HIV and AIDS Services Package
FBO	Faith-Based Organisation
GBV	Gender-Based Violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOL	Government of Lesotho
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HR	Human Resources
HRIS	Human Resource Information System
HTC	HIV Testing and Counselling
IDU	Injecting Drug Use
IPV	Intimate Partner Violence

KYE	Know Your Epidemic
KYR	Know Your Response
KYS	Know Your Status
LAPCA	Lesotho AIDS Programme Coordination Authority
LBTS	Lesotho Blood Transfusion Services
LDHS	Lesotho Demographic and Health Survey
LENASO	Lesotho National AIDS Service Organisation
LENEPHWA	Lesotho Network of People Living with HIV and AIDS
LGA	Local Government Authority
LOMESHA	Lesotho Output Monitoring System for HIV/AIDS
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MOHSW	Ministry of Health and Social Welfare
MOLGC	Ministry of Local Governance and Chieftainship
MOPS	Ministry of Public Service
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NAS	National AIDS Secretariat
NCPI	National Composite Policy Index
NSP	National HIV and AIDS Strategic Plan
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PEP	Post-Exposure Prophylaxis
PEPFAR	The President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PWD	People with Disabilities
RH/FP	Reproductive Health and Family Planning
SADC	Southern Africa Development Committee
SBCC	Social Behavioural Change Communication
SGBV	Sexual and Gender-Based Violence
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	United Nations Programme on HIV and AIDS

UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
WHO	World Health Organisation

1 Introduction

1.1 National Multi-Sectoral HIV Prevention Strategy, 2011 - 2015

The *National Multi-Sectoral HIV Prevention Strategy, 2011 – 2015,* is a reference for the planning, implementation, evaluation, and resource mobilisation of the national HIV prevention response in Lesotho. The strategy offers guidance in scaling-up existing and effective HIV prevention programming interventions while developing new areas of the response. Outlining HIV prevention efforts between 2011 and 2015, the strategy details the behavioural, biomedical and structural interventions needed for a comprehensive yet targeted results-based combination prevention approach.

This strategy builds on a number of existing HIV and AIDS commitments. In 2001, Lesotho signed the United Nations Declaration of Commitment on HIV, which included a broad HIV prevention agenda. Lesotho has participated in regional initiatives and signed the Congo Brazzaville Declaration of Commitment to intensify HIV prevention efforts. Lesotho also participated in Southern African Development Community (SADC) HIV prevention initiatives, including the 2003 Maseru Declaration on HIV and AIDS.

Evidence-based and data-driven programming forms the basis of an intensified national results-based approach to HIV prevention. Each of the drivers of the HIV and AIDS epidemic identified within this strategy were drawn from current surveillance data, the 2009 *Lesotho Demographic and Health Survey* (LDHS), the 2009 *Lesotho HIV Prevention Response* and *Modes of Transmission Analysis* (Modes of Transmission Study), and a number of research studies conducted in Lesotho.

This strategy will guide the public, private, civil society, and NGO responses and development partners to HIV prevention, and complements the revised *National HIV and AIDS Strategic Plan, 2006 – 2011*, the *Health Sector Policy on Comprehensive HIV Prevention*, and the *Essential HIV and AIDS Services Package.* It should be read alongside the *Situational Analysis for the National Multi-Sectoral HIV Prevention Strategy, 2011 – 2015*, which was developed to guide this strategy. Key findings from this Situational Analysis are included in the introductory sections of this strategy.

1.2 Rationale

Lesotho is one of the countries worst affected by HIV and AIDS worldwide, with 23% of adults now living with HIV. HIV prevalence peaks to almost 42 % among some sub-populations in the country. While commitments relating to treatment, care, support, and impact mitigation remain vitally important to the national HIV and AIDS response, an intensified HIV prevention response is recognised as a top priority by the Government of Lesotho (GOL) and internal and external partners. This prevention strategy proposes an aggressive goal of a reduction in the level of new HIV infections by 50% by 2015.

In order to achieve this goal, the main drivers of Lesotho's severe, generalised epidemic must be addressed, including the heterosexual transmission of HIV within serial, multiple, and concurrent partnerships, and vulnerability to HIV infection and low and inconsistent condom use during higher-risk sexual acts. A number of factors have an effect on these drivers and must also be considered in a comprehensive response. These include population mobility attributed mainly to domestic and cross-border migration, low-levels of in-depth HIV knowledge, the

presence of sexually transmitted infections, alcohol and drug abuse, social and gender norms, and gender-based violence and inequality.

1.3 Development Process

Under the guidance and supervision of the National AIDS Commission (NAC), and in consultation with the Prevention Strategy Core Team, the Prevention Thematic Team, and the High-Level Forum, this document was developed through an extensive process of consultation and review at the community, district and national levels. The phases of the process were as follows:

An inception report was developed at the beginning of the process which outlined the planned activities and included the tools, guidelines and requirements necessary for the development of the strategy.

A situation analysis was drafted which gave an overview of the epidemic and the current national HIV prevention response.

Fifteen district and community level consultations were undertaken across the country utilising the District Councils (DCs), District AIDS Committees (DACs), Community Councils (CCs), and Community Council AIDS Committees (CCACs). A number of other stakeholders participated, including representatives from public, private, civil society, and NGO networks such as health care workers, faith leaders, business leaders, traditional leaders, and programme managers and other communities that work in HIV prevention.

Consultations were also conducted at the national level in Maseru in order to solicit the feedback and guidance on the strategy from Government ministries, the private sector, academia, civil society, and HIV and AIDS Thematic Working Groups.

Upon completion of the consultations, several versions of the strategy were circulated for review, each incorporating a further level of input from local and external stakeholders, which resulted in the validation of the final version of the strategy.

1.4 A Combination Prevention Approach

Combination prevention is a human rights-based approach (UNAIDS Prevention Reference Group, 2009). Its aim is to have the greatest sustained effect on reducing the number of new HIV infections through the selection of appropriate interventions for the epidemiological and social context. This strategy utilises a combination prevention approach, which is predicated upon Knowing Your Epidemic (KYE), and Knowing Your Response (KYR). The combination approach acknowledges that HIV incidence is affected by various economic, biomedical, legal, political, cultural and psychosocial factors that must be analysed and addressed at systems and programme levels.

A combination prevention approach stresses the importance of an integrated, comprehensive HIV response, with behavioural strategies to address risky behaviours, biomedical interventions to prevent infection or reduce infectiousness, and structural strategies to change the context that contributes to vulnerability and risk of HIV at a number of levels.

Behavioural elements of this strategy include efforts to change the practices of individuals in relation to sexual risk and demand for HIV prevention services and products. Methods address the reduction of the sexual transmission of HIV through communications delivered through a range of channels, with targeted messages designed to move individuals towards desired

behaviours. Other behavioural elements include HIV testing and counselling (HTC) and the mitigation of substance abuse.

Biomedical elements within this strategy include a four-pronged strategy to prevent PMTCT, the promotion of male circumcision, condoms, sexually transmitted infection (STI) management, reproductive health and family planning (RH/FP), and Positive Prevention interventions. Other key biomedical interventions include preventing HIV transmission within medical settings through blood and injection safety, and the proper disposal of hazardous materials, such as used syringes and blood products.

The range of structural interventions includes addressing harmful social norms relating to gender, sexual and gender-based violence (SGBV), stigma and discrimination, and sexuality. Approaches to addressing these societal level factors are integrated throughout the objectives through key outputs and strategies. A number of policies, legislative and infrastructural components are also outlined for structural level impact.

Achieving results within a combination approach requires robust coordination, management, and information systems, as well as the resources and capacity to execute interventions. This strategy reinforces the need to strengthen the supportive systems necessary for an effective response among stakeholders from the government, CSO, NGO, donor and private sectors.

Figure 1: A Combination Approach for HIV Prevention

A Combination Prevention Approach		
Behavioural	**Biomedical**	**Structural**
Reduction of sexual transmission HIV testing and counselling Reduction of substance abuse	Male circumcision PMTCT STIs Condoms Positive Prevention RH/FP integration Prevention of medical transmission	Gender norms Traditional and cultural practices Sexual and gender-based violence Socio-economic factors Stigma and discrimination
Across all areas: Social and behavioural change communications Service delivery Policy, legislation, and advocacy Measurable referrals Coordinated management of programmes and stakeholders Capacity building Resource mobilisation		

1.5 Results-Based Management Approach

With the development of the *National Strategic Plan for HIV and AIDS*, the GOL moved towards a results-based management approach for the national response. While NAC, the Ministry of Health and Social Welfare (MOHSW), and the many organisations that implement the national HIV prevention response have been working to produce measurable results, the emphasis has often been on managing inputs and activities. As a result, most HIV prevention organisations have not been able to show progress towards achieving key outcomes in terms of changes in reduction of HIV risk or vulnerability among key populations. While it is still vital to demonstrate progress in relation to processes, activities, and outputs, a shift to a results-based management approach places greater emphasis on measuring the effects of outputs and activities in terms of outcomes and overall impact.

The results-based management system outlined in this strategy sets out clear programme and management objectives for all organisations involved in the national response, and establishes indicators to monitor and assess progress in meeting them. Interlinking chains of results are defined, which stretch from the level of programme activities through to output level results and outcome level results, and ultimately to impact level results.

While the move towards results-based language signalled an important step forward for the Lesotho national response, the challenges of measuring results, let alone managing for results, should not be understated. Significant shifts are required within the institutional cultures and work practices within NAC, line-ministries and an array of public, private and civil society bodies. It is likely that these changes will take some time, but the fact that this HIV prevention strategy is articulated in results-based language marks yet another important step in this direction.

2 The HIV and AIDS Epidemic in Lesotho

The following section highlights the key patterns and dynamics that drive Lesotho's epidemic. A more comprehensive analysis of the HIV situation in Lesotho can be found in the *Situation Analysis for the Lesotho HIV Prevention Strategy, 2011 – 2015*, the document that supports the *National Multi-Sectoral HIV Prevention Strategy.*

2.1 The HIV Situation in Lesotho

Lesotho is currently experiencing one of the most serious HIV epidemics in the world, although there is evidence that the epidemic has somewhat stabilised in the past few years. The HIV prevalence rate in 2009 among Basotho aged 15-49 was 23 % and in 2007, annual adult HIV incidence was 1.7% or approximately 21,000 new cases that year.

The 2009 Lesotho Demographic and Health Survey (LDHS) data indicate a rapid rise in HIV prevalence among young people, particularly young women. The total number of HIV-infected females aged 15-49 is 27%, but significantly lower at 18% for men the same age. By age 20-24, approximately 24% of women are infected; prevalence increases to 35% for the age cohort 25-29 and peaks at 41% and 42% for women throughout their thirties. Male prevalence lags behind female prevalence by about five years, but similarly reaches about 40% among men aged 30-35. With such high average levels of prevalence nationally, the pool of at-risk individuals is likely at or near saturation among adult men and women aged 25-44.

HIV prevalence patterns differ by urban-rural residence and throughout the country's districts. Basotho men and women who reside in urban areas have higher rates of HIV infection than their rural counterparts. This is particularly so for urban women, with an infection rate of 31% as compared to 25% for females who reside in rural areas. The epidemic is almost uniformly severe in each of the ten districts in the country. Butha-Buthe and Thaba-Tseka have the lowest rates at 21% each, and Maseru peaks at 31%.

Marital status seems to be correlated closely to HIV status. Rates are high among widows (60%) and widowers (62%), and among both men and women who are divorced or separated (59% for women and 31% for men). HIV infection rates are also high among Basotho who are currently married or in union, at 26% for women and 31% for men.

Mobility among men is correlated to HIV prevalence. Men who have spent more time away from home during the past twelve months have higher infection rates, as do men who have been away from home for more than one month (2009 LDHS).

Children continue to be vulnerable to HIV. The 2009 Modes of Transmission Study estimates that annual incidence in children has dropped to 0.17%, in part attributed to the uptake of PMTCT services to 31% of pregnant women by 2007, and the overall decrease in incidence in adults. Some children might be infected from early sexual debut. According to the 2009 LDHS, 8% 9% of young women and 22% of young men have had sex before the age of 15, with these percentages rising to 47% of young women and 63% of young men who have had sex before the age of 18. Only 24% of children under the age of 18 live with both of their parents. 33% live with their mothers only, 5% with their fathers only, and 36% live with neither, and are considered to be "fostered". 20% of Basotho children under the age of 18 have lost one parent, and 7% have lost both. The 2009 Lesotho National Estimates state that there are 21,000 HIV-infected children under the age of 15 in Lesotho, and 122,000 children orphaned due to HIV and AIDS.

As per the results of mathematic modelling within the Modes of Transmission Study, heterosexual contact is the primary driver of the epidemic in Lesotho. Single partnering contributed between 35-62% of new infections in 2008, with multiple partner behaviours between 32-59%. Three to four per cent of new infections might be attributed to MSM, and HIV transmission linked to unsafe medical practice is less than 1% of total annual incidence. HIV transmission through blood transfusion is 0% because all blood is screened for HIV, although this does not capture potential false negatives.

2.2 Factors and Key Drivers Underlying New Infections

There are multiple layers of drivers of the epidemic, from the proximal drivers such as multiple and concurrent partnerships through to the more distal drivers such as patterns of migrant labour, and the broader macro-economic situation that may affect vulnerabilities for many Basotho. The following describes some of the factors and dynamics that facilitate the transmission of HIV in Lesotho.

Multiple and concurrent relationships

Sexual concurrency, often in the form of long-term secondary partners, is exceptionally high in Lesotho. The prevalence of multiple and concurrent partnerships is estimated at 24%, compared to 10% in the region, and in some studies up to 36% of individuals report having multiple and concurrent partnerships. The 2009 LDHS indicates that multiple and concurrent partnerships are prevalent throughout Lesotho. 26% of women and 45% of men reported having

two or more partners during the past twelve months with (3%) of men reporting having paid for sex during the previous year. Although frequency of multiple and concurrent partnerships appears to be declining, multiple data sources confirm that such partnerships remain at a high level, and are legitimised through deep-rooted traditions that encourage many sexual partners or polygamy. There are a number of different types of multiple and concurrent relationships, and each are different in terms of motivations, practices, and duration.

Low and inconsistent condom use

Many Basotho men and women engaging in sex in the context of a high background level of HIV risk do not protect themselves by using condoms. Of females and males aged 15-49 who had two or more sexual partners during the past twelve months, 38% of women and 51% of men reported using a condom. Among never-married women and men aged 15-24 who had sex in the past twelve months, 65% used a condom at last sexual intercourse, Among youth aged 15-24 who reported having two or more partners during the previous 12 months, 45% of women and 60% of men reported condom use during the last sexual act. (2009 LDHS). Although there is widespread condom distribution, many communities perceive condoms as not readily available and accessible. Urban and rural condom coverage is estimated at 69% and 33%, respectively (2009 PSI condom distribution survey).

Personal knowledge of HIV serostatus

The percentage of Basotho who have taken an HIV test and have received their results has greatly increased since the country has expanded the availability of HIV testing and counselling services, supported by intensive education and demand creation communications. Ninety three percent of Basotho women aged 15-49 know where to get an HIV test and 66% have been tested and received their results. Of these, 42% were tested during the previous 12 months. The same figures are significantly lower for men. For men the same age, 81% know where to get an HIV test and 39% have been tested and received their results, of whom 25% did so during the past 12 months. Although only 43% of women aged 15-19 report having been tested and received results, this figure rises to 75% by the age of 20-25. Only 26% of men aged 15-25 have been tested and received their results.

Male circumcision

According to the 2009 LDHS, 52% of men aged 15-49 report being circumcised. Men aged 15-19 have the lowest rates at 27%. Although this might be attributed to a decrease in the practice of circumcision, it is possible that youth are circumcised at a later age (62% of men age 20-24 are circumcised). Circumcision rates are considerably lower among urban men than rural men (34% and 59%, respectively), and the prevalence of circumcision decreases significantly among men within the highest wealth quintiles (74% of men in the lowest quintile compared to 29% in the highest). Although in clinical trials circumcision has shown to have a protective effect against HIV infection in men, the 2009 LDHS data indicate that Basotho men who are circumcised have higher HIV prevalence rates than uncircumcised men: 21% of circumcised men are HIV-infected, compared to 16% of uncircumcised men. This can partially be attributed to the Lesotho custom of conducting male circumcision at a later stage in life when individuals have already been exposed to the risk of HIV infection. In addition the traditional practice of male circumcision that partially removes the foreskin, and thus traditional male circumcision does not seem to have the same protective and hygienic effect as clinical circumcision. Only the 30% of

men circumcised at health facilities can be considered to have the beneficial protection conferred by male circumcision (2009 LDHS).

Sexually transmitted infections

According to the 2009 LDHS, among Basotho age 15-49 who have ever had sexual intercourse, 15% of women and 13% of men reported having an STI, an abnormal discharge, or a genital sore or ulcer. STIs are associated with HIV prevalence in Lesotho. For women, 43% who reported having an STI or symptoms were HIV infected, compared to those who reported no STI, at 29%. For men, these figures are 33% and 18%, respectively. The 2009 HIV sentinel surveillance among STI clients for two sites indicated an even higher HIV prevalence among STI clients than the 2009 LDHS, at 55% overall. HIV prevalence was lowest among 10 -20 year olds, at 40%, and peaked to 65% for 31-40 year olds, then dropped to 60% for adults between the ages of 41-50.

Late initiation of ART for HIV-Infected Basotho

The timely initiation of antiretroviral therapy (ART) is critical in HIV prevention because a dramatically lowered viral load suppresses the onward transmission of HIV to other people when adherence levels are high. Lesotho's ART guidelines, which were aligned to international guidelines in 2007, adjusted eligibility from a CD4 count of 200 to 350. As such, people could begin treatment before they became ill and more infectious. However, as per the 2009 *Mid-Term Review of the National HIV and AIDS Strategic Plan*, although the GOL dramatically scaled up its ART treatment services, by 2008 only 25% of eligible adults and 26% of eligible children were receiving ART, and adherence and delivery continue to pose grave challenges.

Behavioural disinhibition related to substance abuse

Studies have documented the link between alcohol and drug abuse and increased risk of HIV infection. In addition, alcohol abuse among HIV-infected individuals is associated with poor ART adherence, with implications for the onward transmission of HIV. In Lesotho, while there is little data on alcohol abuse, practices, and their relationship to HIV risk, the 2009 LDHS showed that the HIV prevalence rate among men who reported ever drinking alcohol is 23%, compared to 16% of those who never drank alcohol. There is little data on drug abuse and HIV risk in Lesotho, although some data indicate that the use of cannabis (*matekoane*) is widespread.

Labour migration

A major factor contributing to HIV risk and multiple and concurrent partnering is domestic and international labour migration, which plays a substantive social and economic role in the lives of most Basotho: more than 255,000 individuals have emigrated, mostly for work and mainly to South Africa. Other manifestations of labour migration include the apparel, transportation, and construction industries, as well as uniformed personnel and the informal cross border trade. Furthermore, as a result of having a partner "left behind", migration increases risk to both partners, because women as well as men become infected with HIV through sexual relationships outside of their primary ones. In Lesotho, the partner at home is most often female: the 2009 LDHS indicates that 36% of households in Lesotho are female-headed, partly attributed to labour migration.

Gender and sexual and gender-based violence

Gender dynamics can exacerbate HIV risk, for example, certain manifestations of male and female norms, behaviours and practices create vulnerability to HIV infection. The 2009 LDHS provides information on female empowerment and decision making within the home. Sexual and gender-based violence also increases the risk of HIV infection. In regards to domestic violence and justification for wife beating, 37% of women age 15-49 agreed with at least one reason that justifies hitting a wife (the reasons include burning food, arguing with the husband, going out without telling him, neglecting the children, and refusing to have sexual intercourse). The corresponding response from men age 15-49 was 48%. Among men aged 15-49, 26% thought that men are justified in withholding financial support from his wife if she refused to have sex with him, and 16% thought forced sex was justifiable (2009 LDHS). A study looking at sexual violence against women in Lesotho indicated that 61% of women reported having experienced sexual violence at some point in their life, with 40% reporting coerced sex, 50% assault, and 22% rape.

Traditional and cultural practices

Within the context of HIV and AIDS, some traditional and cultural practices can be harmful and increase risk and vulnerability to HIV infection. In Lesotho, examples include the practice of *chobeliso*, or eloping that involves abduction, rape, and marriage; and the practice of *ho kenela*, or wife inheritance, which may place families at-risk if the practice is non-consensual or family members are infected with HIV. Other practices that might create risk and vulnerability to HIV infection include domestic violence and dry sex. Beliefs in proverbs such as, "*monna ke mokopu oa nama, mosali ke cabbage oa ipopa*" (man is like a pumpkin and spreads, woman is like a cabbage and stays put), can serve to reinforce the acceptability of multiple and concurrent partnerships. Other traditional and cultural practices need to be assessed for their positive contribution, for example in relation to collective decision making, some specific roles of traditional healers, and practices that promote social cohesion and social capital.

Hard-to-reach populations

Only 24% of Lesotho's population lives in urban areas. The 76% of people who live in rural areas have less access to services and in some cases experience poorer health outcomes than their urban counterparts. The challenges for health service delivery are in part due to the difficulty of accessing hard-to-reach people who live in scattered pockets across a rugged and sometimes difficult mountainous terrain.

Stigma and discrimination

Stigma and discrimination can be inculcated throughout a society within a number of levels, and can greatly reduce the effectiveness of HIV prevention initiatives. Stigma and discrimination influence how the environment is experienced and acted upon by individuals, especially with respect to caretaking within the family. At the community level, blame and punishment can be manifested toward those believed to have brought shame on their families and the community. At the political level, policies and legislation can be passed that either aim in theory to protect the rights of society (e.g. compulsory testing and notification), or can protect the rights of PLHIV (e.g. workplace anti-discrimination policies). The 2009 LDHS indicates that while many Basotho have accepting attitudes towards PLHIV, there are still considerable reservations towards

interacting with PLHIV on a daily basis. Forty two percent of women aged 15-49 expressed accepting attitudes to PLHIV on all four indicators – caring for a family member with HIV in the home, buying fresh vegetables from an HIV-infected shopkeeper, saying that an HIV-infected female teacher who is not sick should continue teaching, and would not keep secret the HIV status of a family member – while only 32% of men the same age did so.

3 The National HIV Prevention Response in Lesotho

Under the principles of KYE and KYR, the national HIV prevention response utilises a process that enables the country to match and prioritise responses to the drivers of the epidemic. A comprehensive analysis of the HIV situation in Lesotho can be found in the *Situational Analysis for the Lesotho HIV Prevention Strategy, 2011 – 2015*, the document that supports the *National Multi-Sectoral HIV Prevention Strategy*. The following presents the highlights of the national HIV prevention response in Lesotho.

Behavioural initiatives

There are numerous initiatives in Lesotho that address the reduction of the sexual transmission of HIV, particularly through social behavioural change communication (SBCC) programmes. These include mass media campaigns, life-skills curricula in schools, peer education, and community engagement activities implemented by a range of CSOs, NGOs, PLHIV support groups, faith-based networks, and the private sector. The number of Basotho who know their HIV status has grown dramatically through the implementation of the Know Your Status (KYS) campaign which aimed to provide HTC to every Mosotho over the age of 12 years. Between 2007 and 2008, HTC facilities increased from 163 to 204. Although alcohol and cannabis abuse are the most common forms of substance abuse in Lesotho, there are few organisations addressing these issues. The Blue Cross manages a rehabilitation centre in Thaba-Bosiu and a few local NGOs conduct substance abuse education in schools.

Biomedical initiatives

Biomedical interventions in Lesotho include the roll out of Prevention of Mother-to-Child (PMTCT) services in all ten of Lesotho's districts in public and faith-based facilities, including MOHSW and the Christian Health Association of Lesotho (CHAL) facilities. PMTCT coverage rates have increased from 58.2% in 2007 to 71% in 2009. Another biomedical initiative is male circumcision, and the MOHSW is investigating the possibility of implementing adult and neonatal male circumcision initiatives in Lesotho. To date, the Male Circumcision Task Force has drafted a policy, strategy, and implementation plan for safe, facility-based circumcision. The integration of RH/FP services into HIV prevention is increasing in Lesotho, with PMTCT/RH/FP initiatives underway. Condom promotion and distribution is a national initiative, with male and female condoms supplied through a mix of social marketing, free public sector, and private sector distribution and retailing systems. Lesotho is in the process of rolling out facility- and community-based Positive Prevention services, which are critical for reducing the risk of on-going HIV transmission. The Lesotho Blood Testing Services (LBTS) works on the prevention of HIV infection through medical transmission through its blood safety programme. Other prevention efforts with respect to medical transmission include the roll out of post-exposure prophylaxis (PEP) in facilities where there is the potential for exposure through occupational hazard and sexual assault.

Structural initiatives

Many organisations that implement HIV prevention initiatives mainstream gender, male involvement, SGBV, and stigma and discrimination into their programming. This results in the inclusion of topics on gender within community dialogues as implemented by CSOs, the targeting of male partners within PMTCT services, and loan schemes targeted to female caregivers. In regard to traditional and cultural norms, Lesotho is in the process of expanding dialogue with traditional and cultural leaders. PLHIV network organisations are addressing stigma and discrimination by building linkages among organisations that provide services to PLHIV. Particular areas of concern are discrimination in the workplace, in school/educational settings, and against certain population groups, including sexual minorities, sex workers, and inmates.

Cross-cutting systems strengthening issues

Policy and Legislation: A number of key policies have been passed to guide the national HIV prevention response. For example, in 2006, a revised *National HIV and AIDS Policy* was passed after a National Joint Review identified needs, challenges, and gaps in the 2000 HIV and AIDS policy and in the legislative framework. Lesotho's legislative policy framework (2000) sets the agenda for legislative review to enact specific policies to protect vulnerable groups, children and women and discrimination against PLHIVs. Since then, numerous policies and laws have been drafted, including the recent 2008 Lesotho HIV and AIDS Bill, the Legal Capacity of Married Person's Act, the Sexual Offences Act (2003), and the amended Labour Code No. 5 of 2006.

Coordination and Management: At the national level, Lesotho has adopted a multi-sectoral approach in the coordination and implementation of the national response. This includes the establishment of the National Partnership Forums, HIV and AIDS Thematic groups (e.g. the Prevention Thematic Team), and national self-coordinating entities with mandates to meet and share information, design strategic directions, determine modalities for resource allocation and delegate representations to the wider stakeholder forum. Commencing in 2007, District AIDS Committees were formed to facilitate the district-level coordination for the *Essential HIV and AIDS Services Package*, and to provide assistance to the District Councils. Similarly, some Community Councils also formed Community Council AIDS Committees, and smaller committees were also established at constituency level.

Strategic Information: NAC has responsibility for the overall coordination of the national HIV M&E system, and for ensuring that the country has one national M&E system. With the overarching goal of guiding programme planning using quality data and a solid evidence base, NAC developed a costed *National M&E Plan (2006-2011)*, established its M&E Unit, and has finalised the Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) which is currently being rolled out. In regard to research and HIV prevention, a National HIV and AIDS research agenda was finalised in 2007 and during the last three years, numerous studies and reports were completed.

Human Resources and Capacity: The gravity of the epidemic has severely strained the health care system in Lesotho, and the MOHSW has developed a Human Resources Strategic Plan, an HR Directorate, and an emergency hiring plan to address critical HR and capacity gaps in HIV and AIDS service delivery, including HIV prevention. In addition, CSOs, especially indigenous Basotho organisations, are strengthening their own capacity to implement high quality HIV prevention interventions and improve their organisational capacity.

Infrastructure Facility Development: Improvements to the health facilities and services in the public sector are ongoing. The planned rehabilitation of existing health facilities and clinics, and the construction of new rural and peri-urban health facility clinics under the Millennium Challenge Compact demonstrate the commitment to improve health facilities and services and enhance service delivery in the fight against HIV and AIDS.

Resource Mobilisation: Since 2007, resources for the national HIV and AIDS response have increased by 140%, but only 12% of the national budget is allocated for HIV prevention, and prevention is in 4th place in terms of funding by thematic area, behind OVC, programme management, and treatment, care and support. For the implementation of the forthcoming national strategy, it is imperative that adequate resources are raised for prevention efforts, especially for priority interventions in the areas of HTC, MC, condoms, SGBV interventions, Positive Prevention, PMTCT, and cross-cutting SBCC initiatives.

4 The National Multi-Sectoral HIV Prevention Strategy and Priorities

4.1 Guiding Principles

Addressing the key epidemic drivers

The successful reduction of HIV incidence in Lesotho requires implementing strategies that directly address the drivers of the epidemic. The key epidemic drivers are multiple and concurrent sexual partnerships, mother-to-child transmission, and low and inconsistent condom use. These drivers are exacerbated by a number of underlying factors, including cultural and traditional practices and gender norms. The HIV prevention responses outlined in this strategy are based on the epidemiology of the epidemic, and draw upon local, national, and international best practices to ensure that the interventions are flexible, effective, and responsive to the needs of the Basotho population.

Creating an integrated, comprehensive response

This *National Multi-Sectoral HIV Prevention Strategy, 2011 - 2015* promotes integrated, comprehensive services as the cornerstone of the response. Interventions are based on a combination prevention approach. Some services for key groups are embedded within a package of services that are standardised in line with international best practices, regardless of who delivers them. The prevention strategy also reinforces the integration of HIV prevention services into the existing health care system such as specialty clinics (e.g. STI, Maternal and Child Health (MCH) clinics), community health services, and both acute and primary health care facilities, so that every encounter with the health system is optimally utilised for preventing HIV infections.

Strengthening a decentralised response

While the national HIV response will be guided by the “Three One’s” Principle - one national coordinating authority, one national action framework, and one monitoring and evaluation plan – special attention has been paid to ensure that Lesotho’s national HIV prevention response emphasises strengthening and utilising the “gateway” approach for coordinating HIV and AIDS services at the district and community level. The gateway approach, via the *Essential HIV and AIDS Services Package*, provides NAC and all stakeholders (e.g. ministries, CSOs, private

sector) with a platform to enable the effective facilitation and implementation of their HIV and AIDS responses, and emphasises community participation as paramount in the national response, particularly in the area of HIV prevention.

Improving the use of strategic information

Lesotho's national HIV prevention response must be guided by high quality, up-to-date data, as well as by scientifically rigorous evidence and research. One of the top priorities for the national HIV prevention response is to strengthen the availability and use of strategic information in the decision-making and programme development processes. High quality data must be generated, collected, analysed, and disseminated on a regular basis to all stakeholders involved in the prevention response. Programmes should be evaluated regularly to allow for mid-stream corrections, and assessments of research needs should be undertaken on a regular basis to help inform HIV interventions. To facilitate the strategic use of information, this prevention strategy also calls for the enhancement of the M&E technical capacity of organisations involved in the prevention response.

Human rights-based approach

Prevention efforts will not be successful if the underlying determinants of vulnerability to HIV infection are not addressed, and if the rights of the Basotho people are not respected, promoted, and protected. This strategy is based on the notion that the rights of the people of Lesotho – especially PLHIV, people with disabilities (PWD), and women – are protected and fulfilled, they have equality before the law, and freedom from stigma and discrimination. All of the interventions are in accordance with ratified policies and legislation, are culturally-sensitive and person-centred, and are designed to engage and support individuals, families, and communities in the national response.

Scaling up SBCC

Social and behaviour change communication programming represents a critical ingredient in HIV prevention responses, attempting to create change at both the social and individual levels. The former generally focuses on the social drivers of human rights, stigma and discrimination, and gender inequality, while the latter typically focuses on individual risk reduction and avoidance skills. SBCC involves a range of activities, channels and approaches, which can be applied to a variety of programmatic areas and outcomes to reduce risk, vulnerability and the impact of HIV. Throughout this HIV prevention strategy, integrated, continuous and scaled up SBCC initiatives are emphasised in an attempt to mitigate HIV vulnerability and risk through addressing social norms, knowledge, attitudes, and skills related to the key drivers and factors of Lesotho's epidemic.

4.2 Strategies for Achieving Results

4.2.1 The Overall Goal

The overall goal of this *National Multi-Sectoral HIV Prevention Strategy* is to reduce by 50% the number of new HIV infections by 2015.

Because of the difficulty in measuring HIV incidence at the population level, the indicator that will be used to gauge progress in relation to this goal is an accepted proxy for incidence in the

general population: HIV prevalence in the population aged 15-24. The target for this indicator is a 15% reduction from baseline by 2013 and a 50% reduction from baseline by 2015.

This will be achieved through the following four objectives:

Objective #1: Reduce the sexual transmission of HIV

Objective #2: Reduce mother-to-child transmission of HIV

Objective #3: Prevention of the blood-borne transmission of HIV

Objective #4: Strengthen the systems necessary for an effective national HIV prevention response

These objectives reflect the emphasis on results rather than on processes and incorporate the elements of a combination prevention response.

4.2.2 Strategic Framework and Results

The following shows the strategic framework and results necessary for achieving the overall goal of reducing the number of new HIV infections by 50% by 2015.

Outcomes	Intermediate Outcomes	Outcome Level Results	Output Level results
Objective 1: Reduce the sexual transmission of HIV			
Outcome 1.1: Reduction of risky sexual intercourse	1.1.1: Reduction of the number of youth and adults reporting multiple partners, with a focus on reducing levels of concurrency and intergenerational sex	1.1.1a Increase percentage of population with comprehensive knowledge on the relationship between HIV prevention and multiple and concurrent partnerships	1.1.1.1a Increased number of youth and adults receiving continuous and intensive SBCC on skills, attitudes and practices relating to partner reduction and concurrency
		1.1.1b Decrease percentage of youth and adults aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	1.1.1.1b Increase percentage of women and youth receiving instruction in life skills and income generation activities
		1.1.1c Decrease percentage of the number of youth who report having sexual intercourse with an adult more than 10 years older than themselves	1.1.1.1c Increase percentage of men/young women reached with communication programmes on intergenerational sex
		1.1.1d Decrease percentage of adults reporting having sexual intercourse with a youth more than 10 years younger than themselves	

	1.1.2: Increased numbers of adults and youth using condoms correctly and consistently with a focus on higher risk partners	1.1.2a Increase percentage of adults and youth who reported using a condom the last time they had higher-risk sexual intercourse (non-married, non-cohabitating partner)	1.1.2.1a Increase percentage of randomly selected retail outlets and service delivery points that have condoms in stock at the time of a survey
			1.1.2.1b Increase percentage of youth and adults receiving continuous and scaled up SBCC on skills, attitudes and practices relating to condom use
	1.1.3: Increased numbers of adults and youth who get tested and know their HIV status	1.1.3a Increase percentage of men and women aged 15-49 who have received an HIV test in the last 12 months and know their results	1.1.3.1a Increase percentage of youth and adults receiving continuous and scaled up SBCC on skills, attitudes and practices relating to HTC
			1.1.3.1b Increase percentage of facilities with the capacity and conditions to provide static and mobile HIV testing
	1.1.4: Reduction of HIV transmission between HIV discordant partners	1.1.4a Increase percentage of discordant couples that remain discordant after enrolment in positive prevention services at 12, 24, and 36 months after testing	1.1.4.1a Increase percentage of people accessing a minimum package of Positive Prevention services
			1.1.4.1b Increase percentage in clinical facilities providing the minimum package of services for Positive Prevention, appropriate to the facility level
			1.1.4.1c Increase percentage in the number of couples that are tested and receive results together
	1.1.5: Reduction of HIV transmission resulting from sexual and gender-based violence (SGBV)	1.1.5a Decrease percentage of adults and youth who seroconvert after SGBV	1.1.5.1a Increase percentage of persons provided with post-exposure prophylaxis (PEP) after non-occupational exposure (sexual assault)
		1.1.5b Increase percentage of adults and youth exposed to SGBV who seek assistance from health facilities	1.1.5.1b Increase percentage of facilities offering a minimum package of SGBV services
		1.1.5c Increase percentage of adults and youth exposed to SGBV who report crime to legal authorities	1.1.5.1c Increase percentage of police stations participating in female-friendly SGBV programmes

			1.1.5.1d Increase number of districts implementing policies, legislation and guidelines in relation to SGBV
			1.1.5.1e Increase percentage of trainings and community dialogues on SGBV provided at community level
			1.1.5.1f Increase percentage in the number of people reporting SGBV to law enforcement authorities
	1.1.6: Reduction of the impact of alcohol and drug abuse on HIV transmission	1.1.6a Increase percentage of HIV-uninfected individuals that remain uninfected after participation in community-based or other substance abuse services at 12, 24, and 36 months after testing	1.1.6.1a Increase percentage of people who abuse alcohol that receive agreed-to standard packages of support
			1.1.6.1b Increase percentage of youth and adults receiving continuous and intensive SBCC on skills, attitudes and practices relating alcohol and drug abuse
	1.1.7: Reduction of risky sexual practices among at-risk populations.	1.1.7a Increase percentage of individuals from at-risk groups who reported using a condom the last time they had higher-risk sexual intercourse (disaggregated by non-married non cohabitating partner, and at-risk group)	1.1.7.1a Increase percentage of districts providing minimum packages of prevention services for at-risk groups
		1.1.7b Decrease percentage of at-risk groups who had more than one sexual partner in the last 12 months (disaggregated by at-risk group)	1.1.7.1b Increase percentage of at-risk population accessing HIV prevention services within a minimum package of services
		1.1.7c Decrease percentage of at-risk populations who report experiencing stigma or discrimination (disaggregated by at-risk group)	1.1.7.1c Increase percentage of districts with programmes targeting stigma, discrimination and human rights
	1.1.8: Reduction of risky sexual behaviours among migrant workers and their partners	1.1.8a Decrease percentage of migrant labourers and their partners reporting multiple sexual partners	1.1.8.1a Increase percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes

		1.1.8b Increase percentage of migrant labourers and their partners who reported using a condom the last time they had higher-risk sexual intercourse (non-married, non-cohabitating partner)	1.1.8.1b Increase percentage of large scale construction projects with environmental impact assessments with HIV components at the national standard
		1.1.8c Increase percentage of migrant workers with overall knowledge of HIV prevention and appropriate skills and attitudes	1.1.8.1c Increase percentage of migrant workers and their partners reporting access to HIV prevention services
	1.1.9: Reduced vulnerability to HIV infection among youth and OVC	1.1.9a Increase percentage of youth and OVC with HIV prevention knowledge skills, attitudes, and practices	1.1.9.1a Increase percentage of DACs overseeing comprehensive HIV prevention services for youth and OVC
		1.1.9b Increase percentage of households with OVC who have sufficient income and support services	1.1.9.1b Increase percentage of communities offering a standardised package of services for OVC
		1.1.9c Increase percentage of OVC attending school	1.1.9.1c Increase percentage of the number of educational programmes targeting OVC
	1.1.10: Mitigated HIV vulnerability through addressing social norms, knowledge, attitudes and skills	1.1.10a Increase percentage of youth and adults who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	1.1.10.1a Increase number of social and behavioural change communication strategies and programmes incorporating social norms and HIV vulnerabilities
		1.1.10b Increase percentage of youth and adults with accepting attitudes to PLHIV	1.1.10.1b Increase percentage of prevention programmes that integrate issues around vulnerability and gender norms in existing SBCC initiatives
		1.1.10c Increase percentage of youth and adults that express attitudes that address the vulnerability of women to HIV	1.1.10.1c Increase percentage of men reached by initiatives addressing male involvement and male gender norms

Outcome 1.2: Increased prevalence of male circumcision	1.2.1: Increased numbers of adult men and adolescents (15-49) who have circumcised as a component within a comprehensive HIV prevention programme	1.2.1a Increase percentage of men and adolescents aged 15-49 who have undergone male circumcision	1.2.1.1a Increase percentage of clinical facilities offering male circumcision as per WHO quality standards
			1.2.1.1b Increase percentage of traditional circumcisers receiving capacity building on male circumcision and HIV prevention
		1.2.b Increase percentage of people who have correct knowledge about the benefits and limitations of male circumcision	1.2.1.1 c Increase percentage of men undergoing traditional initiation who receive male circumcision performed to clinical standards
			1.2.1.1d Increase percentage of traditional circumcision schools that partner with clinicians to perform circumcisions
			1.2.1.1e Increase percentage of communities with comprehensive male circumcision, HIV prevention initiatives, and supporting SBCC
	1.2.2: Increased number of infants receiving male circumcision	1.2.2a Increase percentage of infants who have undergone male circumcision	1.2.2.1a Increase percentage of ANC and infant and maternal health facilities offering infant male circumcision
		1.2.2b Increase percentage of parents who have correct knowledge about the benefits and limitations of infant male circumcision	1.2.2.1b Increase number of districts with SBCC programmes for infant male circumcision

Outcome 1.3: Decreased vulnerability to HIV infection and STIs	1.3.1: Reduction in the behaviours that cause STI infections	1.3.1a Increase number of adults and youth reporting comprehensive knowledge of STI prevention	1.3.1.1a Increase number of communities participating in SBCC interventions on STIs
		1.3.1b Increase percentage of adults and youth reporting safer sex behaviours	1.3.1.1b Increase percentage of population accessing information on STIs
	1.3.2 Reduction in the number of adults and youth with STIs	1.3.2a Decreased percentage of the number of adults and youth treated for STIs	1.3.2.1a Increased percentage of facilities meeting quality assured standards in STI management
			1.3.2.1b Increased percentage of people reporting suggestive STI symptoms and seeking treatment for clinical services
			1.3.2.1c Increased percentage of adults and youth with STIs in health care facilities who are appropriately diagnosed, treated, and counselled according to national guidance
Objective 2: Reduce mother-to-child transmission of HIV			
Outcome 2.1:Reduction of vertical (mother to child) transmission of HIV	2.1.1: Reduction of HIV prevalence in women of reproductive age	2.1.1a Reduced incidence among women of reproductive age reported within HIV clinics	2.1.1.1a Increase percentage of women and their partners accessing comprehensive HIV prevention services
	2.1.2 Percentage decrease in levels of unintended pregnancy among HIV – infected women	2.1.2a Reduce levels of unintended pregnancy among HIV-infected women	2.1.2.1a Increase percentage of HIV-infected women accessing reproductive health services
			2.1.2.1b Increase percentage of the number of facilities offering RH/FP counselling and couple counselling with a focus on male involvement initiatives

	2.1.3: Reduction of HIV transmission from mother to child	2.1.3a Transmission rate for perinatal transmission of HIV at 6 weeks, following PMTCT, drops to less than 5%	2.1.3.1a Increase percentage of HIV-infected women giving birth in clinical facilities
			2.1.3.1b Clinical services for PMTCT accessible to more than 98% of pregnant women
			2.1.3.1c Increase percentage in HIV-infected pregnant women receiving ARV prophylaxis
			2.1.3.1d Increase percentage of women who start prophylaxis at 14 weeks and continue on prophylaxis throughout breast feeding
			2.1.3.1e Increase percentage of women eligible receiving ART
	2.1.4: Improved health status for HIV-infected mothers, their children, and their families	2.1.4a Decrease percentage of HIV-related illness in HIV-infected mothers	2.1.4.1a Increase percentage of HIV-infected women accessing follow up services for PMTCT
			2.1.4.1b Increase percentage of men accessing support and social and behavioural change communication for PMTCT
		2.1.4b Decrease percentage of HIV-related illness in infants and young children of HIV-infected mothers	2.1.4.1c Increase percentage of HIV-infected women exclusively breastfeeding
			2.1.4.1d Increase percentage of mothers receiving a minimum package of Positive Prevention and support services
Objective 3: Prevent the blood-borne transmission of HIV			
Outcome 3.1: HIV infection through blood transfusion eliminated	3.1.1: Incidence of HIV infection through blood transfusion is reduced to and remains at zero	3.1.1a Decrease number of infections through HIV transmission through blood transfusion	3.1.1.1a Increase number of units of whole blood collected by LBTS and screened for transfusion-transmissible infections per 1,000 population per year

			3.1.1.1b Decrease percentage of blood units collected and screened by LBTS which are identified as reactive for HIV by an LBTS laboratory
			3.1.1.1c Increase percentage of blood donations from voluntary, non-remunerated donors
Outcome 3.2: Blood-borne HIV transmission in and out of clinical settings is reduced	3.2.1: The number of blood-borne HIV infections in clinical settings is reduced	3.2.1a Decrease percentage of occupational HIV infections in clinical settings	3.2.1.1a Increase percentage of health facilities implementing universal precautions to WHO recognised standards
			3.2.1.1b Increase percentage of persons provided with post-exposure prophylaxis (PEP) after occupational and non-occupational exposure
			3.2.1.1c Increase percentage of health facilities with no stock outs of new sterile syringes/ gloves/safety boxes in the prior six months
			3.2.1.1d Increase percentage of health facilities with final disposal method for health care waste
	3.2.2: The number of blood borne HIV infections outside clinical settings is reduced	3.2.2a Decrease percentage of accidental HIV infections occurring in communities (outside of clinical settings)	3.2.2.1a Increase percentage of target audience (e.g. traditional healers, circumcisers, home-based care givers, elders that assist with home deliveries) implement community focused infection control and waste disposal practices
			3.2.2.1b Increase percentage of people administering home based care and home delivery services accessing a basic infection control package (including gloves and other infection prevention supplies)

Objective 4: Strengthen the Systems Necessary for an Effective National HIV Prevention Response			
Outcome 4.1 A policy, legal, and advocacy environment established for effective implementation of HIV prevention	4.1.1: Increased implementation of policies and legislation related to HIV prevention	4.1.1a: Policies and legislation developed are effectively implemented	4.1.1.1a: Change in score in NCPI reflects progress in the development and implementation of HIV prevention policies and legislation
	4.1.2: Increased leadership by community, religious, and political leaders in development of HIV prevention advocacy, policy, and legislation	4.1.2a: Increased commitment and participation among leaders from community, religious, and political sectors in development of HIV prevention advocacy, policy, and legislation	4.1.2.1a: Increase in number of representatives from civil society organisations and community structures trained in HIV prevention program and advocacy initiatives
	4.1.3: Increased usage of media channels by civil society within the HIV prevention response	4.1.3a: Increased number of radio and community media channels airing civil society perspectives on policies and programmes relating to HIV prevention	4.1.3.1a: Increased number of journalists, editors and media owners engaged on civil society participation in HIV prevention policies and programming
			4.1.3.1b: Increased percentage of communities with active community media channels working on generating dialogue and engagement with HIV prevention
Outcome 4.2: Coordination and management of the decentralised HIV prevention response is strengthened	4.2.1: An effective multi-sectoral response to HIV prevention in accordance with the National Coordination Framework and National Multi-Sectoral HIV Prevention Strategy	4.2.1a: Increased number of annual operational plans for HIV prevention developed by public, private, and civil society organisations that are aligned and implemented in accordance with the National Coordination Framework and the National Multi-Sectoral HIV Prevention Strategy	4.2.1.1a: Increased number of MOUs and/or contracts signed among public, private, and civil society partners for implementing HIV prevention activities in accordance with the national strategies

	4.2.2: Increased capacity at decentralised level to develop and effectively coordinate HIV prevention initiatives	4.2.2a: Percentage increase in districts and communities with operational DACs and CCACs constituted and operating according to their terms of reference	4.2.2.1a: Percentage of district and community councils receiving technical training and support to develop and manage functional DACs and CCACs
		4.2.2b: Percentage increase in DACs and CCACs with Essential HIV and AIDS Services Package annual plans aligned to the objectives of the National Mulit-Sectoral HIV Prevention Strategy, and other prevention policies	4.2.2.1b: Percentage of DACs and CCACs receiving technical training annually on planning and operalisation of the Essential Services Package
	4.2.3: The National HIV Prevention response is adequately funded	4.2.3a: Percentage of key strategies and activities within the costed National Multi-Sectoral HIV Prevention Operational Plan that are fully funded	4.2.3.1a: Annual HIV prevention funding needs to be accurately quantified in the national annual planning and budgeting process
Outcome 4.3: The effectiveness of HIV prevention responses is strengthened through use of strategic information	4.3.1: HIV prevention data utilized in national annual planning and annual partner work plans	4.3.1a: Increased number of DACs and CCACs that incorporate HIV prevention data in annual Essential HIV and AIDS Services Package planning processes	4.3.1.1a: One harmonized, national M&E system strengthened and operationalised at all levels
		4.3.1b: Increased number of civil society organisations implementing HIV prevention programmes that incorporate HIV prevention data in annual work plan processes	4.3.1.1b: Increased number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)
	4.3.2: HIV prevention strategies and initiatives are informed by current, up-to-date research and evidence	4.3.2a: Increased number of HIV prevention research projects, studies and surveillance reports	4.3.2.1a: HIV and AIDS database updated annually
			4.3.2.1b: Increased number of staff who receive training in HIV prevention research and analysis skills

Outcome 4.4 Improved capacity for HIV prevention service delivery	4.4.1: Improved technical and logistical capacity to implement the HIV prevention response	4.4.1a: Percentage increase in government structures providing or coordinating HIV prevention services, programmes, or technical support reporting they have the required level of human resources	4.4.1.1a: Increased number of government structures whose HR policies and practices meet a defined standard
			4.4.1.1b: Increased number of staff from government structures trained in HIV prevention skills, activities, and interventions
		4.4.1b: Percentage increase in government facilities with staff that perform to a defined technical or quality standard in the delivery of HIV prevention services and programmes	4.4.1.1c: Percentage increase of health facilities that make required improvements after undertaking an infrastructure audit
		4.4.1c: Decreased number of government facilities that attribute lack of infrastructure (buildings, vehicles, commodities and equipment) to failure in providing services	4.4.1.1d: Percentage decrease of health facilities at district and community level reporting stock outs of key HIV prevention commodities

4.2.3 Key Priorities

While the Strategic Framework and Results illustrates a full range of outcomes and activities required for a comprehensive national HIV prevention response, there are prioritised intermediate outcomes that address the key epidemic drivers and underlying systems.

Figure 2: First and Second Tier Priorities in HIV Prevention*

First Tier Priority	
Number	**Result**
1.1.1	Reduction of the number of youth and adults reporting multiple partners, with a focus on reducing levels of concurrency, intergenerational sex
1.1.2	Increased numbers of adults and youth using condoms correctly and consistently with a focus on higher risk partners
1.1.3	Increased numbers of adults and youth who get tested and know their HIV status
1.1.4	Reduction of HIV transmission between HIV discordant partners
1.1.5	Reduction of HIV transmission resulting from sexual and gender-based violence
1.2	Increased prevalence of male circumcision
2.1	Reduction of mother-to-child transmission of HIV
4.2	Coordination and management of the HIV prevention response is strengthened
4.3	The effectiveness of HIV prevention responses is strengthened through the use of strategic information
Second Tier Priority	
1.1.6	Reduction of the impact of alcohol and drug use on HIV transmission
1.17	Reduction of risky sexual practices among at-risk populations
3.1	HIV infection through blood transfusion eliminated
3.2	Blood-borne HIV transmission in and out of clinical settings is reduced
4.4	Improved human resources, infrastructure and capacity to implement the

national HIV prevention response

*Numbers in this figure are cross-referenced to the Strategic Framework and Results in 4.2.2 above.

4.2.4 Objectives, Outcomes, Outputs, and Key Strategies and Activities

Objective #1: Reduce sexual transmission of HIV

The prevention of the sexual transmission of HIV is a key intervention under the *National HIV and AIDS Strategic Plan,* the *Health Sector Policy on Comprehensive HIV Prevention.* The sexual transmission of HIV is the leading driver of Lesotho's hyper-endemic epidemic. The reduction of the sexual transmission of HIV requires a complex combination of prevention interventions. Three outcome-level objectives will contribute to reduced sexual transmission: reduction of risky sexual intercourse; increased prevalence of male circumcision; and decreased vulnerability to HIV infection and STIs.

Outcome 1.1: Reduction of risky sexual intercourse

Risky sexual behaviours, especially multiple and concurrent sexual partnerships and inconsistent condom use, are two of the main drivers of Lesotho's epidemic. Reducing risky sexual intercourse requires a comprehensive HIV prevention response that addresses behaviours, infection protection, social norms, and service referrals. These behaviours are rooted in many cultural and societal norms and economic factors surrounding sexuality and sexual partnering in Lesotho. Other factors that influence risky sexual behaviours are knowledge of HIV serostatus, SGBV, and the impact of substance abuse, especially drugs and alcohol, on HIV transmission. Programmes must be targeted to segments within the general population and specific at-risk groups.

Intermediate Outcome 1.1.1: Reduction of the number of multiple sexual partners among adults and youth, with a focus on concurrency and intergenerational sex

Figure 3: Results for Intermediate Outcome 1.1.1

Outcome Results		Baseline	Result by 2013	Result by 2015
1.1.1a	Increase percentage of population with comprehensive knowledge on the relationship between HIV prevention and multiple and concurrent sexual partnerships (using condoms and limiting sexual intercourse to one	Women: 71% Men: 60% 2009	Women: 85% Men: 75%	Women: 95% Men: 95%

	partner)	LDHS		
1.1.1.b	Decrease percentage of youth and adults aged 15-49 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	2009 LDHS	20% reduction	40% reduction
1.1.1.c	Decrease percentage of of youth (15-19) who report having sexual intercourse with an adult more than 10 years older than themselves in the past 12 months	7.2% Women 0.3% Men (2009 LDHS)	20% reduction	40% reduction
1.1.1.d	Decrease percentage of adults reporting having sexual intercourse with a youth more than 10 years younger than themselves	TBD 2009 LDHS	20% reduction	40% reduction
Output Results				
1.1.1.1a	Increase number of youth and adults receiving continuous and scaled up SBCC on skills, attitudes and practices relating to partner reduction and concurrency	TBD in 2011	40% of youth/ adults	70% of youth/ adults
1.1.1.1.b	Increase percentage of women and youth receiving instruction in life skills and income generation activities	TBD in 2011	10% of women/ youth	30% of women/ youth
1.1.1.1.c	Increase percentage of men/young women reached with communication programmes on intergenerational sex	TBD in 2011	30% of men/ women	60% of men/ women

Multiple sexual partnering, including concurrency, is a main driver of Lesotho's epidemic. This outcome is addressed as an area in its own right, and is mainstreamed into a number of other outcomes. Several policies have identified the reduction of multiple partners, with a focus on concurrency, as a priority including the *National HIV and AIDS Strategic Plan*, the *Health Sector Policy on Comprehensive HIV Prevention*, and the *National Behaviour Change Communications Strategy, 2008 – 2013.*

Key strategies and activities:

Review, implement, and assess SBCC addressing multiple and concurrent sexual partnering

- Develop SBCC materials and tools with a focus for use by non-professionals at the community level among others
- Conduct national and community level partner reduction and mutual fidelity campaigns
- Build the capacity of traditional, religious, and other local opinion leaders to address multiple sexual partnering and concurrency through community mobilisation and interpersonal communications
- Evaluate existing strategies and campaigns

- Incorporate elements addressing multiple sexual partnering and concurrency into existing behavioural, biomedical, and structural HIV prevention programmes
  - Develop and implement HIV prevention and multiple sexual partnering communications modules with direction for referrals for incorporation into existing programmes
- Increase the number of programmes providing training and income generation to females
  - Map life skills programmes/ income generation activities in each district
  - Link HIV prevention programmes with services that deliver life skills, vocational training, and income generation activities
- Address the cultural and legislative barriers that prevent females from being economically empowered
  - Conduct advocacy initiatives with national and community leaders
  - Strengthen the dissemination of all relevant legal frameworks across the country with a focus on district and community levels
- Incorporate elements addressing intergenerational sexual relationships and HIV prevention into existing HIV prevention programmes
  - Map intergenerational sexual relationship programming in each district
  - Design, implement, and assess intergenerational sexual relationship programmes
  -

Key considerations:

Sexual networks encompass a wide range of sexual partners and include marital, non-marital but regular, short-term and long-term transactional (*nyatsi*), intergenerational, and commercial sex for payment. Initiatives addressing multiple sexual partnering and concurrency should be targeted to specific partnering types and sexual networks, and clearly address the knowledge, risk perception, attitudes, practices, and social norms. These initiatives should address underlying issues that create risk and vulnerability, including the social tolerance of multiple partnering, gender norms, couples' communications, SGBV, and stigma and discrimination. Another key underlying issue is economic vulnerability, and programmes should strengthen linkages to economic empowerment activities. Current legislation regarding women, legal rights, and economic opportunities should be disseminated and implemented throughout the country.

Intermediate Outcome 1.1.2: Increased numbers of adults and youth using condoms correctly and consistently, with a focus on higher-risk partners

Figure 4: Results for Intermediate Outcome 1.1.2

Outcome Results		Baseline	Result by 2013	Result by 2015
1.1.2a	Increase percentage of adults and youth who had sexual intercourse with more than one sexual partner in the last 12 months and who reported using a condom the last time they had sexual intercourse	37.5% women 50.5% men 2009 LDHS	45% increase	80% increase
Output Results				
1.1.2.1a	Increase percentage of randomly selected retail outlets and service delivery points that have condoms in stock at the time of a survey	TBD in 2011	80% of outlets	95% of outlets
1.1.2.1b	Increase percentage of youth and adults receiving continuous and scaled up SBCC on skills, attitudes and practices relating to condom use	TBD in 2011	30% of Basotho youth and adults	60% of Basotho youth and adults

Condom use, especially during sexual encounters with higher-risk sexual partners (non-married, non-cohabitating partner) is still relatively low in Lesotho. Although there is widespread condom distribution, many communities perceive condoms as not readily available and accessible. The consistent and correct use of condoms, particularly during higher risk sexual acts, and widespread availability of condoms are key interventions under both the *National HIV and AIDS Strategic Plan* and the *Health Sector Policy on Comprehensive HIV Prevention.* The forthcoming *National Condom Strategy* will guide all programming related to condoms in Lesotho.

Key strategies and activities:

- Increase availability of condoms in urban, rural, and “high-risk” outlets and through community distribution
    - Implement condom marketing and distribution utilising a mix of free, private sector, and social marketing approaches
    - Conduct an annual national condom distribution and uptake survey
- Increase condom accessibility through friendly outlets for youth, PLHIV, people with disabilities, and other at-risk populations
    - Develop and implement outlet retail owners and employees peer education programmes with a focus on at-risk populations
- Increase the availability and acceptability of the female condoms
    - Develop, pilot, and assess female condom promotion and distribution models to at-risk populations
    - Distribute and promote uptake of the female condom to the general population
- Incorporate programming addressing condom use and skills into existing behavioural, biomedical, and structural HIV prevention programmes, with age- and context-appropriate approaches for youth
    - Develop a condom use communications module for incorporation into existing HIV prevention programmes
    - Develop and implement community mobilisation activities that include condom promotion and distribution within wider HIV prevention programming
    - Conduct research-informed community mobilisation to address societal beliefs and attitudes towards condoms and condom use in SBCC initiatives
    - Engage opinion leaders and organisations that are reticent about condoms in dialogues about condoms and HIV prevention

Key considerations:

Condom distribution is a combination of socially marketed products available in the private sector and fully-subsidised free GOL condoms available in the public sector. The GOL and stakeholders are in the process of developing a Comprehensive Condom Program, and future condom programming efforts will focus on increasing availability and access of condoms in urban, rural, and “at-risk area” outlets. Particular attention will be paid to ensuring that free subsidised condoms will be made available to those most in need. A roll out of community-based condom distribution will complement condom distribution efforts through Community Health Workers (CHWs), PLHIV support groups, and Community-Based Distributors (CBDs). Local chiefs, members of the local councils, and other community-based leaders should be engaged in the promotion and distribution of condoms.

Intermediate Outcome 1.1.3: Increased numbers of adults and youth who get tested and know their HIV status

Figure 5: Results for Intermediate Outcome 1.1.3

Outcome Results		Baseline	Result by 2013	Result by 2015
1.1.3a	Increase percentage of men and women aged 15-49 who have received an HIV test in the last 12 months and know their results	24.7% Men and 42% Women 2009 LDHS	20% increase	50% increase
Output Results				
1.1.3.1a	Increase percentage of youth and adults receiving continuous and scaled up SBCC on skills, attitudes and practices relating to HTC	TBD in 2011	50% of youth/ adults	80% of youth/ adults
1.1.3.1b	Increase percentage of facilities with the capacity and conditions to provide static and mobile HIV testing	TBD in 2011	Static HTC: 70% Mobile HTC: 10%	Static HTC: 90% Mobile HTC: 30%

The knowledge of one's own HIV status is critical for HIV prevention efforts. Knowledge of status is especially important for admission into Positive Prevention services, and for protecting sexual partners, and for protecting children during and after birth. In addition, it is important for non- HIV-infected individuals to take the steps necessary to preserve their status with the help of counsellors and other support services. HIV testing and counselling (HTC) is articulated as a priority in both the *National HIV and AIDS Strategic Plan* and the *Health Sector Policy on Comprehensive HIV Prevention.*

Key strategies and activities:

- Embed comprehensive HTC communications into existing behavioural, biomedical, and structural HIV prevention initiatives, with a focus on male involvement
  - Develop and implement HTC communications module for incorporation into existing HIV prevention programmes

- Develop and implement HTC mass media, community mobilisation, and interpersonal communication campaigns to improve uptake of HTC
- Organise campaigns to address societal beliefs and attitudes towards HTC and stigma and discrimination in SBCC initiatives

- Expand HTC accessibility to segmented targeted audiences through innovative delivery modules
  - Strengthen service availability through commodity security, recruitment and retraining of Know Your Status counsellors
  - Train and supervise public sector staff on commodity forecasting and management
  - Strengthen measurable referrals and client follow up between HTC and Positive Prevention services
  - Update the HTC monitoring system to capture repeat testers and track clients
  - Include reporting on HTC commodity security in the national M&E plan

Key considerations:

A main consideration under this intermediate outcome is to build on investments made during the Know Your Status HTC initiatives and expand the accessibility and impact of HTC. This includes reaching men and women aged 15-24, at-risk, or hard-to-reach populations with HTC. Accessibility can be greatly increased through the utilisation of innovative delivery models, such as household testing through index clients (clients who have already been identified as HIV-positive and have granted permission to disclose status), mobile services, and moonlight testing, or after-hours services. HTC is an excellent entry-point to expand male involvement and partner communication in HIV prevention. For example, couple counselling should become opportunities for men to evaluate male roles, gender norms, and societal expectations in relation to HIV prevention.

Intermediate Outcome 1.1.4: Reduction of HIV transmission between HIV discordant couples

Figure 6: Results for Intermediate Outcome 1.1.4

Outcome Level Results		Baseline	Result by 2013	Result by 2015
1.1.4a	Increase percentage of discordant couples that remain discordant after enrolment in Positive Prevention services at 12, 24, and 36 months after testing	TBD in 2011	12 mo: 60% 24 mo: 40% 36 mo: 30%	12 mo: 90% 24 mo: 80% 36 mo: 70%
Output Level Results				

1.1.4.1a	Increase percentage of people accessing a minimum package of Positive Prevention services	TBD in 2011	35% of PLHIV	70% of PLHIV
1.1.4.1b	Increase percentage in clinical facilities providing the minimum package of services for Positive Prevention, appropriate to the facility level	TBD in 2011	20% of all facilities	80% of all facilities
1.1.4.1c	Increase percentage in the number of couples that are tested and receive results together	TBD in 2011	20% increase	40% increase

Positive Prevention refers to a core package of services for HIV-infected adults and children that is a routine standard of care in HIV care and treatment settings, and is an emerging HIV prevention priority in Lesotho. This intervention is critical for reducing the risk of on-going HIV transmission. Lesotho is currently in the process of establishing facility- and community-based Positive Prevention services in key facilities with ART clinics.

Key strategies and activities:

- Embed comprehensive Positive Prevention services communications into existing behavioural, biomedical, and structural HIV prevention initiatives, with a focus on male involvement
    - Develop a Positive Prevention communications module for incorporation into existing HIV prevention programmes
    - Capacity building at the community level with public, community, religious, and traditional leaders to provide SBCC and referrals in Positive Prevention services
    - Develop and implement Positive Prevention and mitigation of stigma and discrimination interventions and include them in mass media, community mobilisation, and interpersonal communications campaigns
- Strengthen capacity for the provision of comprehensive Positive Prevention services within facilities and communities
    - Train and supervise public sector staff on the provision of Positive Prevention services
    - Train and supervise PLHIV networks to support the provision of facility- and community-based Positive Prevention services
    - Integrate Positive Prevention data into the national M&E system
    - Pilot, evaluate, and roll out Positive Prevention referral and case management models
- Strengthen capacity for the provision of couples-focused HTC and disclosure services within facilities
    - Train and supervise public sector staff on the provision of couples-focused HTC

- Develop and implement couples-focused HTC interventions and include them in mass media, community mobilisation, and interpersonal communications campaigns

Key considerations:

Lesotho is currently in the process of establishing facility- and community- based Positive Prevention services for adults and children. The minimum package of services for HIV-infected adults addresses healthy living, including prevention of onward transmission by and re-infection of PLHIV, good nutrition, and regular exercise. Specific activities and services include risk reduction counselling (partner reduction, condom use, disclosure to partners, adherence counselling, and the reduction of alcohol and drug intake), condom distribution, the management of opportunistic infections (TB treatment and screening, including for multi-drug resistant and extensively drug resistant tuberculosis (MDR/XDR TB), cotrimoxizole) and STIs, referrals to RH/FP, substance abuse counselling, home-based care, nutritional education services, and ART.

Positive Prevention programs should work with clients and their families to mitigate misunderstandings about HIV infection and treatment. This includes beliefs around the “curable” effect of ART and sharing ART among family members. SBCC to the overall population should also address beliefs about treatment and “cures, and emphasize accurate risk perceptions around HIV infection and the realities of living with HIV, such as ARV stock outs, potential virus mutations, and the like.

PLHIV networks play an essential role in creating demand and support for Positive Prevention services, particularly as expert patients and assisting with case management. Other roles include advocacy, community mobilisation, and interpersonal communications for behaviour change. PLHIV support groups can be diversified, for example: for men only, families as a whole, and adolescent men and women with their parents or family members as support. Churches, and work places can sponsor support groups among their members. HIV-infected Basotho should be supported to advocate and publicly disclose their status to help with awareness creation for Positive Living and to help reduce stigma and discrimination.

Traditional healers can be involved with Positive Prevention initiatives, including HTC referrals and ART and TB treatment adherence. Traditional healers can also support counselling on safer sexual behaviours and nutrition, and can assist health facilities with adverse-effects monitoring.

Intermediate Outcome 1.1.5: Reduction of HIV transmission resulting from sexual and gender-based violence

Figure 7: Results for Intermediate Outcome 1.1.5

Outcome Results		Baseline	Result by 2013	Result by 2015
1.1.5a	Decrease percentage of adults and youth who seroconvert after SGBV	TBD in 2011	30% reduction	70% reduction
1.1.5b	Increase percentage of adults and youth exposed to SGBV who seek assistance from health facilities	TBD in 2011	20% of adults and youth	50% of adults and youth
1.1.5c	Increase percentage of adults and youth exposed to SGBV who report crime to legal authorities	TBD in 2011	10% of adults and youth	30% of adults and youth
Output Results				
1.1.5.1a	Increase percentage of persons provided with post-exposure prophylaxis (PEP) after non-occupational exposure (sexual assault)	TBD in 2011	20% of persons experiencing SGBV	50% of persons experiencing SGBV
1.1.5.1b	Increase percentage of facilities offering a minimum package of SGBV services	TBD in 2011	20% of all facilities	40% of all facilities
1.1.5.1c	Increase percentage of police stations participating in female-friendly SGBV programmes	TBD in 2011	50% of all police stations	80% of all police station
1.1.5.1d	Increase number of districts implementing policies, legislation and guidelines in relation to SGBV	TBD in 2011	50% of all districts	100% of all districts
1.1.5.1e	Increase percentage of trainings and community dialogues on SGBV provided at	TBD in	30% of all	60% of all

	community level	2011	villages receive trainings/dialogues	villages receive trainings/ dialogues
1.1.5.1f	Increase percentage in the number of people reporting SGBV to law enforcement authorities	TBD in 2011	20% increase	40% increase

Sexual and gender-based violence targeting women and intimate partner violence (IPV) increases the risk of HIV infection. The provision of PEP to individuals exposed to HIV through sexual or gender-based violence is a key intervention under both the *National HIV and AIDS Strategic Plan* and the *Health Sector Policy on Comprehensive HIV Prevention.* Some of the key strategies proposed for this indicator are closely related to Indicator 3.2: Blood-borne transmission of HIV in and out of clinical settings is reduced.

Key strategies and activities:

- Strengthen capacity for the facility-based provision of SGBV services including PEP
  - Train and supervise public sector staff on the provision of PEP
  - Train and supervise public sector staff on PEP commodity forecasting and management
  - Integrate SGBV screening and referrals into existing policy, guidelines, standards, and service delivery tools
  - Develop and implement tracking mechanisms for sexually abused persons
- Strengthen capacity for the provision of comprehensive SGBV services within facilities and communities
  - Pilot, evaluate, and roll out comprehensive facility-based SGBV and HIV prevention services that are linked to law enforcement
  - Integrate facility-based SGBV data into the national M&E system
- Strengthen capacity for the provision of comprehensive legal and post-trauma SGBV services linked to health care facilities
  - Pilot, evaluate, and roll out comprehensive legal and post-trauma SGBV and HIV prevention services that are linked to health facilities
  - Integrate law enforcement SGBV data into the national M&E system
- Advocate with parliamentarians and government leaders the enforcement of all ratified conventions on SGBV
  - Conduct interactive educational campaigns on SGBV legislation, including the Sexual Offences Act, with participation from national and local leaders
  - Train and supervise community councils, traditional leaders, and law enforcement authorities on the implementation of SGBV services and adherence to law

- Embed comprehensive SGBV communications into behavioural, biomedical, and structural HIV prevention initiatives
    - Develop SGBV module for incorporation into existing HIV prevention programmes
    - Develop and implement mass media, community mobilisation, interpersonal communications for SGBV and HIV prevention campaigns

Key considerations:

Building on regional promising best practices, community-based SGBV and HIV prevention programmes should include health care provider training on sexual and gender-based violence, evidence preservation, and post-rape case management including RH/FP services and PEP (see Result 3.2.1 for a description of the roll out of PEP services in health care facilities). Other elements include prosecutorial assistance, local law enforcement sensitisation, and victim support. Coalitions of community-based organisations can provide referrals between health care facilities, other health services, legal aid, and family-centred trauma counselling. Referrals to SGBV programmes should be incorporated in existing HIV prevention initiatives.

The legislative foundation for SGBV initiatives exists but requires operationalising and enforcement. The GOL should domesticate all ratified conventions on sexual and gender-based violence, and mainstream HIV prevention and gender into sectoral plans. Lawmakers, enforcement bodies, and government officials require sensitisation and training on SGBV polices and implementation. Communication priorities should include addressing prevalent related social norms, such as the practice of *chobeliso*, or “eloping”. Community *pitsos*, or community meetings, can be used as a forum to sensitise communities on sexual assault and GBV, with meetings specifically held for and conducted by men.

Intermediate Outcome 1.1.6: Reduction of the impact of alcohol and drug abuse on HIV transmission

Figure 8: Results for Intermediate Outcome 1.1.6

Outcome	Results	Baseline	Result by 2013	Result by 2015
1.1.6a	Increase percentage of HIV-uninfected individuals that remain uninfected after participation in community-based or other substance abuse services at 12, 24, and 36 months after testing	TBD in 2011	12 mo: 50% 24 mo: 40% 36 mo: 30%	12 mo: 80% 24 mo: 70% 36 mo: 60%

Output Results				
1.1.6.1a	Increase percentage of people who abuse alcohol that receive agreed-to standard packages of support	TBD in 2011	10%	25%
1.1.6.1b	Increase percentage of youth and adults receiving continuous and scaled up SBCC on skills, attitudes and practices relating to alcohol and drug abuse	TBD in 2011	20% of youth and adults	50% of youth and adults

There is an emerging global body of knowledge that documents the link between substance abuse and HIV infection. Tackling substance abuse, specifically alcohol and cannabis, is an important issue for HIV prevention in Lesotho. Within communities, alcohol abuse is perceived to be related to sexual risk taking and violence, including rape, and among HIV-infected individuals is associated with poor ART adherence, compromised treatment efficacy, and an overall decline in health. Although the selling and consumption of alcohol is regulated, there is little law enforcement in some communities. There is little data in Lesotho on cannabis consumption, but some communities perceive it to be related to behavioural disinhibition and sexual risk taking.

Key strategies and activities:

- Develop a national substance abuse and HIV prevention roadmap
  - Conduct formative research to determine the dynamics and prevalence of alcohol and drug abuse on HIV prevention
  - Cost the national substance abuse and HIV prevention roadmap
- Pilot, evaluate, and roll out community-based substance abuse programmes with addiction treatment services
  - Pilot, evaluate, and roll out community-based substance abuse programmes that integrate out-reach-based HIV prevention services with addiction recovery treatment services, community support groups, and HIV case management for infected clients
  - Incorporate substance abuse data into the national M&E system
- Incorporate elements addressing substance abuse and HIV prevention into existing behavioural, biomedical, and structural HIV prevention programmes
  - Integrate substance abuse screening and referrals into existing policy, guidelines, standards, and service delivery tools
  - Establish measurable entry point referral linkages from existing HIV prevention, care, and treatment services to piloted substance abuse programmes, including ART, TB/HIV, RH/FP, and STI clinics and PMTCT and HTC services
- Advocate with parliamentarians and government leaders the review of existing legislation and policies regulating alcohol and drug consumption, and the enforcement of such

- Develop and implement advocacy programmes for national and community level leaders
- Develop a substance abuse enforcement module and training for law enforcement authorities

- Embed comprehensive substance abuse communications within mass media, community-level, and interpersonal initiatives
  - Conduct formative assessments to determine the nature, breadth, and depth of alcohol and cannabis abuse on HIV prevention efforts, as outlined in the National HIV and AIDS Research agenda
  - Develop and implement a HIV prevention and substance abuse module for incorporation into existing training programmes
  - Develop and implement mass media and community mobilisation substance abuse campaigns

Key considerations:

Many stakeholders perceive substance abuse to be a major driver of Lesotho's epidemic but few substance abuse services exist in country to date. Building on regional promising practices, substance abuse programmes should integrate outreach-based HIV prevention services with addiction recovery treatment services, community support groups, and HIV case management for infected clients. Addiction recovery treatment services should include detoxification, residential rehabilitation, family- and community-focused transitional services, and after-care and self-help support. Local organisations should have the capacity to host Alcoholics Anonymous support groups. During the piloting phase, substance abuse programmes should target HIV-infected individuals on ART treatment.

Substance abuse regulation should address gaps in enforcement, including alcohol outlet licensing, sales to minors, and opening and closing times. Advocacy with parliamentarians and government leaders should lead to a review of existing legislation and policies regulating substance abuse. Enforcement solutions might include partnerships at the district and community levels with government, community, and traditional leaders and law enforcement bodies and increasing the tax on alcohol sales.

Intermediate Outcome 1.1.7: Reduction of risky sexual practices among at-risk populations

Figure 9: Results for Intermediate Outcome 1.1.7

Outcome Results		Baseline	Result by 2013	Result by 2015
1.1.7a	Increase percentage of individuals from at-risk groups who reported using a condom the last time they had higher-risk sexual intercourse (disaggregated by	TBD in 2011	50% increase	80% increase

	non-married non cohabitating partner, and at-risk group)				
1.1.7b	Decrease percentage of at-risk groups who had more than one sexual partner in the last 12 months (disaggregated by at-risk group)		TBD in 2011	20% decrease	40% decrease
1.1.7c	Decrease percentage of at-risk populations who report experiencing stigma or discrimination (disaggregated by at-risk group)		TBD in 2011	40% decrease	80% decrease
Output Results					
1.1.7.1a	Increase percentage of districts providing minimum packages of prevention services for at-risk groups	all target	TBD in 2011	CSWs: 50% MSM: 50% Prisoners: 50% Herd boys: 50% Disabilities: 50% Single, separated, divorced 50%	CSWs: 100% MSM: 100% Prisoners: 100% Herd boys: 100% Disabilities: 100% Single, separated, divorced 100%
1.1.7.1b	Increase percentage of at-risk population accessing HIV prevention services within a minimum package of services	All target audiences:	TBD in 2011	CSWs: 20% MSM: 10% Prisoners: 50% Herd boys: 30% Disabilities: 20% Single, separated, divorced 30%	CSWs: 60% MSM: 30% Prisoners: 90% Herd boys: 60% Disabilities: 60% Single, separated, divorced: 60%

1.1.7.1c	Increase percentage of districts with programmes targeting stigma, discrimination and human rights	TBD in 2011	50% of districts	100% of districts

Although Lesotho's HIV and AIDS epidemic is severe and generalised, it is important to target at-risk populations with tailored HIV prevention initiatives since many of these populations are embedded within complex sexual networks.

Key strategies and activities:

- Establish and reinforce policy and legislation to enable at-risk populations' access to HIV prevention services
    - Update existing policy, guidelines, standards, and service delivery tools with HIV prevention services for at-risk populations
- Strengthen capacity for the provision of a minimum package of HIV services for at-risk populations within facilities and communities
    - Conduct formative research on at-risk populations to understand dynamics and HIV prevention (sex workers, MSM, prisoners, herd boys, PWD, single, separated, or divorced adults)
    - Map at-risk population size estimates and programming in each district
    - Develop and implement comprehensive HIV prevention programmes targeting sex workers
    - MSM, prisoners, herd boys, adults that are single, separated, or divorced adults, and people with disabilities
    - Train and supervise facilities and outlets that provide "friendly" services to at-risk populations
- Incorporate programming for at-risk populations and stigma and discrimination in all districts as appropriate

Key considerations:

HIV prevention programmes targeted to at-risk population should prioritise the reduction of risky sexual intercourse. The delivery model for reaching at-risk populations should include outreach-based components and be linked to existing resources through functioning referral systems.

Sex workers and MSM: There is little data on sex workers and MSM and HIV prevention in Lesotho, and an immediate priority is formative research to understand the magnitude, dynamics, and behaviours of these populations. HIV prevention strategies targeted to sex workers and MSM should include prioritising a human rights-based approach to ensure access to friendly, high quality services. International best practices for a minimum package of services for sex workers and MSM include: access to legal protection with supporting policies and advocacy, risk reduction counselling, condom and water-based lubricant distribution, HTC,

substance abuse and STI services, viral hepatitis prevention and treatment, support groups, and referrals to vocational training and IGAs. Sex workers and MSM and their male and female partners should also receive referrals to HTC, care, and treatment services. Stigma and discrimination and SGBV services, including PEP, should be incorporated into interventions.

Prisoners: The Department of Correctional Services has developed a workplace HIV and AIDS policy and strategic plan, and a forthcoming strategy on HIV prevention for inmates will be launched. HIV prevention initiatives should be conducted separately for inmates and correctional staff. The minimum package of services should include risk reduction counselling, condom distribution, HTC, SGBV and PEP, STI, and substance abuse services, and the roll out of Positive Prevention services. "Before you go home" HTC and supporting services should be conducted with inmates before they return to their families, and HIV-infected inmates should be referred to Positive Prevention services within their home community with client tracking and follow up by prison authorities and local health facilities.

Herd boys: Herd boys spend many months in the mountains and can be difficult to reach. Initiatives should reach herd boys within their communities when they arrive on a periodic basis, such as during sheep shearing at wool sheds. Programs should ensure that a comprehensive set of referrals is made to HIV prevention services that are "friendly" to this population's situation and needs. Male norms and SGBV initiatives should be stressed in HIV prevention activities. Partners should link into the existing umbrella network for herd boys, *Monna ka Khomo* (The Men of the Cattle), and strengthen the ability of community councils to oversee and report on the activities targeted to herd boys.

Single, separated, or divorced adults: The highest HIV prevalence rates in Lesotho are among adults were previously in union but then become single (such as widowed), separated, or divorced. HIV prevention initiatives should target these adult populations and reach individuals with programs that forcefully address the dynamics that place this segmented part of the population at risk.

People with disabilities: HIV prevention initiatives should be tailored to the needs of disabled children, adolescents, adults and the people who care for them, and address underlying stigma and discrimination. More research should be conducted to understand the specific HIV prevention needs for each type of disability. Activities includes making SBCC and services directly available to PWD in the appropriate format and language (such as sign language and Braille) and conducting comprehensive HIV prevention education in vocational and rehabilitation institutions.

Intermediate Outcome 1.1.8: Reduction of risky sexual behaviours among migrant workers and their partners

Figure 10: Results for Intermediate Outcome 1.1.8

Outcome Results		Baseline	Result by 2013	Result by 2015
1.1.8a	Decrease percentage of migrant labourers and their partners reporting	TBD in	20%	40%

	multiple sexual partners	2011	reduction	reduction
1.1.8b	Increase percentage of migrant labourers and their partners who reported using a condom the last time they had higher-risk sexual intercourse (non-married, non-cohabitating partner)	TBD in 2011	50% increase	80% increase
1.1.8c	Increase percentage of migrant workers with overall knowledge of HIV prevention and appropriate skills and attitudes	TBD in 2011	50% increase	80% increase
Output Results				
1.1.8.1a	Increase percentage of large enterprises/companies that have HIV/AIDS workplace policies and programmes	TBD in 2011	50%	90%
1.1.8.1b	Increase percentage of large scale construction projects with environmental impact assessments with HIV components at the national standard	TBD in 2011	50%	100%
1.1.8.1c	Increase percentage of migrant workers and their partners reporting access to HIV prevention services	TBD in 2011	30%	70%

Labour migration is a major factor contributing to HIV risk, multiple sexual partnering, and concurrency. Labour migration can be international (mostly to South Africa) or domestic. Both the person who migrated for the work and the person left behind at home can engage in risky sexual behaviours that place them and their partners at-risk. The recommendations in this section build on the International Organisation for Migration's *Country Assessment on HIV Prevention Needs of Migrants and Mobile Populations*.

Key strategies and activities:

- Work place programmes in Lesotho implement HIV and AIDS work place policies and programmes in their companies, with a focus on developing a minimum packages of HIV prevention services and outreach programmes to sexual partners
    - Oversee private sector HIV and AIDS work place programme implementation
    - Support MOLE to enhance its coordination role of HIV and AIDS issues within the workplaces
    - Domesticate international and regional protocols relating to health and human rights by the GOL to enable greater legal protection of migrants and mobile populations
    - Integrate work place programme data into the national M&E system

- Conduct advocacy with government officials locally and internationally to gain support for HIV prevention initiatives for migrant populations that work in South Africa
    - Develop and implement advocacy programmes for local and international level leaders
- Integrate HIV prevention components into work place environmental impact assessments
    - Update environmental impact assessment framework with an HIV prevention module
- Develop and implement SBCC to address the issues of risks and protective behaviours for “families left behind”
    - Update HIV prevention sections within work place modules for incorporation into work place programmes and community mobilisation activities
    - Create a sustainable welfare association for seasonal farm/casual migrants for providing HIV and AIDS services

Key considerations:

Mobile populations in Lesotho include international and domestic migrant, casual cross-border migrants, and transportation workers. Many migrant populations can be reached through work place programmes that implement comprehensive HIV prevention programmes targeting workers and their sexual partners. The minimum package of prevention services includes risk reduction counselling, condom distribution, HTC, and referrals to PMTCT, STI, SGBV, and substance abuse and Positive Prevention services. Workplace programmes should build on and expand existing national promising practices, such as the Apparel Lesotho Alliance to Fight AIDS (ALAFA) HIV and AIDS work place programme. Programs targeting mobile populations should map “hotspots” along transportation routes and work place hubs, and design interventions that target the full range of sexual partners, including the range of partners involved in various forms of transactional and commercial sex. Initiatives should consider the use of mobile services and drop-in centres for the target audiences.

Intermediate Outcome 1.1.9: Reduced vulnerability to HIV infection among youth and OVC

Figure 11: Results for Intermediate Outcome 1.1.9

Outcome Results		Baseline	Result by 2013	Result by 2015
1.1.9a	Increase percentage of youth and OVC with HIV prevention knowledge, skills, attitudes, and practices	TBD in 2011	40% increase	80% increase
1.1.9b	Increase percentage of households with OVC who have sufficient income and support services	TBD in 2011	20% of households	50% of households
1.1.9c	Increase percentage of OVC attending school	TBD in 2011	30% of OVC attend school	70% of OVC attend school
Output Results				
1.1.9.1a	Increase percentage of DACs overseeing comprehensive HIV prevention services for youth and OVC	TBD in 2011	20% of DACs	50% of DACs
1.1.9.1b	Increase percentage of communities offering a standardised package of services for youth and OVC	TBD in 2011	30% of communities	60% of communities
1.1.9.1c	Increase percentage of educational programmes targeting OVC	TBD in 2011	50% increase	100% increase

The prevention of the sexual transmission of HIV among youth is a key intervention under both the *National HIV and AIDS Strategic Plan* and the *Health Sector Policy on Comprehensive HIV Prevention*, and this outcome focuses specifically on reducing vulnerability to HIV infection. Throughout the country, youth are vulnerable to HIV. According to the 2009 LDHS, only 24% of children under the age of 18 live with both of their parents. One of every four Basotho children lives with no parents, and is considered to be “fostered”.

Key strategies and activities:

- Embed youth and vulnerability elements into behavioural, biomedical, and structural HIV prevention initiatives
    - Conduct formative research to understand the range and magnitude of attitudes, vulnerability, and risky sexual behaviours for specific segments of youth and OVC
    - Develop and implement a youth and vulnerability communications module for incorporation into existing HIV prevention programmes
    - Expand HIV prevention programmes targeted to youth, with a focus on youth centres and recreational activities
    - Provide training, materials, equipment and personnel to DACs and CCACs so that they have the resources necessary to provide comprehensive services
    - Ensure enforcement of the Child Protection and Welfare Act through advocacy and training
    - Train and supervise DACs and CCACs in overseeing youth, vulnerability, and HIV prevention programmes
    - Scale up the efforts to improve reporting/integration of youth and vulnerability programme data into the national M&E system
- Delivery of a minimum package of services to OVC within all districts of Lesotho
    - Implement and supervise the delivery of a minimum package of services to OVC within all districts
    - Collaborate with the Ministry of Health and Social Welfare to integrate HIV prevention into the 2006 National OVC Policy
- Delivery of programmes to ensure that vulnerable youth and OVC remain in school
    - Update primary and secondary HIV prevention school curricula
    - Implement and supervise the delivery of a standardised package of services to OVC within all districts, including schooling incentive programmes
    -

Key considerations:

Programmes addressing youth and vulnerability should be embedded within comprehensive HIV prevention programmes linked to Intermediate Outcomes 1.1.1 – 6. The following are additional considerations for youth:

Young women aged 15-19 and 20-24: HIV prevalence soars among women at these ages. A key priority is to identify the dynamics, behaviours, and context that drive these infection rates among young women. Issues include the range of behaviours around sexual partnering before and during marriage, reproductive health choices, as well as issues surrounding SGBV. Approaches should address underlying structural issues such as gender norms and cultural practices, and aim to strengthen agency among young women through improved self-efficacy and skill building.

Young men aged 15-19 and 20-24: HIV prevalence also soars among men these ages; HIV prevalence among men aged 15-17 is 0.7% but by the age of 24 is 17.4%. Issues include understanding the behaviours and factors that are driving infections among young men, and the need to created highly focused and targeted programs for this age group.

In-school youth: Partners should work with the Ministry of Education to update primary and secondary school curricula with age-appropriate HIV prevention and life skills messages. Stakeholders should explore whether HIV and AIDS should be a free-standing subject within schooling. Teachers should be leaders in HIV prevention among youth since they work directly

with this audience. Parents' meetings in schools should be used as a forum for HIV prevention, and for enhancing skills around parent – child communication.

Out-of-school youth: Initiatives targeting out-of-school youth should consider peer-based and peer mentor outreach strategies including community-based condom distribution. Age- and context- specific messages should be tailored to specific types of youth, such as "mature" youth under the age of 15 but who are at-risk of HIV infection and/or are sexually active. These youth should be linked to comprehensive health services, including RH/FP, and activities should include recreational activities, IGAs, and counselling to strengthen self-esteem and confidence.

OVC: Many Basotho communities see OVC as very vulnerable to HIV infection. Communities report that male and female OVC are vulnerable to SGBV and rape. Female OVC are seen to be drawn into intergenerational sexual relationships in order to cover their basic living needs, and OVC are not seen as having access to sufficient HIV prevention services. An immediate priority is formative research to understand the magnitude, dynamics, and behaviours for male and female OVC. The recommendations from the research should be used to update the national policy of OVC as well as prevention strategies and programmes targeted to OVC. HIV prevention programmes targeted to OVC should be age- and context-specific, recognising that the inherent vulnerability of being an OVC places children at-risk for HIV infection, even at very young ages.

Parents and caretakers of youth: HIV prevention programmes targeted to youth should include parents and caretakers as key audiences in their approach. Programmes should enhance parent-/caretaker-child communication about HIV, HIV prevention, and sexuality. Parents and caretakers should build skills to help guide their children through the complicated and often confusing choices that affect HIV prevention.

Intermediate Outcome 1.1.10: Mitigated HIV vulnerability through addressing social norms, knowledge, attitudes, and skills

Figure 12: Results for Intermediate Outcome 1.1.10

Number	Results Outcome Level Results	Baseline	Result by 2013	Result by 2015
1.1.10a	Increase percentage of youth and adults who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	38%Women 29% Men 2009 LDHS	50% increase	100% increase
1.1.10b	Increase percentage of youth and adults with accepting attitudes to PLHIV	42% Women 33% Men	50% increase	100% increase

		2009 LDHS			
1.1.10c	Increase percentage of youth and adults that express attitudes that address the vulnerability of women to HIV	TBD	in 2011	50% increase	100% increase
Output Level Results					
1.1.10.1a	Increase number of social and behavioural change communication strategies and programmes incorporating social norms and HIV vulnerabilities	TBD	in 2011	30% increase	60% increase
1.1.10.1b	Increase percentage of prevention programmes that integrate issues around vulnerability and gender norms in existing SBCC initiatives	TBD	in 2011	50% of prevention programmes	90% of prevention programmes
1.1.10.1c	Increase percentage of men reached by initiatives addressing male involvement and male gender norms	TBD	in 2011	30% of men	60% of men

In Lesotho, there are a number of factors that create risk and vulnerability to HIV infection, and these include traditional and cultural practices, risk and vulnerability, the economic climate, and gender norms. Many of these underlying factors are identified as priority areas under the *National HIV and AIDS Strategy* and the *Health Sector Policy on Comprehensive HIV Prevention.* These issues cross cut all HIV prevention initiatives.

Key strategies and activities:

- Embed social norms and vulnerability elements into behavioural, biomedical, and structural HIV prevention initiatives
  - Conduct formative research to understand the nature and dynamics of cross-cutting gender and social norms, cultural practices, and stigma and discrimination
- Embed anti-stigma and anti-discrimination elements into behavioural, biomedical, and structural HIV prevention initiatives
  - Develop and implement stigma and discrimination module for incorporation into existing HIV prevention programmes

- Embed gender, cultural norms, and male involvement elements into behavioural, biomedical, and structural HIV prevention initiatives
    - Develop and implement gender, cultural norms, and male involvement module for incorporation into existing HIV prevention programmes

Key considerations:

There are a number of cross-cutting issues that, within the context of HIV and AIDS, become harmful and increase risk and vulnerability to HIV infection. These include the practice of *chobeliso* (eloping) or *ho kenela* (wife inheritance), which may place families at-risk if the practice is non-consensual or if individuals are infected with HIV. Other cultural practices and beliefs include the widespread acceptability of male prominence in decision-making, dry sex, or domestic violence. Behavioural, biomedical, and structural HIV prevention programmes should address these social norms and practices in their programmes. Key people within families and communities who have the potential to create or mitigate the risk of HIV through their cultural and traditional roles should be engaged in HIV prevention initiatives. For example, mothers-in-law have an influential role in breastfeeding and accessing PMTCT services. Churches and traditional healers are seen as able to support families and individuals affected by HIV – or to undermine HIV prevention efforts, such as encouraging people not to get tested or to discontinue treatment – and should be engaged as key stakeholders in HIV prevention initiatives. SBCC should utilise a whole person approach – spirit, soul, and body – to address deeply rooted behaviours, beliefs, and attitudes.

Outcome 1.2: Increased prevalence of male circumcision

Male circumcision is identified as a key HIV prevention priority in the *Health Sector Policy on Comprehensive HIV Prevention.* High coverage of male circumcision has been shown to be effective in reducing the heterosexual transmission of HIV. It is only the 30% of Basotho men who were circumcised at health facilities who can be considered to have the beneficial protection conferred by the procedure. This is because it is possible that men who were traditionally circumcised did not have their foreskin fully removed.

Intermediate Outcome 1.2.1: Increased numbers of adult and adolescent males (15-49) who have been circumcised as a component within a comprehensive HIV prevention programme

Figure 13: Results for Intermediate Outcome 1.2.1

Outcome	Results	Baseline	Result by 2013	Result by 2015
1.2.1a	Increase percentage of men and adolescents aged 15-49 who have undergone male	52% 2009 LDHS	45%	80%

	circumcision			
1.2.1b	Increase percentage of people who have correct knowledge about the benefits and limitations of male circumcision	TBD in 2011	30%	60%
Output Results				
1.2.1.1a	Increase percentage of clinical facilities offering male circumcision as per WHO quality standards	TBD in 2011	20% of clinical facilities	60% of clinical facilities
1.2.1.1b	Increase percentage of traditional circumcisers receiving capacity building on male circumcision and HIV prevention	TBD in 2011	30% of traditional circumcisers	80% of traditional circumcisers
1.2.1.1c	Increase percentage of men undergoing traditional initiation who receive male circumcision performed to clinical standards	TBD	20% of men	50% of men
1.2.1.1d	Increase percentage of traditional circumcision schools that partner with clinicians to perform circumcisions	TBD in 2011	30% of schools	60% of schools
1.2.1.1e	Increase percentage of communities with comprehensive male circumcision, HIV prevention initiatives, and supporting SBCC	TBD in 2011	30% of communities	60% of communities

Currently, the MOHSW is investigating the possibility of implementing adult and neonatal male circumcision initiatives in Lesotho. The Male Circumcision Task Force has drafted a policy, strategy, and implementation plan for safe, facility-based circumcision. Key tools have been drafted, including the facility readiness assessment and quality assurance tools. The MOHSW has identified nine facilities for potential male circumcision services. The target audiences for male circumcision are adult males, adolescent males, and male neonates.

Key strategies and activities:

- Strengthen capacity for the provision of male circumcision and HIV prevention services
    - Pilot, evaluate, and roll out facility-based male circumcision programmes
    - Integrate male circumcision data into the national M&E system to track personnel, equipment, consumables, and other overheads
- Pilot, evaluate, and roll out facility – traditional circumcision models to standardise the provision and quality of male circumcision and HIV prevention services
    - Train and supervise clinicians who perform circumcision and wound care in traditional circumcision schools
    - Develop and distribute safe male circumcision kits
    - Train traditional circumcisers and leaders in HIV prevention and male circumcision
    - Train youth and men undergoing traditional circumcision in HIV prevention and male circumcision
- Embed male circumcision and HIV prevention elements into behavioural, biomedical, and structural HIV prevention initiatives
    - Develop a national male circumcision communications strategy
    - Advocate for stakeholder buy-in for male circumcision among health policy makers, traditional leaders, and parliamentarians
    - Develop and implement male circumcision communications module for incorporation into existing HIV prevention programmes
    - Develop and implement mass media, community mobilisation, and interpersonal communication campaigns about male circumcision and HIV prevention

Key considerations:

The roll out of safe male circumcision services as an element within a greater package of prevention services for men will require considerably multi-sectoral advocacy at the national, district, and community levels. This comprehensive package of services includes HTC, STI management, infection control, risk reduction counselling, condoms, RH/FP services, and referrals to other social support services. Patient follow up will include an assessment of counselling effectiveness, monitoring of adverse effects, and possibly sero-conversion. Services and capacity must be in place before demand creation and communications are scaled up

Traditional circumcisers should be included as respected key partners in national male circumcision initiatives. In partnership with these traditional leaders, stakeholders should develop, pilot, evaluate, and roll out service models that link facilities to traditional initiation schools. Using promising best practices from within Lesotho, clinical nurses should partner with initiation schools and, during initiation rites, conduct the actual cutting involving the full removal of the foreskin and assist with wound treatment. Health care facilities should provide safe male circumcision kits, including razors and infection prevention supplies, to the initiation schools. Traditional circumcisers already oversee the quality of initiation schools, and quality assurance standards should be expanded to include the provision of HIV prevention education, safe male circumcision kits, and the application of universal precautions. Chiefs and traditional circumcisers should engage families and young men prior to initiation rites on HIV prevention education and the role of safe male circumcision within a wider package of prevention services.

Intermediate Outcome 1.2.2: Increased numbers of infants receiving male circumcision

Figure 14: Results for Intermediate Outcome 1.2.2

Outcome Results		Baseline	Result by 2013	Result by 2015
1.2.2a	Increase percentage of male infants who have undergone circumcision	TBD in 2011	20% of infants	40% of infants
1.2.2b	Increase percentage of parents who have correct knowledge about the benefits and limitations of infant male circumcision	TBD in 2011	40% of parents	80% of parents
Output Results				
1.2.2.1a	Increase percentage of ANC and infant and maternal health facilities offering infant male circumcision	TBD in 2011	30% of facilities	70% of facilities
1.2.2.1b	Increase number of districts with SBCC programmes for infant male circumcision	TBD in 2011	50% of districts	100% of districts

Male circumcision for infants is identified as a key HIV prevention priority in the *Health Sector Policy on Comprehensive HIV Prevention.*

Key strategies and activities:

- Strengthen capacity for the provision of medical neonatal male circumcision and HIV prevention services in facilities
  - Pilot, evaluate, and roll out facility-based medical infant male circumcision services
  - Develop and distribute safe infant circumcision kits
  - Establish entry point referral linkages from ANC and infant and maternal health care services
  - Incorporate medical infant male circumcision data into national M&E system
- Embed neonatal male circumcision and HIV prevention elements into behavioural, biomedical, and structural HIV prevention initiatives
  - Develop and implement medical infant male circumcision module for incorporation into existing programmes
  - Promote infant male circumcision within communities
  - Conduct infant male circumcision programmes for parents

Key considerations:

Infant male circumcision is a relatively safe and inexpensive form of male circumcision that is carried out in facilities by trained staff. Infants can be referred to counselling and services from ANC and infant and maternal health care services. Since male circumcision is irreversible, providers must work with parents to determine what might be in the best interest of the child. Parental counselling must include all of the pros and cons of the procedure. Informed consent must be obtained from the parents, the legal guardians, or in absence of both, the primary caretaker.

Outcome 1.3: Decreased vulnerability to HIV infection and STIs

The prevention of STIs and the quality management of STIs is a key intervention under both the *National HIV and AIDS Strategic Plan* and the *Health Sector Policy on Comprehensive HIV Prevention.* Although research indicates that STI treatment is limited as an HIV prevention strategy, the reported presence of an STI is associated with higher HIV prevalence, and it is possible that STIs facilitate HIV transmission between partners.

Intermediate Outcome 1.3.1: Reduction in the behaviours that cause STI infections

Figure 15: Results for Intermediate Outcome 1.3.1

Outcome Results		Baseline	Result by 2013	Result by 2015
1.3.1a	Increase number of adults and youth reporting comprehensive knowledge of STI prevention	TBD in 2011	40% of adults and youth	80% of adults and youth
1.3.1b	Increase percentage of adults and youth reporting safer sex behaviours (see above Intermediate Outcomes 1.1.1, 1.1.2)	Measured by Results 1.1.1, 1.1.3		
Output Results				
1.3.1.1a	Increase number of communities participating in SBCC interventions on STIs	TBD in 2011	30% of communities	60% of communities
1.3.1.1b	Increase percentage of population accessing information on STIs	TBD in 2011	30% of the population	70% of the population

Key strategies and activities:

- Embed STI messages and referrals into behavioural, biomedical, and structural HIV prevention initiatives
  - Develop and implement STI prevention module for incorporation into existing programmes
  - Promote condom use as a method for reducing STIs
  - Conduct interactive mass media and interpersonal communications in concert with STI prevention campaigns.

Key considerations:

Within communities, there is a general low level of awareness of STIs and the relationship with HIV, and stigma associated with STIs and HIV prevent people from seeking early diagnosis and treatment. HIV prevention services and SBCC initiatives should address STIs, including the promotion of safer behaviours such as partner reduction and condom use to reduce STI incidence. Communication priorities include issues surrounding self-diagnosis and the use of over-the-counter or traditional medication, stigma and discrimination as a barrier to accessing services, and the need to treat exposed partners. Community mobilisation should include a stronger male involvement in STI management and other HIV prevention activities.

Intermediate Outcome 1.3.2: Reduction in the number of adults and youth with STIs

Figure 16: Results for Intermediate Outcome 1.3.2

Outcome Results		Baseline	Result by 2013	Result by 2015
1.3.2a	Increase percentage of adults and youth seeking treatment for STIs from a health facility	63% women 51% Men 2009 LDHS	20% reduction	40% reduction
Output Results				
1.3.2.1a	Increase percentage of facilities meeting quality assured standards in STI management	TBD in 2011	40% of facilities	80%of facilities

1.3.2.1b	Increase percentage of people reporting suggestive STI symptoms and seeking treatment for clinical services	TBD in 2011	30% seek clinical services	80% seek clinical services
1.3.2.1c	Increase percentage of adults and youth with STIs in health care facilities who are appropriately diagnosed, treated, and counselled according to national guidance	TBD in 2011	60%	90%

Key strategies and activities:

- Increase the quality of STI services
  - Train and supervise clinical staff in STI management
  - Expand the number of functioning STI surveillance sites from two to eight sites
  - Build laboratory capacity for STI testing
- Incorporate STI prevention communications into existing behavioural, biomedical, and structural HIV prevention programmes
  - Develop and implement an STI prevention module for incorporation into existing programmes
- Increase the quality of the management of STIs within facilities
  - Pilot, evaluate, and scale up innovative STI follow up models, including patient tracking and partner notification and treatment
  - Scale up the provision of "friendly" STI services as a routine component of Positive Prevention and at-risk populations services
  - Integrate STI management into health care services, including ART, TB, and RH/FP services

Key considerations:

Only two of the eight designated STI surveillance sites are functioning, and the data available provides an incomplete picture of the magnitude and nature of STIs in Lesotho. STI surveillance should be expanded to the full eight sites, with data collection and use integrated into the existing HMIS routine data collection system. The provision of high quality STI management should be expanded into primary health care, sexual and reproductive health services, and HIV services, including PMTCT, mobile services, and Positive Prevention. STI management programmes should be targeted to populations at higher risk for sexual transmission of HIV, such as sex workers, discordant couples, and mobile populations. Comprehensive STI services include correct diagnosis by syndrome or laboratory test, the provision of effective treatment at first encounter, risk reduction counselling, the promotion and provision of condoms, partner notification and treatment, and HTC. Facilities should increase the availability of STI management within health centres through laboratory capacity building, commodities security, and systems to ensure treatment adherence.

Objective #2: Reduce mother-to-child transmission of HIV

The prevention of mother-to-child HIV transmission is a key intervention under both the *National HIV and AIDS Strategic Plan* and the *Health Sector Policy on Comprehensive HIV Prevention.* The provision of a full package of PMTCT services can reduce mother-to-child transmission of HIV to less than 2%. These interventions include: antiretroviral (ARV) prophylaxis given to women during pregnancy and labour and to the infant during the first weeks of life; obstetric interventions including elective caesarean delivery, and; safer infant feeding practices. Other aspects of a full PMTCT package of services include: RH/FP services to reduce unintended pregnancies; Positive Prevention services especially focused on safer sexual practices, and; initiatives targeted to the immediate family, extended family, and the surrounding community to create support for the affected individuals and mitigate vulnerability.

Outcome 2.1: Reduction of vertical (mother-to-child) transmission of HIV

The forthcoming revised *National Guidelines for the Prevention of Mother-to-Child Transmission of HIV* from the MOHSW guides all PMTCT programmes in Lesotho and forms the basis for the recommendations made for this outcome. The policy provides direction on the prevention of HIV infections among women and the prevention of unintended pregnancies among HIV infected women, HTC, HIV management in HIV infected pregnant women, ARV regimens for PMTCT, care of the exposed infant, and infant feeding and maternal nutrition in the context of PMTCT.

Intermediate Outcome 2.1.1: Reduction of HIV prevalence in women of reproductive age

Figure 17: Results for Intermediate Outcome 2.1.1

Outcome Results		Baseline	Result by 2013	Result by 2015
2.1.1a	Reduce incidence among women of reproductive age reported within HIV clinics	2.1% 2009	1.88%	1.65%
Output Results				
2.1.1.1a	Increase percentage of women and their partners accessing comprehensive HIV prevention	TBD in 2011	TBD in 2011	TBD in 2011

Key strategies and activities:

- Support HIV disclosure to partners and partner testing

- Promote couple counselling and testing, condom promotion, STI screening and treatment services
- Provide comprehensive clinic-based prevention services that are family-focused and involve couples and active male participation

- The delivery of comprehensive HIV prevention services to all women of reproductive age and their partners, with a focus on the reduction of risky sexual intercourse
  - Develop and implement a comprehensive PMTCT plan with numerical population-based targets and specific strategies for strengthening health systems to achieve scaled-up implementation
- Integration of male involvement into all HIV prevention initiatives
  - Develop and implement male involvement in PMTCT module for incorporation into existing HIV prevention programmes
  - Build the capacity of health care workers, and traditional, religious, and other local opinion leaders to address male involvement in PMTCT through community mobilisation and interpersonal communications

Key considerations:

The primary goal of HIV prevention programmes is to prevent men and women from ever contracting HIV. The associated strategies and activities of Objective #2 intertwine with those from Objective #1: the reduction of the sexual transmission of HIV. These strategies and activities include the reduction of multiple and concurrent sexual partners (Result 1.1.1), consistent and correct condom use (Result 1.1.2), early diagnosis and treatment of STIs (Result 1.3), and the provision of suitable counselling for women and families who are or are not HIV infected (Result 1.1.3). Activities under this objective should position PMTCT as a family-focused approach with the engagement of the mother, father, and other family members as appropriate, with an emphasis on male involvement.

Intermediate Outcome 2.1.2: Reduction of unintended pregnancy in women with HIV

Figure 18: Results for Intermediate Outcome 2.1.2

Outcome Results		Baseline	Result by 2013	Result by 2015
2.1.2a	Reduce levels of unintended pregnancy among HIV – infected women	27%	20%	13%
Output Results				
2.1.2.1a	Increase percentage of HIV-infected women accessing reproductive health services	To be established in 2011	40%	75%

2.1.2.1b	Increase percentage of the number of facilities offering couple counselling with a focus on male involvement initiatives	TBD	TBD	TBD

Key strategies and activities:

- Improved linkages between ART clinics, Positive Prevention services, and PMTCT to RH/FP and "family friendly" HTC services
  - Strengthen measurable referrals and client follow up between ART clinics and Positive Prevention services to RH/FP and HTC services
  - Strengthen capacity of community-based workers and volunteers, lay counsellors, traditional birth attendants, and adherence supporters to promote RH/FP services
- RH/FP services embedded within the PMTCT minimum package of services
  - Integrate RH/FP services into existing PMTCT policy, guidelines, standards, and service delivery tools
- Community-based distributors and community health workers promote and distribute condoms and work with clients to ensure FP needs are being met
  - Strengthen capacity of community-based workers and health workers to promote RH/FP services and distribute condoms
  - Incorporate reporting on community-based condom distribution and RH/FP referrals into national M&E system
- SBCC initiatives incorporate messages and referrals addressing RH/FP and the reduction of unintended pregnancies for HIV-affected families
  - Develop and implement RH/FP and PMTCT module for incorporation into existing HIV prevention programmes
  - Develop and implement mass media, community mobilisation, and interpersonal communications campaigns addressing RH/FP and PMTCT
- Increased male involvement in RH/FP programmes
  - Develop and implement a male involvement chapter in the PMTCT communications module and incorporate it into existing HIV prevention programmes

Key considerations:

RH/FP services help HIV-affected families to better plan their reproductive lives and choose if and when to have children. RH/FP must be established as a core component within PTMCT services with the appropriate development of tools and training updates. Measurable linkages between HIV and AIDS and RH/FP services must be strengthened. PMTCT services, ART clinics, and Positive Prevention programmes should provide counselling on RH/FP, distribute condoms, and refer clients to FP clinics for more counselling and method options (this activity links to Result 1.1.2: correct and consistent condom use).

Intermediate Outcome 2.1.3: Reduction of HIV transmission from mother to child

Figure 19: Results for Intermediate Outcome 2.1.3

Outcome Results		Baseline	Result by 2013	Result by 2015
2.1.3a	Transmission rate for prenatal transmission of HIV at 6 weeks, following PMTCT, drops to less than 5% Reduce transmission rate for mother to child HIV transmission to less than 5% by 2015.	TBD 15% 2007	TBD 7.5%	5% 5%
Output Results				
2.1.3.1a	Increase percentage of HIV-infected women giving birth in clinical facilities	61% (2009 LDHS)	80%	90%
2.1.3.1b	Clinical services for PMTCT accessible to more than 95% of pregnant women	60-65% routine programme data)	85%	9%
2.1.3.1c	Increase percentage in HIV-infected pregnant women receiving ARVs for PMTCT.	TBD 71% (MOHSW AJR 2009)(	TBD 87%	98% 95%
2.1.3.1d	Increase percentage of women who start prophylaxis at 14 weeks and continue on prophylaxis throughout breast feeding	0%	40%	75%
2.1.3.1e	Increase percentage of women eligible receiving ART	TBD in 2011	TBD in 2011	95%

Key strategies and activities:

- Expand the number of pregnant women tested for HIV and who know their results
  - Integrate partner-focused HTC in ANC and labour and delivery and reduce potential barriers such as signed consent forms for HIV testing in MCH settings
  - Train health workers to provide both paediatric and adult HIV counselling and testing services as well as psychosocial support, especially for children ·
  - Develop and implement mass media, community mobilisation, and interpersonal communication campaigns addressing ANC attendance and earlier first attendance
  - Strengthen capacity of community-based workers and health workers to promote facility-based labour and delivery services
- Increase ANC attendance and PMTCT service uptake by pregnant women and their infants through service expansion and SBCC

- Integrate the package of services for prevention of mother-to-child transmission (PMTCT) and paediatric HIV care services into the routine maternal and child health package
- Strengthen referral networks for mothers and children that require other HIV and AIDS services within and between health facilities, and between the community and health facilities
- Strengthen capacity for the provision of the minimum package of PMTCT services at all facility levels with strengthened adherence support and case-finding
- Develop and implement district scale-up plans (including the primary health care level) that are aligned with the national PMTCT scale up plan

- Strengthen capacity for the provision of the minimum package of PMTCT services within facilities and communities

  - Review and revise existing national ARV and PMTCT policy and guidelines, and training curricula as needed
  - Strengthen capacity to provide improved access to CD4 testing and clinical staging with advocacy for next generation ARV regimens
  - Strengthen human capacity in PTMCT services delivery at all facility levels through training of core groups of master trainers, orientations of district health teams and integrated supervision of quality improvement
  - Integrate PMTCT programme components of ART, HTC, focused antenatal care, STI management, safe delivery, post natal and TB at all PMTCT sites as well as across partners for effective referral and continuity of care
  - Pilot, evaluate, and roll out innovative mobile and male-friendly PMTCT models to increase accessibility and client follow up
  - Support private medical practitioners to provide comprehensive PMTCT services on the basis of public-private partnership arrangements
  - Strengthen capacity of community health workers and other community leaders to promote and support PMTCT activities.

Key considerations:

There are still significant gaps in the provision of comprehensive PMTCT services throughout Lesotho. Services need to be greatly scaled up and expansion should include increased numbers of health posts in underserved areas, mobile outreach services, and public-private partnership agreements with supervised accreditation among private providers. A comprehensive package of services will include the provision of ARV drugs to mother and infant, safer delivery practices to decrease the risk of infant exposure to HIV, and infant feeding information, counselling, and support for safer practices. Case-finding should be strengthened so that HIV-infected pregnant women who initiated PMTCT and their infants are followed up to completion.

A large proportion of women deliver their infants outside of health facilities. Community health workers, community elders who assist with home deliveries and traditional healers should be educated on PMTCT and appropriate referral mechanisms. At a structural level, PMTCT programmes and SBCC should address a number of economic, cultural, and traditional practices that might hinder access to or full compliance with a comprehensive PMTCT programme. These include the roles of the father and mother-in-law in family planning, service access, and breastfeeding practices and infant feeding practices.

Intermediate Outcome 2.1.4: Improved health status for HIV-infected mothers, their children, and their families

Figure 20: Results for Intermediate Outcome 2.1.4

Outcome Results		Baseline	Result by 2013	Result by 2015
2.1.4a	Decrease percentage of HIV-related illness in HIV-infected mothers	TBD	TBD	TBD
2.1.4b	Decrease percentage of HIV-related illness in infants and young children of HIV-infected mothers	TBD in 2011	TBD in 2011	TBD in 2011
Output Results				
2.1.4.1a	Increase percentage of HIV-infected women accessing follow up services for PMTCT	TBD in 2011	TBD in 2011	TBD in 2011
2.1.4.1b	Increase percentage of men accessing support, and social and behavioural change communication for PMTCT	TBD	TBD	TBD
2.1.4.1c	Increase percentage of HIV-infected women exclusively breastfeeding	30%	TBD in 2011	90%
2.1.4.1d	Increase percentage of mothers receiving a minimum package of Positive Prevention and support services	TBD	TBD	TBD

Key strategies and activities:

- Provide long-term prevention, treatment, care and support services to families with young children born of HIV-infected mothers
    - Scale up access to early infant diagnosis at all PMTCT sites in all the districts ·
    - Strengthen the linkages between PMTCT services, paediatric HIV treatment, the integrated management of childhood illness (IMCI) services, and care and support services
    - Strengthen capacity for the provision of the minimum package of PMTCT services at all facility levels with strengthened adherence support and case-finding
    - Develop and implement mass media, community mobilisation, and interpersonal communication campaigns addressing treatment literacy for HIV exposed infants
- Develop and implement SBCC, with a focus on community mobilisation, to increase male involvement in PMTCT services
    - Develop and implement mass media, community mobilisation, and interpersonal communications addressing male involvement and PMTCT
    - Strengthen capacity of health care providers and community volunteers to support male participation in PMTCT and reproductive health services
- Strengthened systems to manage client flow and follow up through the breastfeeding period

- Integrate nutrition support as a component of the package of services for rolling out antiretroviral therapy and promoting innovative approaches such as nutritional kits and ready-to-use food
- Build capacity of staff in selected facilities to adopt national PMTCT guidelines on infant feeding
- Ensure that appropriate messages on the importance of infant feeding and nutrition are incorporated into existing communication plans, especially for HIV-infected lactating women and children

- Provide Positive Prevention services to HIV-infected mothers with client follow up
  - Strengthen Positive Prevention referrals for mothers and children that require other HIV and AIDS services within and between health facilities, and between the community and health facilities

Key considerations:

PMTCT requires a family approach with active participation from such key family figures as fathers and mothers-in-law. Men greatly influence their wives' decision to attend ANC, PMTCT, and Positive Prevention services, or their participation in partner testing. Mothers-in-law are also highly influential in PMTCT matters, including when to start breastfeeding and the length, duration, and types of infant feeding practices within the extended family. Programmes should form men- and mother-in-law support groups and services to help support affected families and infants, as well as male-friendly PMTCT services in which men can receive health care services from male providers. HIV-infected women and children should be referred to adult and paediatric Positive Prevention services for long-term support.

Objective #3: Prevent the blood-borne transmission of HIV

The prevention of blood-borne transmission of HIV is a key intervention under both the *National HIV and AIDS Strategic Plan* and the *Health Sector Policy on Comprehensive HIV Prevention.* Although blood-borne transmission of HIV is not thought to account for many new infections in Lesotho, it is important to maintain low levels of blood-borne transmission.

Outcome 3.1: HIV infection through blood transfusion eliminated

The 2006 MOHSW's *National Blood Transfusion Policy* guides the practices of the Lesotho Blood Transfusion Service (LBTS) and forms the basis for the recommendations made for this outcome. The policy provides direction on the coordination of a national blood transfusion service and delivery system and guidelines for blood donor recruitment. Other elements include guidelines on the provision of safe blood and blood products, related clinical use, quality assurance standards and processes, data collection, and human resources management.

Intermediate Outcome 3.1.1: Incidence of HIV infection through blood transfusion is reduced to and remains at zero

Figure 21: Results for Intermediate Outcome 3.1.1

Outcome Results		Baseline	Result by 2013	Result by 2015
3.1.1a	Decrease number of infections through HIV transmission through blood transfusion	TBD in 2011	0	0
Output Results				
3.1.1.1a	100% of donated blood units screened for HIV in a quality assured manner	1.4 units/1,000 (2007) 100%	6 units/1,000 100%	10 units/1,000 (WHO minimum) 100%
3.1.1.1b	Decrease percentage of blood units collected and screened by LBTS which are identified as reactive for HIV by an LBTS laboratory	4.5% (2007)	1% (WHO minimum)	1% (WHO minimum)
3.1.1.1c	Increase percentage of blood donations from voluntary, non-remunerated donors	TBD in 2011	Voluntary non-remunerated donations account for 4 units/1000	Voluntary non-remunerated donations account for 8 units/1000

Key strategies and activities:

- Ensure that the screening of all blood donated for transfusion meets WHO standards
  - Build capacity of staff to perform and supervise state-of-the-art blood screening procedures
  - Procure and maintain blood screening supplies and commodities
- Decentralise blood screening and transfusion services to three additional districts

- Build capacity of new clinical staff in blood screening, testing procedures, and supervision
- Procure equipment and commodities to expand blood screening and transfusion services to three additional districts
- Conduct advocacy among parliamentarians to increase financial support for appropriate blood safety infrastructure, staffing, and supplies

- Increase the number of voluntary, non-remunerated donors, especially among youth, to increase blood donations
  - MOHSW and LBTS to pilot, evaluate, and roll out mobile blood collection services
  - Conduct community mobilisation, especially among young people, to expand and increase the blood donor pool through voluntary, non-remunerated donors
  - Develop and implement a blood donation communications module to be incorporated into existing HIV prevention programmes
  - Develop and implement blood donor clubs, especially for young people
  - Incorporate blood donor data into the national M&E system

Key considerations:

In order to maintain low levels of blood-borne transmission, blood screening will continue to be implemented and monitored to WHO standards with the intent to reduce the percentage of screened blood units infected with HIV from 4.5% to the WHO standard of 1% or less. To increase the national blood supply, partners will support the MOHSW and LBTS to increase the number of voluntary non-remunerated donors. LTBS is establishing decentralised blood collection centres in Maseru, Leribe, and Mohale's Hoek districts and advocacy among parliamentarians will help ensure adequate funding levels for national blood transfusion services.

Outcome 3.2: Blood-borne HIV transmission in and out of clinical settings is reduced

The World Health Organization estimates that approximately 5% of new infections in developing countries are attributed to unsafe health care infections. Infection prevention, injection safety, and waste management aim to protect health care workers, clients, and other facility- and home-base personnel from accidental HIV exposure. These include the proper use and disposal of hazardous materials, the use of PEP within a comprehensive set of services to reduce HIV infection during occupational exposure, and a reduction in the number of unnecessary injections.

Intermediate Outcome 3.2.1: The number of blood-borne HIV infections in clinical settings is reduced

Figure 22: Results for Intermediate Outcome 3.2.1

Outcome Results	Baseline	Result by 2013	Result by 2015

3.2.1a	Decrease percentage of occupational HIV infections in clinical settings	TBD in 2011	30% decrease	70% decrease
Output Results				
3.2.1.1a	Increase percentage of health facilities implementing universal precautions to WHO recognised standards	TBD in 2011	40% of facilities	80% of facilities
3.2.1.1b	Increase percentage of persons provided with post-exposure prophylaxis (PEP) after occupational and non-occupational exposure	TBD in 2011	70% exposed provided PEP	95% exposed provided PEP
3.2.1.1c	Increase percentage of health facilities with no stock outs of new sterile syringes/ gloves/safety boxes in the prior six months	TBD in 2011	50% of facilities	95% of facilities
3.2.1.1d	Increase percentage of health facilities with final disposal method for health care waste	TBD in 2011	50% of facilities	95% of facilities

The 2006 MOHSW's *Health Sector Policy on Comprehensive HIV Prevention* states that all HIV prevention interventions in the health sector shall be offered as a comprehensive HIV prevention package, and these include the application of universal precautions, PEP, medical waste disposal, and injection safety in all health care settings. The *National Strategic Plan for HIV and AIDS* has also prioritised the reduction of blood-borne HIV transmission in clinical settings.

Key strategies and activities:

- Develop and implement a national strategy for the provision of PEP in occupational and other settings
  - Train and supervise public sector staff on the provision of PEP
  - Integrate PEP data into the national M&E system
- Strengthen the capacity of health and non-health care workers who have the potential to be exposed accidentally to HIV to implement infection prevention measures; provide appropriate supplies
  - Train and supervise public sector staff on infection control, waste management, and waste disposal
  - Develop infection control and PEP module for incorporation into existing HIV prevention programmes

- Develop and implement a national strategy for the provision of PEP in occupational and other settings
- Integrate PEP and infection control communications into community mobilisation activities

- Ensure the consistent and continuous forecasting, distribution, and availability of supplies
  - Train and supervise public sector staff on PEP commodity forecasting and management
  - Train and supervise public sector staff on waste disposal boxes commodity forecasting and management

Key considerations:

An updated strategy to reduce blood-borne HIV transmission in clinical settings, based on a national assessment, should be finalised by 2011. The strategy will address the clinical and managerial staff capacity building, quality assurance, and supportive supervision in infection prevention, infection control, universal precautions, waste management, and PEP. Other recommendations will address the continuous availability of supplies and equipment, including safety syringes and needles, gloves, PEP kits, and safety boxes.

A national PEP strategy will addresses issues around health worker capacity, supply, rolling out PEP to the defined appropriate level of health facility, and health care worker and community education on PEP. PEP administration includes first aid care, counselling and risk assessment, HTC, and short-term ARV drug provision with follow up. The development and delivery of a national PEP strategy overlaps with Result 1.1.5 (sexual assault and PEP).

Intermediate Outcome 3.2.2: The number of blood-borne HIV infections outside clinical settings is reduced

Figure 23: Results for Intermediate Outcome 3.2.2

Outcome Results		Baseline	Result by 2013	Result by 2015
3.2.2a	Decrease percentage of accidental HIV infections occurring in communities (outside of clinical settings)	TBD in 2011	30% decrease	70% decrease
Output Results				
3.2.2.1a	Increase percentage of target audience (e.g. traditional healers, circumcisers, home-based care givers, elders that assist with home deliveries) that implements community focused infection	TBD in 2011	20%	60%

	control and waste disposal practices			
3.2.2.1b	Increase percentage of people administering home-based care and home delivery services accessing a basic infection control package (including gloves and other infection prevention supplies)	TBD in 2011	40%	80%

A gap in the national HIV prevention response is the reduction of blood-borne HIV infections in community settings, and many Basotho at the community level have expressed concern about this issue. These include people who are involved in traditional healing, traditional circumcision, home-based care of PLHIV, and home-based deliveries. There is little data on infection control and waste disposal methods at the community level.

Key strategies and activities:

- Develop and implement national programmes for the prevention of blood-borne HIV transmission outside of clinical settings
    - Conduct an assessment to inform a strategy to reduce blood-borne HIV transmission outside of clinical settings
    - Capacity building in HIV prevention, waste disposal and the provision of a basic infection control kit for people in the community who have the potential to be exposed accidentally to HIV (targeted to traditional healers and circumcisers and people who assist with home-based deliveries and home-based care of PLHIV)
    - Develop and implement a national policy on the reduction of blood-borne HIV transmission outside of clinical settings
- Strengthen the capacity of health and non-health care workers who have the potential to be exposed accidentally to HIV to implement infection prevention measures; provide appropriate supplies
    - The development, procurement, and distribution of a basic infection prevention kit for community settings
    - Develop and implement infection control and a PEP module for incorporation into existing HIV prevention programmes for community settings
    - Develop and implement blood-borne HIV transmission prevention and a PEP module for incorporation into existing programmes
    - Conduct interactive mass media and interpersonal communications for the prevention of blood-borne HIV transmission within community settings and PEP services

Key considerations:

Accidental HIV exposure may occur in community settings such as during home-based labour and delivery, while performing home-based care for HIV-infected individuals, or during

traditional circumcision. A strategy to reduce blood-borne HIV transmission outside clinical settings and in the community should be finalised by 2011. The strategy will address capacity building among members of the community who have the potential to be exposed to HIV, the provision of supplies and protective equipment through a basic infection control kit, community-based disposal of waste materials, and referrals to PEP services. These recommendations link to other indicators in this document (Result 2.1 PMTCT; Result 1.1.4 Positive Prevention services and the provision of a basic care kit; and Result 1.2 male circumcision, specifically within traditional settings).

Objective #4: Strengthen the systems necessary for an effective National HIV prevention response

Lesotho must continue to invest the financial, technical, and material resources into strengthening key support systems in order to sustain an effective national HIV response. The main elements of a systems strengthening approach, as outlined in the following section, are policy and legislation, coordination, an enhanced evidence base, human resources and technical capacity, sound infrastructure and functioning supply chains. Strong, informed, and committed leadership that is accountable to the GOL and to the people of Lesotho is necessary to ensure that equitable and effective processes and systems for HIV prevention will sustain the impact of investments and achievements over time. Functioning systems will require participation in and commitment from stakeholders at national and decentralised levels, and the strategy therefore outlines key strategies to build the capacity of stakeholders so that they have requisite knowledge and skills to plan, implement and monitor HIV prevention interventions.

Outcome 4.1: A policy, legal, and advocacy environment established for effective implementation of HIV prevention

Lesotho has made a concerted effort to strengthen its policy and legislative environment, and has focused on enacting laws and policies designed to protect individuals made most vulnerable by HIV from discrimination and exploitation. However, there are still major gaps in policy development with respect to at-risk and vulnerable populations, and challenges remain with the finalisation, dissemination, application, and enforcement of laws and policies relevant to HIV prevention

Intermediate Outcome 4.1.1: Increased implementation of policies and legislation related to HIV prevention

Figure 24: Results for Intermediate Outcome 4.1.1

Outcome	Result	Baseline	Result by 2013	Result by 2015
4.1.1a	Policies and legislation developed are effectively implemented	TBD, 2011 NCPI	TBD in 2011	TBD in 2011

		score		
Output	Result			
4.1.1.1a	Change in score in NCPI reflects progress in the development and implementation of HIV prevention policies and legislation	TBD, 2011 NCPI score	TBD in 2011	TBD in 2011

As noted in Intermediate Outcome 1.1.8, dissemination and monitoring of existing policies have been cited as weaknesses in several reviews of the national HIV and AIDS response, particularly at the community level and in the workplace. The timely dissemination of key strategic documents, and increased advocacy efforts, including education and sensitisation campaigns are urgently needed. With respect to HIV prevention and the need for increased evidence-based programme planning, one of the major priorities is to develop and finalise policies and legislation that specifically target at-risk groups, including herd boys, MSM, sex workers, prisoners, and migrant workers.

Key strategies and activities:

- Strengthen the HIV prevention component of new (to be developed) HIV and AIDS-related policies, legislation, and strategies, as well as current policies when they are under review
  - Ensure that key HIV prevention stakeholders assist in the review and development of existing and new policies, legislation, and strategies
  - Domesticate ratified conventions, policies and regulations
  - Document all the policies that have been developed (e.g., via a database)
- Develop standardised, basic procedural guidelines for dissemination of new HIV prevention policies, strategies, and legislation at national and decentralised levels
  - Translate laws and policies into operational activities and deliverables that can be monitored
  - Ensure all policies and laws are translated into Sesotho; create shorter, synthesised documents tailored to different audiences at the community and district levels
  - Provide public, private, and civil society sectors with training on the application and enforcement of policies and laws, especially at district and community levels
- Improve implementation and enforcement of key policies, legislation, and strategies among public, private, and civil society sectors
  - Organise multisectoral forums/mid-term reviews for all strategies and programme areas with respect to policy and legislation development and implementation, and ensure findings feed into ongoing programming
  - Develop a monitoring tool (questionnaire) for use by a multisectoral taskforce to assess implementation among key stakeholders

Key considerations:

Chronic delays in policy development, dissemination, and implementation with respect to HIV prevention need to be systematically addressed. The GOL should focus on accelerating the development of all outstanding policies and legislation and prioritise an agenda for new document development. In addition, a clear strategy for the organised dissemination and monitoring of strategic documents – one that is feasible at the national and decentralised levels – should be created and implemented. Mid and/or annual reviews should include a specific component dedicated to reporting on the progress of implementation of activities under this Intermediate Outcome. Documents need to be translated into Sesotho in as timely a manner as possible, and the district and community level structures should facilitate sensitisation meetings to ensure that the communities have access to policies and directives in a timely and appropriate fashion.

Intermediate Outcome 4.1.2: Increased leadership by community, religious, and political leaders in development of HIV prevention advocacy, policy, and legislation

Figure 25: Results for Intermediate Outcome 4.1.2

Outcome	Result	Baseline	Result by 2013	Result by 2015
4.1.2a	Increased commitment and participation among leaders from community, religious, and political sectors in development of HIV prevention advocacy, policy, and legislation	TBD, 2011 NCPI score	TBD in 2011	TBD in 2011
Output	**Result**			
4.1.2.1a	Increase in number of representatives from civil society organisations and community structures trained in HIV prevention program and advocacy initiatives	TBD, 2011	TBD in 2011	TBD in 2011

Opportunities under this strategy include expanding support among key constituencies, especially at the community level. A range of networks have significant influence in Lesotho, notably the faith-based organisations, the labour movement, PLHIV, NGOs, and CSOs. In addition, traditional and cultural leaders, including chiefs, elders, and medical healers, play a vital role within their communities, especially with respect to sexual and cultural practices, health seeking behaviour, and service access within villages and communities. Political leaders have influence both at the national and local levels, and have the mandate and authority to advocate on behalf of their constituents. Enlisting leadership within these networks is essential to

achieving effective results in decentralised HIV prevention initiatives, particularly with respect to addressing key structural drivers of the epidemic via policies and legislation.

Key strategies and activities:

- Develop a comprehensive national HIV advocacy strategy that includes significant representation of and participation from traditional, religious, labour and political leaders, especially at the community level
    - Identify advocacy capacity needs in the country
    - Develop community advocacy package and strategy targeted to traditional, religious, labour and political leaders to build their capacity
    - Train community and district structures (CCs, DCs, CCACs, DACs), umbrella organisations and networks, and CSOs (including FBOs, CBOs and NGOS) working at community level in coordination, lobbying, and advocacy to influence HIV policies and programmes
    - Ensure regular stakeholder forums for advocacy, policy and legislation include traditional, religious, and political leaders
    -

Key considerations for achieving the outputs:

Advocacy work is critical in order to influence policy decisions, prioritise resource allocation, and assist communities in understanding how to access, utilise, and demand key HIV prevention services. Structures that help coordinate activities among specific constituencies should be targeted in efforts to increase advocacy efforts at the community level. In addition, districts should continue to work with existing fora specifically for traditional leaders. There is a need for focused capacity building at the community and district level focusing on building skills both in advocacy (media engagement, community engagement) and in understanding and addressing how HIV impacts their communities. This is especially important for addressing structural issues that influence the epidemic, such as stigma and discrimination or gender norms, as well as epidemic drivers such as multiple and concurrent partnerships, condom use, and alcohol abuse.

Intermediate Outcome 4.1.3: Increased usage of media channels by civil society within the HIV prevention response

Figure 26: Results for Intermediate Outcome 4.1.3

Outcome	Result	Baseline	Result by 2013	Result by 2015
4.1.3.a	Increased number of radio and community media channels airing civil society perspectives on policies and programmes relating to HIV prevention	TBD in 2011; Media monitoring data needed	To be established in 2011	To be established in 2011

Output	Result			
4.1.3.1a	Increased number of journalists, editors and media owners engaged in civil society participation in HIV prevention policies and programming	Baseline to be established in 2011	TBD in 2011	TBD in 2011
4.1.3.1b	Increased percentage of communities with active community media channels working on generating dialogue and engagement with HIV prevention	Baseline to be established in 2011	TBD in 2011	TBD in 2011

The media covers HIV prevention issues within Lesotho, and during the last few years has moved beyond simple sponsored public service announcements (PSAs) into more integrated campaigns, including *Know Your Status* and *One Love*. National political figures, such as the Right Honourable the Prime Minister Pakalitha Mosisili, have increasingly engaged the media to highlight the scourge of HIV in the country. However, more attention and effort could be paid to utilising the media – especially radio – for advocacy purposes, to generate increased discussion and debate on key policy and legislative issues, and combat audience fatigue around HIV prevention issues. The media is also an important mechanism for fostering government accountability for HIV prevention responses, and stakeholders should engage the media in relation to this role. Community media is also important in providing locally tailored information and communication opportunities within appropriate formats to defined audiences.

Key strategies and activities:

- Build capacity of the media via trainings and workshops so that it reports issues of HIV prevention legislation and programmes in a critical, accurate and responsible way
    - Engage youth groups in the development of relevant programming for radio shows, working in collaboration with Lesotho stations
    - Provide trainings/workshops to print media organisations, TV, and radio stations and agencies on issues related to HIV as well as correct messaging
    - Ensure high media coverage for key HIV prevention days, e.g., national testing day
    - Continue to provide motivators/incentives to journalists (e.g., the Red Ribbon Media Award)
    - Promote and support radio talk shows about HIV, especially with phone-in/question and answer formats
    - Develop mechanisms to provide accurate and topical information to journalists on issues of HIV prevention (e.g. websites, reporting toolkits, etc.)
- Include a section in the Draft media policy to regulate reporting on HIV and AIDS and Sexual/Reproductive Health issues

- Strengthen community media channels (including dance, theatre, music groups) to generate dialogue, debate and engagement with HIV prevention issues
    - Ensure access to necessary infrastructure in communities, e.g., community halls, radio and TV channels
    - Promote cultural activities at community level

Key considerations:

The media environment within Lesotho is increasingly more open to the airing of plural perspectives on HIV, and can play an important role in improved national debate and dialogue on HIV prevention. Stakeholders should adopt a number of strategies around media training, working with editors and media gate-keepers, strengthening community media, and improving access to the media. The aim of these strategies is to build the media's capacity for reporting on HIV prevention, fostering accountability among all sectors on performance in relation to HIV prevention, particularly with CSOs. While all types of media should be utilised, community media and radio are particularly important forms of media (primarily due to low levels of television ownership) followed by print.

Outcome 4.2: Coordination and management of the decentralised HIV prevention response is strengthened

Lesotho has adopted a multisectoral approach in the coordination and implementation of the national response, which is premised on the "Three-Ones" principles. NAC has the overall responsibility for the coordination of the national response and is responsible for the development and coordination of national policies, strategies and programmes for combating HIV and AIDS, while the MOHSW is responsible for coordinating the HIV and AIDS response within the health sector. At the operational level, the coordination of the response to HIV and AIDS has been decentralised to districts, umbrella organisations, and key government ministries such as the Ministry of Local Government and Chieftainship (MOLGC) and the Ministry of Gender, Youth, Sport and Recreation. While coordination mechanisms are in place, there are opportunities to clarify the roles and responsibilities of stakeholders from a number of sectors with respect to HIV prevention activities, and to increase the capacity of coordinating structures, especially at the decentralised level.

Intermediate Outcome 4.2.1: An effective multi-sectoral response to HIV prevention in accordance with the National Coordination Framework and National Multi-Sectoral HIV Prevention Strategy

Figure 27: Results for Intermediate Outcome 4.2.1

Outcome	Result	Baseline	Result by 2013	Result by 2015
4.2.1a	Increased number of annual operational plans for HIV prevention developed by	75%	85%	90%

	public, private, and civil society organisations that are aligned and implemented in accordance with the National Coordination Framework and the *National Multi-Sectoral HIV Prevention Strategy*			
Output	Result			
4.2.1.1a	Increased number of MOUs and/or contracts signed among public, private, and civil society partners for implementing HIV prevention activities in accordance with the national strategies	Baseline to be established in 2011	TBD in 2011	TBD in 2011

The success of the national HIV prevention response depends in large part on ensuring effective management and coordination of all key stakeholders involved in the response. In addition to a strong policy and legislative environment, there must be clearly defined and understood roles and responsibilities of all partners involved in the response, especially to avoid duplication of services. NAC has made efforts to carry out advocacy work to ensure that all stakeholders are familiar with the National Coordination Framework and the *National HIV and AIDS Strategic Plan*. However, additional effort is required to ensure ongoing commitment by all stakeholders to the national prevention response with respect to coordination of efforts.

Key strategies and activities:

- Strategic partnerships and alliances for the implementation of the national prevention response are consolidated and improved through strengthened implementation of the *National Strategic Plan on HIV and AIDS* and *National Multi-Sectoral HIV Prevention Strategy*
    - Scale-up the effectiveness of the working groups among key stakeholders from all sectors at national, district, and community levels by defining roles and responsibilities in the prevention response
    - Review and disseminate HIV strategy documents and frameworks – e.g. *the National Coordination Framework*, the *National HIV and AIDS Strategic Plan* and the *National Multi-Sectoral HIV Prevention Strategy* – to all key stakeholders from all sectors
    - Revise or develop a standardised manual and curriculum for training on the strategies and frameworks
    - Scale-up technical assistance to sectors and development partners to harmonise and align their prevention action plans with the *National Strategic Plan on HIV and AIDS* and the *National Multi-Sectoral HIV Prevention Strategy*

Key considerations:

At the national and decentralised levels, there is a need for an increase in the number of formalised partnerships among public sector entities, civil society, and private sector

organisations involved in HIV prevention. The *National Framework* specifically mandates relevant stakeholders at central and district levels to enter into MOUs, which can provide guidance for agreements between the sector specific bodies and their affiliates, stipulate the M&E requirements at each level, and ensure accountability and transparency. Also, as suggested in the *National Strategic Plan for HIV and AIDS* mid-term report, a national HIV and AIDS coordination manual outlining specific roles and responsibilities for each coordinating institution should be developed, with a clear focus on HIV prevention service provision.

Intermediate Outcome 4.2.2: Increased capacity at decentralised level to develop and effectively coordinate HIV prevention initiatives

Figure 28: Results for Intermediate Outcome 4.2.2

Outcome	Result	Baseline	Result by 2013	Result by 2015
4.2.2a	Percentage increase in districts and communities with operational DACs and CCACs constituted and operating according to their terms of reference	DACs: 100% CCACs: 26%	DACs: 100% CCACs: 75%	DACs: 100% CCACs: 100%
4.2.2b	Percentage increase in DACs and CCACs with *Essential HIV and AIDS Services Package* annual plans aligned to the objectives of the *National Multi-Sectoral HIV Prevention Strategy*, and other prevention policy documents	TBD in 2011	DACs: 75% CCACs: 75%	DACs: 100% CCACs: 100%
Output	**Result**			
4.2.2.1a	Percentage of district and community councils receiving technical training and support to develop and manage functional DACs and CCACs	TBD in 2011	DCs: 75% CCs: 75%	DCs: 100% CCs: 100%
4.2.2.1b	Percentage of DACs and CCACs receiving technical training annually on planning and operalisation of the *Essential HIV and AIDS Services Package*	TBD in 2011	DACs: 75% CCACs: 75%	DACs: 100% CCACs: 100%

The *National Coordination Framework* articulates a vision for HIV and AIDS programme coordination at the district level via the Gateway Approach, which is the government's

decentralisation plan for all development activities, including HIV prevention. Local Authorities serve as “gateways” for development activities, using existing district government coordination mechanisms under the auspices of the MOLGC. With respect to HIV and AIDS, the Gateway Approach was operationalised via a strategy known as the *Essential HIV and AIDS Services Package* launched in 2007. This document provides all stakeholders (NAC, MOHSW, other ministries, CSOs, NGOs, private sector) with a platform to enable the effective facilitation and implementation of their HIV and AIDS responses, and emphasises community participation as paramount in the national response, particularly in the area of HIV prevention.

Key strategies and activities:

- Provide technical assistance to DCs and CCs to create and/or formalise CCACs in every community council area, including the development of terms of reference for technical assistance to help DACs and CCACs to develop, implement, and document community participatory planning and engagement processes
    - Use existing partnership forums to disseminate information on DAC and CCAC functions
    - Create formal platforms for involving community members and generating dialogue on community planning that align to the GOL annual budgeting cycle
    - Support DACs and CCACs to develop, implement, and document community participatory planning and engagement processes
- Support CCs and DCs to initiate process of CCAC development
    - Engage in advocacy work with CCs and DCs, as well as with community-based organisations to motivate finalising CCACs in each council
    - Ensure that District AIDS Chairpersons attend high-level meetings
- Provide training to DACs, CCACs, and community-based service providers in coordinating and implementing evidence-based HIV and AIDS strategies aligned to national strategic plans
    - Use forthcoming MOHSW tools being developed for DHMTs integration of HIV prevention at district, facility, and community levels
    - Ensure MOHSW's district HIV prevention operational plans are in synch with CCACs and DACs plans
    - Facilitate annual workshops at community level (involving CCACs) for CSOs, NGOs, FBOs, and the private sector to set strategy for the application of the *Essential HIV and AIDS Services Package*
    - Provide technical assistance to CCSPs on using evidence in proposal/strategy development

Key considerations:

Securing buy-in from stakeholders for the *Essential HIV and AIDS Services Package* approach has been inconsistent across districts, and overall, there is variation in the level of participation among districts and communities. Advocacy work, technical support, and community engagement efforts should be increased to motivate finalising CCACs in each of the 128 community councils, and to ensure the ongoing participation of both CCACs and DACs. Capacity should be built with respect to managing programmatic planning and implementation,

financial reporting, and data collection. Decentralised structures should also focus on capitalising on existing platforms or developing new ones for involving community members in the HIV programme planning process, with a particular focus on involving traditional chiefs.

Intermediate Outcome 4.2.3: The National HIV prevention response is adequately funded

Figure 29: Results for Intermediate Outcome 4.2.3

Outcome	Result	Baseline	Result by 2013	Result by 2015
4.2.3a	Percentage of key strategies and activities within the costed National Multi-Sectoral HIV Prevention Operational Plan that are fully funded	TBD in 2011	100% (starting in year 2012)	100%
Output	**Result**	**Baseline**	**Result by 2013**	**Result by 2015**
4.2.3.1a	Annual HIV prevention funding needs accurately quantified in the national annual planning and budgeting process	TBD in 2011	TBD in 2011	TBD in 2011

Since 2007, resources for the national HIV and AIDS response have increased by 140% but only 12% of the financial resources is spent on HIV prevention. Also, prevention is in 4th place in terms of funding by thematic area, behind OVC, programme management, and care and treatment. For the implementation of this national strategy, it is imperative that adequate resources are raised and disbursed for prevention efforts, especially for priority interventions in the areas of HTC, male circumcision, condoms, SGBV interventions, Positive Prevention, PMTCT, and cross-cutting SBCC initiatives. Furthermore, as discussed in the following section, an adequately funded research strategy will complement the national M&E system, which is being strengthened and decentralised in order to inform planning and resource allocation.

Key strategies and activities:

- Build capacity at central and district levels to mobilise and manage resources
    - Train stakeholder representatives on resource mobilisation skills (proposal writing and grant negotiations), including the development of joint stakeholders fundraising proposals (e.g. Global Fund proposals)
    - Provide training to DACs and CACs on fundraising and financial management and reporting, and development of annual budgets

- Advocate for increased funding from the GOL for prevention activities
    - Provide technical support to line Ministries to aid the development of annual budget plans to include HIV prevention activities (minimum 2% of recurrent budget)
    - Re-issue policy directive on mainstreaming HIV prevention activities in all government ministries, departments, and agencies
    - Finalise and disseminate local government policies on HIV and AIDS prevention funding, allocation criteria, disbursements and sustainability to decentralised structures (with provision of training)
    - Earmark/"ring fence" prevention funds versus other HIV thematic areas
- Fast-track implementation of the National HIV and AIDS Resource Mobilisation Strategy and Resource Tracking and Management Systems
    - Develop terms of reference for implementation of the system
    - Hire technical advisors to develop the system

Key considerations:

In order for Lesotho to effectively mobilise the resources it needs for HIV prevention activities, there must be increased collaboration in annual planning among all sectors and stakeholders. Stakeholders would also benefit from training on resource mobilisation skills (e.g., proposal writing, performance-based disbursements), including the development of joint stakeholders fundraising proposals (e.g., Global Fund proposals). In addition, training on financial management and reporting should be a priority, especially at the district and community level. The policy directive on mainstreaming HIV prevention activities in all government ministries, departments, and agencies should be reissued and technical support should be provided to line Ministries to aid the development of annual budget plans to include HIV prevention activities. Development partners should also try, where possible, to channel funding through government coordinated mechanisms that support the overall national response, as opposed to funding implementing partners directly. In addition, development partners should try to report their contributions on an annual basis to the GOL to ensure that the figures are included in the annual budgets.

Outcome 4.3: The effectiveness of HIV prevention responses is strengthened through use of strategic information

Evidence-based, informed HIV prevention interventions are a priority cited in both the *National Strategic Plan* for *HIV and AIDS* and the *Health Sector Policy on Comprehensive HIV Prevention.* Commitment to and investment in expanding access to quality strategic information is needed to ensure that programmes are grounded in empirical data and regularly evaluated. Data from the monitoring and evaluation systems should constantly be used to inform programme and policy decision-makers. The national prevention response must incorporate research, surveillance and monitoring and evaluation data into its routine review. Underscoring these efforts is a need to invest in building the capacity of staff to ensure a workplace trained in generating and using quality data.

It is critical to scale up the undertaking of baseline surveys, studies and operational research as well as implementing the research agenda to address the existing gaps on the baseline information in this prevention strategy 2011-2015 during its implementation.

Intermediate Outcome 4.3.1: HIV prevention data utilised in national annual planning and annual partner work plans

Figure 30: Results for Intermediate Outcome 4.3.1

Outcome	Result	Baseline	Result by 2013	Result by 2015
4.3.1a	Increased number of DACs and CCACs that incorporate HIV prevention data in annual *Essential HIV and AIDS Services Package* planning processes	TBD in 2011	TBD in 2011	TBD in 2011
4.3.1b	Increased number of civil society organisations implementing HIV prevention programmes that incorporate HIV prevention data in annual work plan processes	TBD in 2011	TBD in 2011	TBD in 2011
Output	**Result**	**Baseline**	**Result by 2013**	**Result by 2015**
4.3.1.1a	One harmonised, national M&E system strengthened and operationalised at all levels	TBD in 2011	TBD in 2011	TBD in 2011
4.3.1.1b	Increased number of individuals trained in strategic information (includes M&E, surveillance, and/or HMIS)	TBD in 2011	TBD in 2011	TBD in 2011

One of the top priorities for the national HIV prevention response is to ensure that high-quality data is generated, collected, compiled, and disseminated on a regular basis to all stakeholders involved in the prevention response. Progress has been made in terms of the scale and quality of strategic information necessary for useful planning, primarily through concentrated efforts to strengthen the M&E system and the capacity of M&E staff at all levels. However, serious challenges remain that impact HIV prevention efforts, especially at the district and community levels. There are still multiple formats for data collection being used by the public sector, and between the public and private sector. Data collection, analysis, and usage remain limited, particularly at the decentralised level, and data quality is inconsistent.

Key strategies and activities:

- Promote and enable adherence to soon-to-be-completed national M&E plan
  - Finalise development of national M&E plan; train stakeholders at national and decentralised levels
  - Finalise development of M&E indictors for the *Essential HIV and AIDS Services Package* that are linked to the national framework
- Complete rollout of LOMSHA at all levels (national, district, and community)
  - Carry out advocacy with stakeholders for compliance (reporting, use of national indicators, etc.) with requirements for LOMSHA
  - Facilitate necessary trainings among stakeholders on how to work with LOMSHA
- Invest in and expand capacity to implement newer technologies to capture and analyse data from the community to the national level; where possible, replace paper-based reporting
  - Conduct assessment of viability of switching from paper to electronic formats; evaluate developments in MIS to determine if new, appropriate technologies could be implemented
- Strengthen community monitoring systems and utilisation of information to improve programme development
  - Support efforts to improve regular attendance at M&E Technical Working Team monthly meetings at national level, and district Technical Working Group M&E teams' quarterly meetings
- Ensure cross-border collaboration on data collection for HIV prevention within migrant populations
  - Continue to support the SADC initiative to harmonise data collection tools and indicators for mobile/migrant populations (14 country cross-border initiative)
- Strengthen M&E capacity of staff in all sectors involved in HIV prevention response
  - Develop national human resources plan for increasing the number and capacity of M&E personnel, especially for MOHSW and CHAL, and at district and community levels
  - Provide training and support on data collection, analysis, and compilation skills to all stakeholders, especially at community level
  - Create and institutionalise accredited M&E training, and/or identify and support a training institution that would provide M&E trainings

Key considerations:

Finalising the rollout of LOMSHA should be prioritised and completed in tandem with the revised National M&E Plan. An emphasis should be placed on building the capacity of a cadre of M&E specialists including at the sub-national level.

Data quality remains a significant problem and is a result primarily of a lack of human capacity. There is also a need to ensure that programme indicators are harmonised as much as possible with national indicators, for purposes of reporting. This includes indicators for the *Essential HIV and AIDS Services Package*, which were not developed during the initial phase of the project.

Intermediate Outcome 4.3.2: HIV prevention strategies and initiatives are informed by current, up-to-date research and evidence

Figure 31: Results for Intermediate Outcome 4.3.2

Outcome	Result	Baseline	Result by 2013	Result by 2015
4.3.2a	Increased number of HIV prevention studies undertaken i.e research projects, studies and surveillances	TBD in 2011	TBD in 2011	TBD in 2011
Output	**Result**			
4.3.2.1a	HIV and AIDS database updated annually	Database exists	Annual update	Annual update
4.3.2.1b	Increased number of staff who receive training in HIV prevention research and analysis skills	TBD in 2011	TBD in 2011	TBD in 2011

Empirical evidence is needed in order to make informed decisions on the nature and type of HIV prevention strategies to adopt. Without evidence, identifying the “last 1,000 infections” becomes nearly impossible. A robust research agenda – with adequate financial and human resources to support it – is needed to inform the HIV prevention response and guide programme planning, especially the identification of key factors, drivers, and populations. Significant opportunities remain with respect to research in Lesotho, including activities that strengthen organisations’ abilities to align interventions to the most current data on the epidemic.

Key strategies and activities:

- Implement the national Research Agenda and prioritise surveillance, population, and operational research studies, and studies on at-risk populations
    - Plan for and conduct the third Demographic Health Survey (DHS) in 2014
    - Conduct sentinel surveillance studies (STIs, ANCs) every 2 years
    - Convene stakeholder symposium to define national priorities for studies on at-risk populations
    - Implement a national HIV prevention service mapping survey
    - Ensure that funding needs for HIV prevention research are quantified in the annual HIV prevention budget
- Develop mechanisms for improved sharing and dissemination of research

- Develop a national repository for HIV prevention research reports, including research and assessments
- Strengthen the already ongoing documentation of best practices to cover lessons learned, case studies, etc. in HIV prevention in Lesotho and regionally
- Establish clear linkages between the Research Coordination (NAC) and key sectors involved in the HIV prevention response
- Establish a formal mechanism for non-governmental agencies involved in conducting research to share studies with NAC

- Develop national capacity building programmes for research
  - Conduct capacity needs assessment for biomedical, operational and social research
  - Initiate continuous human resources development programmes for HIV and AIDS research

Key considerations:

In addition to identifying the need for a more robust M&E system, as outlined in the previous section, Lesotho should focus on developing a robust HIV research plan, and initiate continuous human resource capacity building to conduct qualitative and quantitative research. The HIV research and evaluation agenda should be prioritised based on input from key HIV and research stakeholders, and should include surveillance studies on key populations, and assessments. In addition, there is a need to further investigate the factors that put youth at-risk of HIV. This includes the dynamics and behaviours of particular types of youth, such as in- and out- of school youth, herd boys, and young women who work away from home, and by type of partner, such as casual partners, transactional, and intergenerational partners. In addition, more operational research is needed to determine the effectiveness of HIV interventions. Other research needs include service delivery mapping, which can provide valuable information on types and levels of activity per geographical (or administrative) area, especially if it can be linked to epidemiological data. In addition, mechanisms to disseminate studies in a timely fashion among stakeholders (not only those involved in commissioning the report) need to be strengthened. Support for training in the use and application of research, especially among implementers, should also be introduced.

Outcome 4.4: Improved capacity for HIV prevention service delivery

The gravity of the HIV epidemic has severely strained the health care system in Lesotho. There is a need to build and maintain levels of capacity in relation to staffing, technical competence and infrastructure. Many organisations and institutions lack the numbers of staff required and the levels of skills required for effective service delivery. Skills shortages are particularly acute in programme management, financial management, SBCC, and M&E. In addition, more and improved facilities are required, including vehicles, buildings and equipment. The procurement system must be strengthened to allow for the timely delivery of the right commodities and supplies to the right facilities, in the right amounts and at the right time. The following outcomes focus on building capacity, including improved standards of service provision, client flow and supply chain management.

Intermediate Outcome 4.4.1: Improved technical and logistical capacity to implement the HIV prevention response

Figure 32: Results for Intermediate Outcome 4.4.1

Outcome	Result	Baseline	Result by 2013	Result by 2015
4.4.1a	Percentage increase in government structures providing or coordinating HIV prevention services, programmes, or technical support reporting they have the required level of human resources	TBD in 2011	TBD in 2011	TBD in 2011
4.4.1b	Percentage increase in government facilities with staff that perform to a defined technical or quality standard in the delivery of HIV prevention services and programmes	TBD in 2011	TBD in 2011	TBD in 2011
4.4.1c	Decreased number of government facilities that attribute lack of infrastructure (buildings, vehicles, commodities and equipment) to failure in providing services	TBD in 2011	TBD in 2011	TBD in 2011
Output	**Result**	**Baseline**	**Result by 2013**	**Result by 2015**
4.4.1.1a	Increased number of government structures whose HR policies and practices meet a defined standard	TBD in 2011	TBD in 2011	TBD in 2011
4.4.1.1b	Increased number of staff from government structures trained in HIV prevention skills, activities, and interventions	TBD in 2011	TBD in 2011	TBD in 2011
4.4.1.1c	Percentage increase of health facilities that make required improvements after undertaking an infrastructure audit	TBD in 2011	TBD in 2011	TBD in 2011
4.4.1.1d	Percentage decrease of health facilities at district and community level reporting stockouts of key HIV prevention commodities	TBD in 2011	TBD in 2011	TBD in 2011

Key strategies and activities:

- Implement the health sector human resources development and strategic plan
  - Support the implementation of the Health Sector's Human Resources and Strategic Plan
  - Develop a Human Resources Strategic Plan for MOLGC structures at the district and community level, based on the MOHSW's plan
- Develop and execute a comprehensive training plan specifically to address gaps identified in a capacity needs assessment
  - Conduct capacity assessment to map and gauge capacity in relation to human resources, and technical capacity for HIV prevention
  - Implement a standardised technical capacity audit for government structures involved in HIV prevention response to assess gaps
  - Develop a training programme for health sector project activities
  - Provide opportunities for health staff to access long distance learning through National Health Training College, and extensive in-service or on-the-job training in a number of HIV prevention areas
  - Provide training to community workers, lay counsellors, TBAs, DOTS facilitators, CBCGs, VHWs and service providers from FBOs (and CHAL) in HIV prevention
  - Provide regular training to community health workers, DACs and CCACs on HIV prevention issues, including HTC, PMTCT and infant and young child nutrition and support
- Develop the infrastructure capacity (available facilities and service provision) for the national HIV prevention response
  - Identify areas of need for infrastructure development
  - Mobilise resources for the identified needs
- Improve supply chain management for HIV prevention commodities
  - Map and appraise the quality of storage and distribution mechanisms
  - Conduct rapid assessments to identify skills gaps in basic supply chain management for HIV prevention commodities among community-based organisations
  - Disseminate procurement guidelines to all stakeholders involved in procurement, storage, and distribution of HIV prevention commodities
  - Develop a profile of key role-players and structures in HIV commodity distribution
  - Develop community-based storage facilities for HTC materials and condoms
  - Develop and execute a training plan to address gaps identified in the assessment; focus on procurement, supply and management procedures to ensure legal compliance
  - Finalise the Comprehensive Condom Programme strategy
  - Ensure regular working groups/meetings of the Reproductive Health Commodity Security – Condom Programming Technical Working Group and RHCS/CCP Coordinating Committee to monitor policy implementation, identify challenges, and lobby for needed resources

Key considerations:

The human resources, technical capacity and infrastructure required for a functioning HIV prevention response require urgent attention. The on-going rehabilitation of existing health facilities and clinics and the construction of new rural and peri-urban health facility clinics under the Millennium Challenge Account reflects an ongoing commitment to provide improved health

facilities and services to enhance service delivery in the fight against HIV and AIDS. Additional assessments, including mapping exercises, are required to gauge what support is still needed to build the human resources, technical capacity, infrastructure and procurement systems for an effective response. Special attention is given to procurement, as regardless of the specific type of prevention intervention, or type of facility providing the services, successful HIV prevention efforts require a continuous availability of adequate numbers of supplies, commodities, and equipment.

Recruitment and retention across all sectors remains a challenge. A number of improvements within the public health sector are now underway and should be closely monitored. Local Basotho organisations also suffer from a lack of staff skilled in HIV prevention. Under the aegis of NAC, CSOs are identifying barriers to their ability to implement programmes, and are developing strategic plans for capacity building. Self-identified issues include governance, financial and programme management, and M&E. These plans should be supported via funding, and/or the provision of technical assistance and support.

5.0. Resources required for full coverage

The resources required to achieve the coverage targets of the National Multi-sectoral HIV Prevention Strategy will be approximately US$ 293 million over the five year period from 2011 to 2015. Condom provision will require more resources than any other intervention. PMTCT and Women and Girls focused interventions will be second and third respectively. The annual scale up of resources required and the distribution by intervention are shown below:

Figure 33: Financial requirements for prevention strategy by intervention for 5 years (In Millions of US Dollars)

Interventions	2011	2012	2013	2014	2015	2011-2015
Priority Populations						
Youth	1.99	1.59	1.16	0.71	0.38	5.83
Female sex workers	0.11	0.11	0.12	0.13	0.13	0.60
Workplace programs	3.87	3.98	4.12	4.26	4.43	20.66
Men who have sex with men	0.09	0.12	0.15	0.18	0.21	0.75
Community mobilization	0.46	0.60	0.76	0.93	1.13	3.87
Women and Girls	4.58	5.20	5.88	6.61	7.41	29.69
Prisoners	0.03	0.05	0.06	0.07	0.09	0.29
Migrant Populations	0.17	0.22	0.28	0.34	0.41	1.41
People with Disabilities	0.18	0.23	0.29	0.36	0.43	1.49
Herd Boys	0.05	0.06	0.08	0.09	0.11	0.39
Service Delivery						
Condom provision	19.91	21.17	22.52	23.92	25.41	112.94
STI management	0.45	0.46	0.47	0.47	0.48	2.33
HIV Testing and Counseling	1.19	1.02	0.85	0.65	0.44	4.14
Male circumcision	1.44	1.50	1.57	1.64	1.71	7.86
PMTCT	4.19	5.10	6.10	7.15	8.27	30.81
Mass media	3.28	3.42	3.58	3.74	3.91	17.92
Health Care						
Blood safety	0.02	0.02	0.02	0.02	0.02	0.08
Post-exposure prophylaxis	0.01	0.01	0.01	0.01	0.01	0.05
Safe medical injection	0.03	0.03	0.03	0.04	0.04	0.16
Universal precautions	0.10	0.12	0.14	0.16	0.18	0.70
Sub-Total	**42.13**	**45.02**	**48.15**	**51.48**	**55.19**	**241.96**
Policy, admin., research, M&E	8.87	9.48	10.14	10.84	11.62	50.96
TOTAL (Millions of US Dollars)	**51.00**	**54.50**	**58.29**	**62.32**	**66.81**	**292.92**
TOTAL (Millions of Maloti)	**357.00**	**381.50**	**408.04**	**436.23**	**467.67**	**2,050.43**

5.1 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.

6.0 Implementation Arrangements

6.1 Ensuring Implementation

Implementation of this National HIV Prevention Strategy 2011-2015 will take place at community, district and national (central) levels. Various stakeholders have specific interventions to implement on the basis of their mandates and comparative advantage. Management and coordination of interventions is done at all the three levels; while at policy decision making and leadership level, the accomplishment of the efficacy and efficiency of the results in scaling-up the national response to the HIV epidemic are enhanced and endorsed accordingly.

Coordination is guided by the National Coordination Framework that was developed in close consultation with all stakeholders. All sectors are obliged to align their prevention interventions and annual action-plans to the HIV Prevention strategy where the country's priorities are articulated. The strategy is accompanied by a three-year rolling operational plan that is updated on an annual basis to ensure effective implementation. The Operational Plan clearly spells out activities to be undertaken by players in different sectors so as to provide a general guide in downstream planning on Prevention.

6.2 High Level Multi-Sectoral National Response Committee.

There is a need to establish a high level Multi-Sectoral National Response Committee which is a high level HIV and AIDS results and service delivery assurance committee that will oversee and advise on the implementation of the National HIV and AIDS Strategic Plan that encompasses all other national HIV and AIDS strategies including the National Prevention Strategy.

6.3 The National Prevention Thematic Team

The national prevention thematic team with NAC as its secretariat is to ensure that the results in scaling-up the national response to the HIV and AIDS epidemic are achieved through a multi-sectoral and participatory approach at the policy decision making level in the country through the participation of the Public, Private Sector and Parastatal Organizations, the Civil Society Organization, the Development Partners and International NGOs.

6.4 Operationalisation of the HIV Prevention strategy at the District and Community Levels

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 at the district level, and therefore, they are the most appropriate bodies to be the custodians of this strategy 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, each of the 128 Community Councils have Community Council AIDS Committees (CCACs) which are multi-sectorally constituted by all key stakeholders to coordinate implementation of HIV and AIDS interventions and ensure stakeholder involvement in planning and execution of planned activities.

6.5 Monitoring and Evaluation

Effective implementation of this National HIV Prevention Strategy 2011-2015 is monitored and evaluated by using updated and revised versions of the monitoring and evaluation tools that will collect, process, validate, analyze 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 National M&E plan 2011-2015 with clear indicators will be used to monitor and evaluate implementation of this strategy. Furthermore, monitoring of progress on implementation will be done through bi-annual and annual partnership fora at both district and national levels.

7.0 Conclusion

Although Lesotho has made significant strides in its national HIV prevention response, incidence in the country remains high and, due to the complexity of the epidemic, current challenges require a reinvigorated multi-level, combination programme approach. The fact that HIV prevalence rates have not improved during the five years between the two LDHS studies underscores this need. The Government of Lesotho is committed to an intensified, comprehensive response in HIV prevention, one that involves stakeholders from multiple sectors at national, district, and community levels. Therefore, the goal in developing this five-year *National Multi-Sectoral HIV Prevention Strategy* has been to create an ambitious, results-oriented agenda, aimed at reducing HIV incidence by 50% by 2015.

The strategic framework, accompanying five-year M&E plan, and costed Operational Plan will serve to guide and coordinate the efforts of those agencies and institutions working at national, district and community levels. Narrative sections of this document on key strategies, activities and considerations describe target audiences and the manner in which the interventions can be operationalised.

The priorities identified (listed as objectives in section 4.2.1 of this document), and interventions addressing them include:

- reducing the sexual transmission of HIV, through, among others, HTC, increased SBCC and Positive Prevention, male circumcision, and OVC and youth friendly prevention initiatives and services
- reducing mother-to-child transmission through PMTCT
- preventing blood borne transmission of HIV, through improved medical practice and monitoring, and through improved workplace safety and SGBV initiatives
- strengthening systems, through an improved policy, legal and advocacy environment, coordinated programme management, enhanced use of strategic information, improved human resources and infrastructure, and resource mobilisation for the foregoing.

The National Multi-Sectoral HIV Prevention Strategy presents an opportunity to redouble HIV prevention efforts in Lesotho. It is a strategy for a comprehensive programme, using evidence-based, innovative approaches. Implementation of the strategy will be most effective with strong coordination and the committed engagement of all stakeholders involved in Lesotho's HIV prevention response.

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