



LESOTHO
UNGASS COUNTRY REPORT

**STATUS OF THE NATIONAL RESPONSE TO THE
2001 DECLARATION OF COMMITMENT ON HIV/AIDS**

January 2006 - December 2007



Abbreviations and Acronyms		NFE	Non-Formal Education
AIDS	Acquired Immuno-Deficiency Syndrome	NGO	Non-Governmental Organisation
ALAFA	Apparel Lesotho Alliance to Fight AIDS	NOCC	National OVC coordination committee
ANC	Ante-Natal Clinics	OPD	Out Patient Department
ART	Anti-retroviral Therapy	OVC	Orphan and Vulnerable Children
ARV	Anti-retroviral	PCR	Polymerase Chain Reaction
BCC	Behaviour Change Communication	PEPFAR	US President's Emergency Plan for AIDS Relief
CCM	Country Coordination Mechanism- Global Fund	PMTCT	Prevention of Mother To Child Transmission
CRIS	Country Response and information System	PSI	Population Services International
DCPT	District Child Protection Team	SAFAIDS Dissemination	Southern African HIV/AIDS Information Service
DFID	Department for International Development (United Kingdom)	STI	Sexually Transmitted Infections
DHS	Demographic Health Survey	TB	Tuberculosis
DNA	Dioxyribose Nucleic Acid	UNAIDS	Joint United Nations programme on HIV/AIDS
EC	European Commission	UNDP	United Nations Development Programme
FAO	Food and Agriculture Organisation	UNFPA	United Nations Population Fund
GBEM	Girls & Boys Education Movement	UNGASS	United Nations General Assembly Special Session
GFCU and	Global Fund Coordination Unit, Ministry of Finance Development Planning	UNICEF	United Nations Children's Fund
GIPA	Greater Involvement of People living with HIV-AIDS	USG	United States Government
GoL	Government of Lesotho	WFP	World Food Programme
GTZ	German Technical Assistance	WHO	World Health Organisation
HAART	Highly Active Antiretroviral Therapy		
HIV	Human Immunodeficiency Virus		
HMS	Health Management Information System		
HTC	HIV testing and Counselling		
ICW	International Council of Women living with HIV		
IEC	Information Education & Communication		
ILO	International Labour Organisation		
IMAI	Integrated Management of Adult Illnesses		
KYS	Know Your Status (Campaign)		
LBTS	Lesotho Blood Transfusion Service		
LDHS	Lesotho Demographic Health Survey		
LENEPHWA	Lesotho Network of People Living with HIV-AIDS		
LIPAM	Lesotho Institute of Public Administration & Management		
LIRAC	Lesotho Inter- religious AIDS Council		
LPPA	Lesotho Planned Parenthood Association		
M&E	Monitoring & Evaluation		
MGYSR	Ministry of Gender, Youth, Sport and Recreation		
MOET	Ministry of Education and Training		
MOHSW	Ministry of Health and Social Welfare		
NAC	National AIDS Commission		
NAP+	Network of African People Living with HIV/AIDS		

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Preparation of the UNGASS Report 2008

The preparation of the UNGASS report was led by the National AIDS Commission and involved all the key players and stakeholders in the national response to AIDS. The M&E working group of the National AIDS Commission was tasked with bringing together the report and organizing the consultations. An advisory committee involving key Government ministries, Development partners and civil society organizations was constituted to provide oversight and review the progress made in the preparation of the report. The Ministry of Health and Social Welfare played an important role in analyzing the data related to HIV estimates and prevalence and in providing information related to progress made in the health sector, especially related to HIV testing, ART access, PMTCT, STI treatment, condom programming and OVC. Other key ministries involved include the Ministry of Education and Training, Ministry of Local Government and Chieftainship and the Ministry of Labour. Civil society organizations were involved in the data collection and providing information on programmatic progress. They were also involved in the completion and analysis of the National Composite Policy Index. Members of the civil society organizations as well as development partners were involved in the identification of the major challenges and in proposing remedial actions. The report's best practices were selected after an open and transparent process. The final draft report and indicators were then reviewed and validated at a national workshop.

Status at a glance/ Executive Summary

Epidemiological overview

Lesotho has the third highest adult HIV prevalence in the world at 23.2%. There are an estimated 62 new HIV infections and about 50 deaths due to AIDS each day, as shown in Figure 1. There are an estimated 270,273 people living with HIV in Lesotho as of end 2007. Of these, there are 11,801 infected children and 258,472 infected adults. Females continue to be more infected with an estimated 153,581 infected compared to 116,692 males. There has been no significant change in the national adult HIV prevalence since 2005. The sentinel surveillance conducted in 2007 showed that there is no major difference in HIV prevalence among women attending ANC clinics.

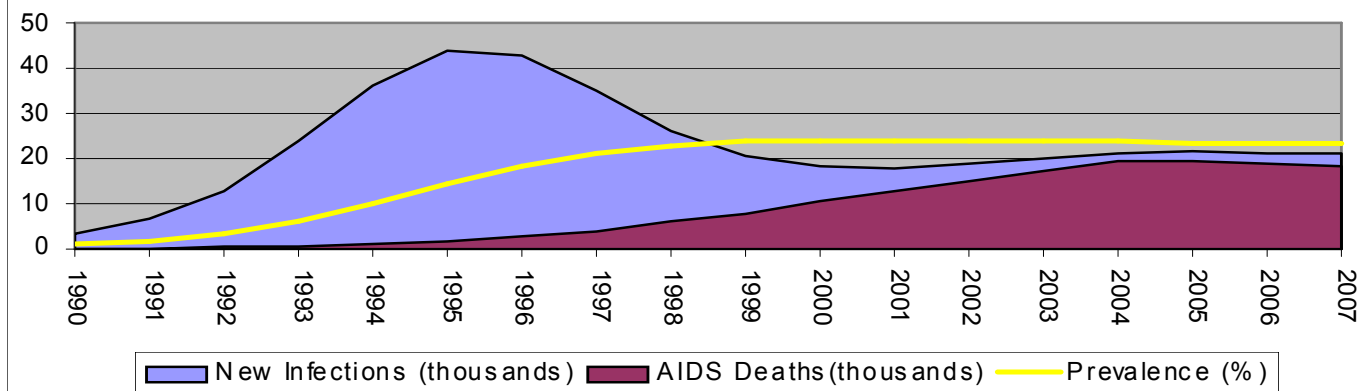
However, there appears to be a slightly downward trend in the HIV prevalence among 15-24 year old young people dropping to 8.9% (7.2% - 11.0%) in 2007 from 11% in 2005. The adjusted HIV prevalence among females aged 15-24 was 14.9% compared to 5.9% among males of the same age. It is now estimated that 81,270 (63,100-98,200) people were in need of ART at the end of 2007. The sentinel HIV Surveillance of 2007 shows that 1.4% of ANC clients and 2.3% of STI clients had syphilis. The prevalence of HIV among STI patients was high at 56.2%, indicating a need for accelerating STI treatment along side other prevention measures.

Policy overview

Lesotho has embarked on an accelerated programme to achieve universal access to HIV prevention, treatment, care and support by 2010, in line with the commitments made at the UN General Assembly Special Session High Level meeting on HIV and AIDS in 2006. At an institutional level, Lesotho has embraced the “three ones” principles and in the last two years has crossed several milestones in the road towards its full implementation. Following an in-depth review of the national response in 2005 involving a range of internal and external stakeholders, an updated National AIDS Policy as well as the National Strategic Plan for 2006-2011 and the National Monitoring and Evaluation Plan was approved by the Government of Lesotho (GoL) in December 2006.

Lesotho has also shown consistent political leadership on HIV and AIDS. Since the declaration of HIV and AIDS as an emergency in 2000, the top political leadership has consistently spoken out and supported the HIV and AIDS response at the highest level. In line with the National HIV and AIDS Policy’s recommendation of preparing sector specific policies, several policies have been developed to support the national HIV and AIDS response. Many of these are in draft stage while a few have been approved. Prominent among the policies approved are the National Orphan and Vulnerable Children Policy and the Blood Transfusion Policy and HIV Testing and Counselling Policy. Lesotho has started a process of developing a comprehensive HIV and AIDS Bill. In developing

Figure 1 Estimated Number of annual new infections and AIDS related deaths in relation to stabilizing trends in prevalence among adults (Source : GoL/UNAIDS estimates)



the Bill it has adopted an inclusive process by setting in motion a widespread consultancy process. The Labour Code (Amendment) Act, No. 5 of 2006 prohibits pre-employment testing, testing during employment,

ensures confidentiality and non-disclosure and prohibits discrimination in employment, amongst others. In 2006, Lesotho passed the Legal Capacity of Married Person's Act providing equal status to married women, who had been previously considered minors under customary law. The enactment of this bill, along with full implementation of the Action Plan on Women, Girls and HIV, is considered key to removing barriers to accessing HIV prevention, treatment, care and support services for women and girls. Further, Lesotho has developed national guidelines for the implementation of HIV workplace programmes.

People living with HIV have come to the forefront of the national response to HIV. The Lesotho Network of People living with HIV and AIDS (LENEPWA) formed in 2005 is increasingly taking a leadership role in coordinating the needs of people living with HIV and in spearheading the Greater Involvement of People living with AIDS (GIPA) principles. They actively participated in the preparation of the National AIDS Policy, Strategic Plan and M&E Plan and were in the consultation process for the drafting of the National HIV and AIDS Bill. Representatives of People living with HIV are included in national decision-making bodies like the Country Coordination Mechanism (CCM), the National HIV and AIDS Forum and the Multi-sectoral Partnership Forum. LENEPWA is also increasingly involved in implementing programmes. They actively participate in promoting the "Know Your Status" campaign, promoting treatment literacy, nutrition support and supporting income generation activities for their members.

In 2007, 15 senior Christian church leaders belonging to various denominations signed a statement of commitment on HIV and AIDS in the presence of His Majesty King Letsie III and the Rt. Honourable, the Prime Minister Pakalitha Mosisili. Since the signing of the statement of commitment, the church leaders have openly spoken about HIV prevention and have also developed a set of key messages to be promoted through the different churches. An inter-faith coordination body to coordinate the faith based response on AIDS, called the

Lesotho Inter-Religious AIDS Consortium (LIRAC) has been established.

Programmatic overview

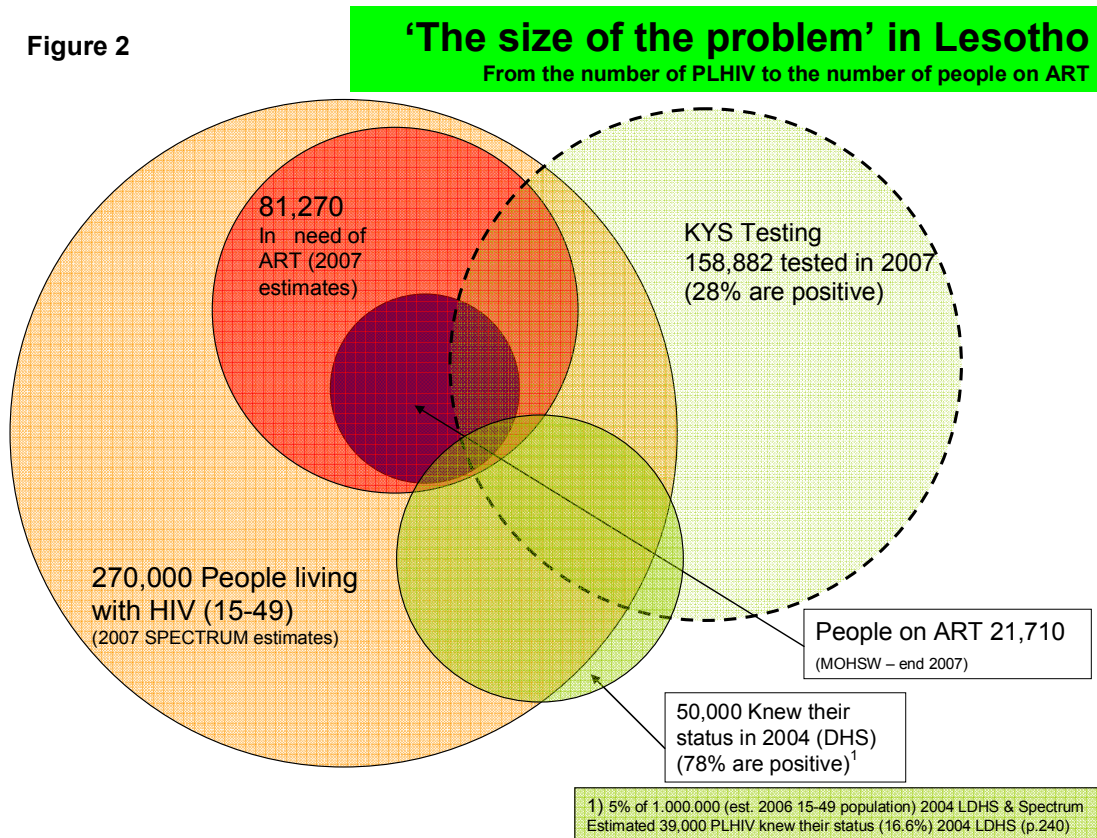
There has been significant progress the rolling out of antiretroviral therapy and food support to people on treatment. At the end of 2007, an estimated 21,710 people were receiving anti-retroviral treatment. At least 3,966 pregnant women with HIV received anti-retroviral treatment to prevent mother to child transmission (PMTCT) of HIV in 2007. The coverage of PMTCT programmes has increased from an estimated 5% in 2005 to 31% in 2007, which is a five fold increase over the corresponding period. A total of 19 hospitals and 116 health centres and private clinics out of 167 health facilities are offering antenatal care (ANC), postnatal care (PNC) and maternity services (103).

In 2007, the total number of people who have ever received an HIV test in Lesotho was 229,092 or 12% of the population, which is about 1.8 million. This represents an increase of nearly three times the number tested in 2005. At the end of 2007, 161 health centres offered HIV Testing and Counselling (HTC). The HTC drive also received strong political support from the top government leadership. Also, several workplace programmes have been initiated in Lesotho. Prominent amongst them is the workplace programme at the Apparel industry, one of the biggest employers in the private sector accounting for nearly 80% of the workforce.

A cumulative total of 376,318 out of school young people learned life-skills in 2006, increasing to 388,741 by June 2007. STIs were among the top ten causes of frequent Out Patient Department (OPD) consultations at health facilities in 2006. Of the 1,091,752 OPD new contacts in 2006, 74,520 (7%) attended for STI complaints. A literature review indicates the presence of sex work in several locations in Lesotho. Around 1.7% of men reported having had paid sex in the last 12 months (2004 LDHS). Out of those, 58% responded that they had used a condom in the most recent encounter. There is also anecdotal evidence on the presence of males who have sex with males. In Lesotho, all blood used for transfusion purposes is screened for HIV.

The current school attendance among orphans and non-orphans aged 10-14 in Lesotho is 1:1 according to the LDHS 2004. This has been achieved through making primary education free and providing bursaries for those in secondary schools. Programmatic data indicates that roughly 32% of OVC are receiving free basic support.

Figure 2



Support of Development Partners

The main development partners involved with the HIV and AIDS response in Lesotho are Irish Aid, United States Government-PEPFAR, European Union, GTZ, DFID, the Global Fund for AIDS, TB and Malaria, World Bank and the UN system. The development partners are committed to the implementation of the “three ones principles” and have used the various platforms provided to them to reiterate their support for the principles.

M&E Environment

The set up and functioning of the NAC in 2005 was instrumental in the development of a National Strategic Plan (2006-2011) with a costed Monitoring and Evaluation Framework (2006 – 2011). The development process of the M&E plan was consultative and endorsed by key stakeholder in M&E such as development partners, local and international NGOs, government ministries and civil society organizations.

Programmatic Challenges

Although Lesotho has made significant progress since the last UNGASS reporting period, the country has been faced with a number of major challenges towards the implementation of the national response, see Figure 2.

Thus, the response is still largely fragmented at the national and district level. The institutionalization of the National AIDS Commission (NAC) in Lesotho is a key achievement towards addressing and coordinating HIV efforts in Lesotho.

Some of the main challenges currently faced include slow progress in achieving behaviour change; low coverage of prevention programmes; limited human resources, especially in the health sector; no proper mechanisms in place to make sustainable and appropriate programmes to mitigate the economic and social impact of HIV and AIDS; increased number of OVC but no clear registration process in place; lack of timely data collection and dissemination; stakeholders not collaborating and coordinating at district and community level and lack of clarity of roles and responsibilities at all levels, and finally the acceptance of NAC as the organization to lead the national HIV and AIDS response.

Resources

It is estimated that a minimum of 547 million US dollars will be required for the period 2006-2011 to fully fund the national response. Five key ministries and of the Government of Lesotho spent approximately US\$ 8.4 Million in 2005-06 and US\$ 8 million in 2006-07 fiscal years.

There has been a significant increase in the amount of resources pledged and available for the HIV and AIDS response in Lesotho. Lesotho has been successful in getting a cumulative of US\$ 114,473,978 from the Global Fund for AIDS, TB and Malaria. Of this support, US\$102,922,867 is earmarked for HIV

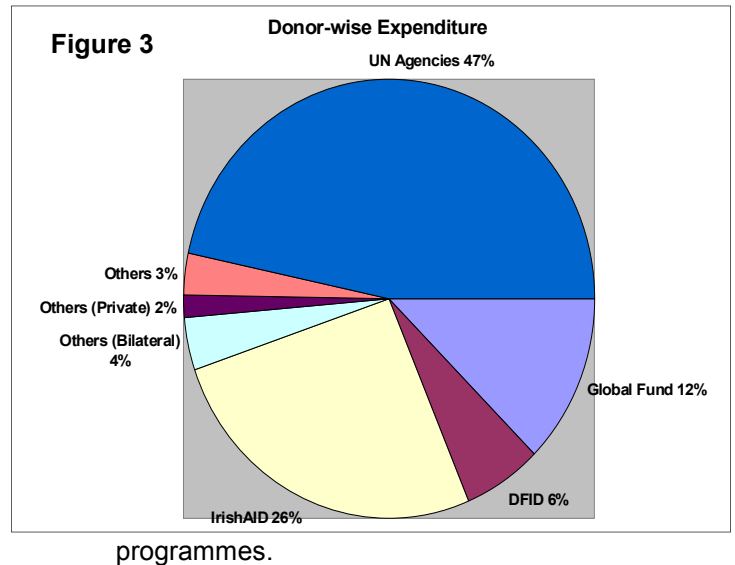


Figure 4 Current sources of funding by programme area (2006-2011)

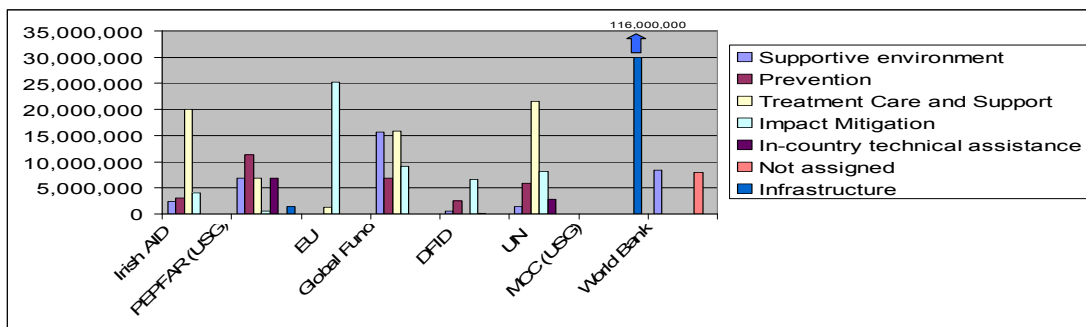
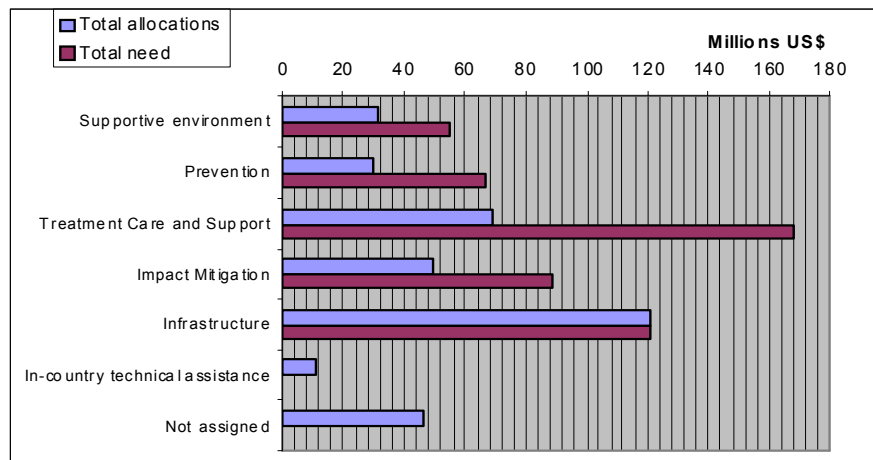


Figure 5 Estimated costs and resources pledged



2007/08 UNGASS Core Indicators Progress

Indicator	2005	2007	Additional Programmatic progress data ¹	Comments
Expenditure				
1) Domestic and International AIDS spending by categories and financial resources.	2003/2004 USD 1,336,949.75 2004/2005 USD 1,357,874.76	Public Expenditure (Fiscal Year – Apr to Mar)* 2005-06: M 58,921,026 2006-07: M 55,779,134 2007-08: M 25,874,428 \$		* Provisional data & collected from 5 ministries. \$ The expenditure for 2007 is reported upto the first half of 2007 1US\$ = 7M (approx)
		External Expenditure (Calendar Year)* 2005-06: M 83,298,401 2006-07: M 122,627,478 2007-08: M 93,273,311\$	The US Government spends an additional 13 million US dollars annually, but expenditure data regarding that was not available.	* Provisional data \$ The expenditure for 2007 is reported upto the first half of 2007 1US\$ = 7M (approx)
Policy Development and Implementation Status				
2) National Composite Policy Index.		Refer to annex I		
National Programmes				
3) Percentage of donated blood units screened for HIV in a quality assured manner.	100%	100% for 2006, 100% for 2007	Lesotho has only one central lab and therefore all the collected blood donated units are sent through to the central lab. The blood units are screened in a quality assured manner.	For the last 12 months (Dec 2006 – Nov. 2007) Numerator: Number of donated blood units screened for HIV in blood centers/blood screening laboratories that have both: (1) followed documented standard procedures and (2) participated in external quality assurance scheme (3026) Denominator: Total number of blood units donated (3026) (Data Source: LBTS 2007)
4) Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.	10.2% ²	25.6%		For the reporting period of Dec 2006 – Nov 2007 Numerator: Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period (21,710) Denominator: Estimated number of adults and children with advanced HIV infection (84,791) Projected from updated 2007 Lesotho population HIV/AIDS estimates produced in Spectrum. (Data Source: MOHSW 2007)

Indicator	2005	2007	Additional Programmatic progress data	Comments
5) Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission.	5%	31.1%		For the reporting period Jan – Dec 2007 Numerator: <i>Number of HIV infected pregnant women who received anti-retrovirals during the last 12 months to reduce mother-to-child transmission (3,966)</i> Denominator: <i>Estimated number of HIV-infected pregnant women in the last 12 months (12,750)</i> (Data source: MOHSW, 2007)
6) Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV.	Not reported on in 2005	No Data Available		Number of adults with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines) within the reporting year. Estimated number of incident TB cases in people living with HIV. It is estimated that the 76% of patient suffering from TB in the country are also infected with HIV according to the WHO TB Global Report (2006). In 2006, only 1907 HIV positive people with TB were identified. However there has been a three fold increase in the first three quarters of 2007 with nearly 4500 people with TB found to be HIV positive and put on treatment. (Date source: MOHSW, 2007)
7) Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results.	Not reported on in 2005	Both male and female: 5.5% 6.3% for women and 4.8% for men (2004 LDHS)	Since the scaling up of the KYS campaign over 200,000 people have taken the HIV test. Between 2006 & 2007, 239,629 people have taken the HIV test representing nearly 12.7% of the total population. In 2007, 158,882 people took the HIV test representing 8.5% of the total population.	Numerator: <i>Number of respondents aged 15-49 who have been tested for HIV during the last 12 months and who know their results (Total: 570 Male: 120 Female: 450)</i> Denominator: <i>Number of all respondents. (Total: 9591 Male: 2496 Female: 7095)</i> (Data Source: 2004 LDHS)
8) Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results.	No data available	No data available		
9) Percentage of most-at-risk populations reached with HIV prevention programmes.	No data available	No data available		

Indicator	2005	2007	Additional Programmatic progress data ¹	Comments
10) Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child.	25%	No available data on this indicator in the 2004 LDHS	About 32% of all OVC get some form of free basic support. In addition, all orphans have access to free primary education and nutritional support while at school.	The measurement tool for this indicator is a population based survey. The measurement criteria is: Medical support within the last 12 months, School-related assistance within the last 12 months, Emotional/psychological support within the last 3 months, Other social support (socio-economic support and/or instrumental support) in the last 3 months
11) Percentage of schools that provided life skills based HIV education in the last academic year.	0%	No data available	The Ministry of Education has trained 450 teachers till August 2007 on life skills education. A total of 30,883 children were taught life skills in school. A draft curriculum has been piloted and is awaiting finalization.	For the reporting year Jan – Dec 2007 Numerator: <i>Number of schools that provided life-skills based HIV education in the last academic year</i> Denominator: <i>Number of schools surveyed</i> .
Knowledge and Behaviour				
12) Current school attendance among orphans and among non-orphans aged 10-14.	1:1 (2004 LDHS)	1:1 (2004 LDHS)	Lesotho has provided for free primary education, and providing for access to education for all children.	Orphan school attendance aged 10-14 Numerator: <i>Number of children who have lost both parents and are still in school (333)</i> Denominator: <i>Number of children who have lost both parents (373)</i> Non orphan school attendance aged 10-14 Numerator: <i>Number of children both whose parents are alive, who are living with at least one parent and who attend school (2,310)</i> Denominator: <i>Number of children both whose parents are alive who living with at least one parent (2,463)</i> (Data source: 2004 LDHS)

Indicator	2005	2007	Additional Programmatic progress data ¹	Comments
13) Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	Male 18% Female 26%	Male 18% Female 26%	Awareness programmes to reach young people have been initiated in all the 10 districts of Lesotho. A total of 376,318 young people out of school have been provided with life skills education. In addition, the outreach programme in the workplace especially the garment industry has targeted young men and women aged 19-24.	This indicator is calculated on the basis of 5 questions: Numerator: <i>Number of respondents aged 15-24 years who gave the correct answer to all five questions (Males: 229 Females: 818)</i> Denominator: <i>Number of respondents aged 15-24 (Males: 1,250 Females: 3173)</i> (Data source: 2004 LDHS)
14) Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	No data available	No available data		
15) Percentage of young women and men aged 15-24 who had sexual intercourse before the age of 15.	Male: 27% Female: 15% (2004 LDHS)	Male 27% Female 15% (2004 LDHS)	A recent analysis of the DHS data showed that the reported age of first sexual intercourse was 19 for girls and 16 for boys.	Numerator: <i>Number of respondents (aged 15-24 years) who report the age at which they first had sexual intercourse as under 15 years (Males: 343 Females: 470)</i> Denominator: <i>Number of all respondents aged 15-24 years (Males: 1,250 Females: 3,173)</i> (Data source: 2004 LDHS)
16) Percentage of women and men aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months.	Male: 21.1% Female: 7.2% (2004 LDHS)	Male: 21.1% Female: 7.2% (2004 LDHS)		Numerator: <i>Number of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months (Male: 528 Female: 511)</i> Denominator: <i>Number of all respondents aged 15-49 (Male: 2496 Female: 7095)</i> (Data Source: 2004 LDHS)

Indicator	2005	2007	Additional Programmatic progress data ¹	Comments
17) Percentage of women and men aged 15-49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse.	Male: 48% Female: 50% (2004 LDHS) (% of young women and men aged 15-24 reporting the use of a condom the last time they had sex with a non-marital, non-cohabiting sexual partner)	Male: 48.6% Female: 41.9% (2004 LDHS) (The DHS indicator however looks at % who reported using a condom at last higher-risk intercourse)	There were 17 million condoms distributed in 2006.	Numerator: Number of respondents (aged 15-49) who reported using a condom at last higher risk intercourse (Male: 532 Female: 736) Denominator: Number of respondents (aged 15-49) who had high risk intercourse in the past 12 months (Male: 1096 Female: 1,757) (Data Source: 2004 LDHS)
18) Percentage of female and male sex workers reporting the use of a condom with their most recent client.	No data available	No available data		
19) Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.	No data available	No available data		
20) Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse.	No data available	No available data		
21) Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected.	No data available	No available data		
Impact				
22) Percentage of young women and men aged 15-24 who are HIV infected.	Both male and female: 10% Male: 6% Female: 14% (2005 GOL/UNAIDS Estimates)	Both male and female: 18.7% (2007 GOL/UNAIDS Estimates)	Spectrum Analysis was undertaken by UNAIDS and Government of Lesotho at an estimates workshop organized in Jan 2008. Modelling indicated that prevalence among young women aged 15-24 years is 14.9% in 2007 as opposed to 14.8% in 2005. Prevalence among young men aged 15-24 is 5.9% in 2007. The combined prevalence, men and women (15-24), is 10.4% and has not changed since 2006. There are an estimated 12,942 young people infected with HIV of whom 33,172 were women and 12,942 were men.	Numerator: Number of antenatal clinic attendees (aged 15-24) tested whose HIV test results are positive (428) Denominator: Number of antenatal clinic attendees (15-24) tested for their HIV infection status (2285) (Data Source: MOHSW 2007)

Indicator	2005	2007	Additional Programmatic progress data ¹	Comments
23) Percentage of most-at-risk populations who are HIV infected.	No data available	No available data		
24) Percentage of adults and children with HIV known to be on treatment 12 months after initiation of anti-retroviral therapy.	82% (2005 MOHSW)	74.4%	A cohort analysis was carried out for this indicator, using data from ART patient registers. The cohort was from December 2006 to November 2007.	Numerator: Number of adults and children who are still alive and on ART at 12 months after initiating treatment (5957) Denominator: Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who died, those who have stopped ART, and those lost to follow-up (8005) (Data Source: Cohort analysis, MOHSW 2007)
25) Percentage of infants born to HIV-infected mothers who HIV infected.	25% (Modeled at UNAIDS headquarters based on programme coverage)	To be modeled at UNAIDS headquarters, based on programme coverage		

¹The additional programmatic data is being provided for indicators in which results of the 2005 UNGASS report are repeated and no new data that fits the criteria as per the reporting guidelines was available, but significant progress has been made in the area. In most cases such data has been generated from the routine M&E system in place in the country. Please also refer to the summary and the narrative in the main document for additional information about progress made.

² The coverage reported in the 2005 UNGASS report was 19% calculated on the basis that 8000 people out of 42640 people in need received ART. However the need in 2005 has been revised to 77986 for adults and children resulting in the revised coverage of 10.2%.

Overview of the AIDS Epidemic

Lesotho has the third highest adult HIV prevalence in the world at 23.2%. There are an estimated 62 new HIV infections and about 50 deaths due to AIDS each day. Over the last few years the epidemic has remained stable at this high prevalence rate making it among countries that are hyper-endemic (i.e. with adult HIV prevalence more than 15%). However, this prevalence rate is likely to increase in the coming years as more people are put on HIV treatment and in turn live longer. It is also anticipated that the number of orphans due to AIDS might have a slight decline in the coming years as increased treatment access leads to increased survival among parents.

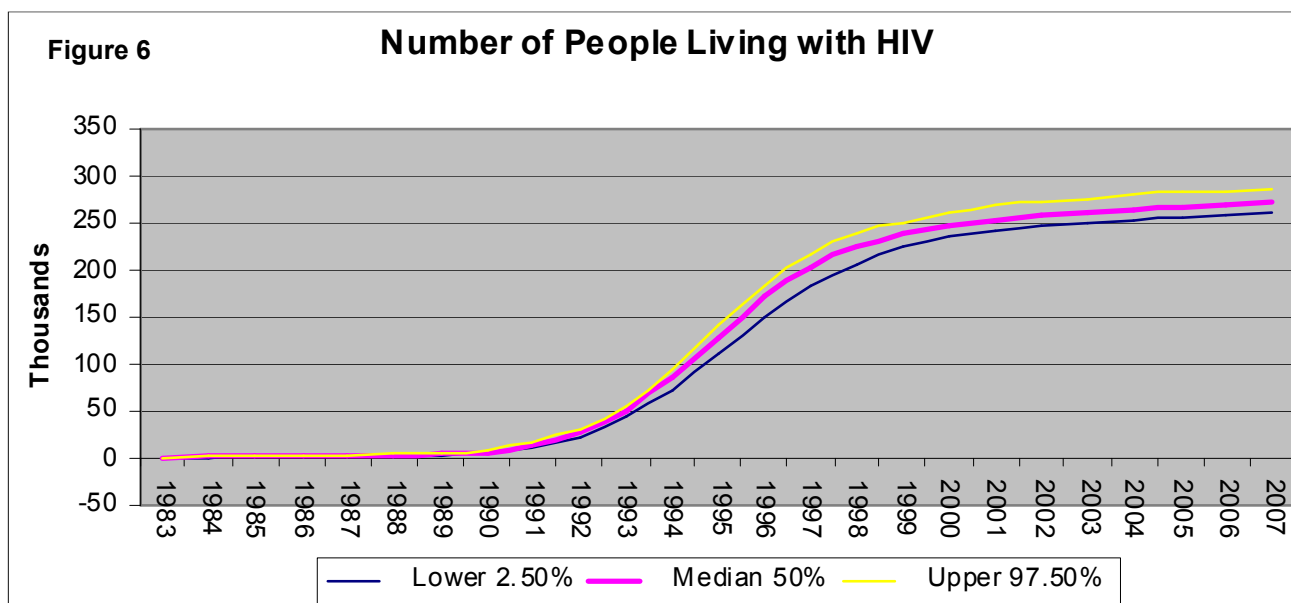
There are an estimated 273,273 people living with HIV in Lesotho as of end 2007, see Figure 6. Of these, the total number of children infected are 11,801 and adults 258,472. Women continue to be more infected with an estimated 153,581 (56%) infected compared to 116,692 (44%) men. The total number of young people aged 15-24 is estimated at 46,116 of these 33,174 (71.9%) were young women. The total number of people who died of HIV in 2007 is estimated to be 18,244. The total number of children orphaned due to AIDS is estimated at 108,700. This number has increased from 2005 where an estimated 97,000 were orphaned due to AIDS. The estimated number of dual orphans is around 46,600, while there are around 73,000

paternal orphans and 77,000 maternal orphans at the end of 2007.

There has been no significant change in the national adult HIV prevalence since 2005. While 23.2% prevalence is the national average, it is important to consider the prevalence across the age segments. For example, HIV prevalence among the ages 25-49 is around 40% for men and women, as shown in Figure 7. The sentinel surveillance conducted in 2007 showed that there has been no major difference in HIV prevalence among women attending ANC clinics. However there appears to be a slightly downward trend in the HIV prevalence among 15-19 year old young females dropping to 8.9% (7.2%- 11.0%) in 2007 from 11% in 2005, as shown in Figure 9.

The HIV prevalence among those from rural areas was lower than those living in urban areas, as shown in Figure 11. The sentinel HIV and syphilis survey showed that the prevalence of HIV among STI patients was high at 56.2% (52.6%- 59.7%). Among young people aged 15-19 and 20-24, HIV prevalence among STI clients was around 20% and 40% respectively compared to the prevalence among young people surveyed in 2004 LDHS which was at 7.72%.

The adjusted HIV prevalence among young women aged 15-24 was 14.9% compared to 5.9% among young men in the same age. Also, there are significant variations within the age group as shown in the 2004 LDHS study, refer to Figure 10 on next page for the graph. HIV prevalence among young boys aged 15-17 was around 0.7% while it is five times more for the age group 18-19 and



17 times more for the age group 23-24. Similarly among girls HIV prevalence is around 6% between the ages 15-17 and nearly doubles in the age group 18-19 and 20-22.

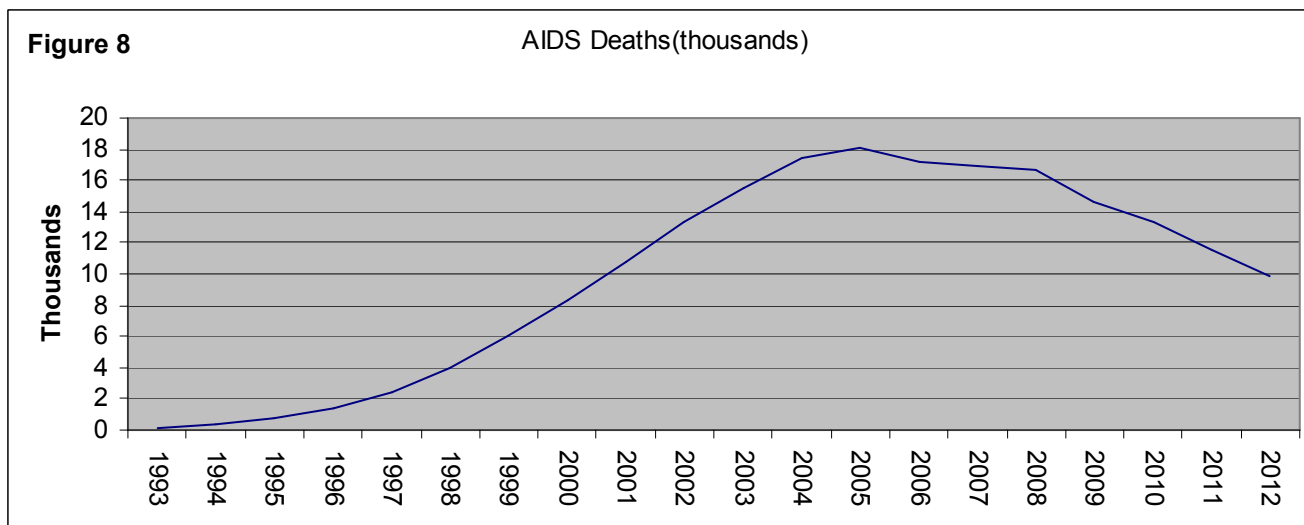
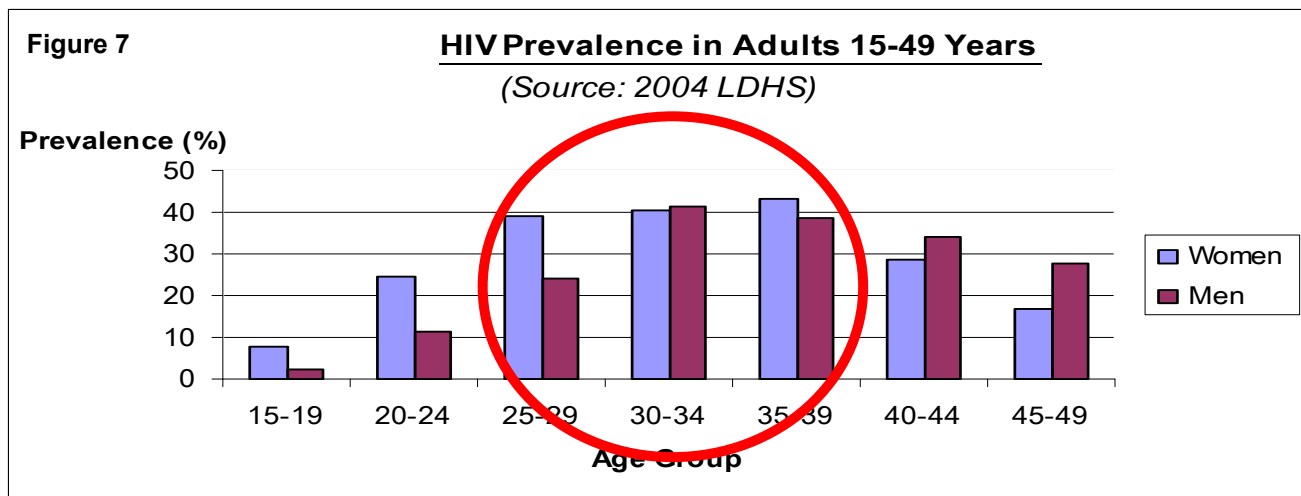
There is very little data on the HIV prevalence among sex workers and other most at risk populations such as males who have sex with males. While drug use is observed, there are no known cases of injecting drug use in the country.

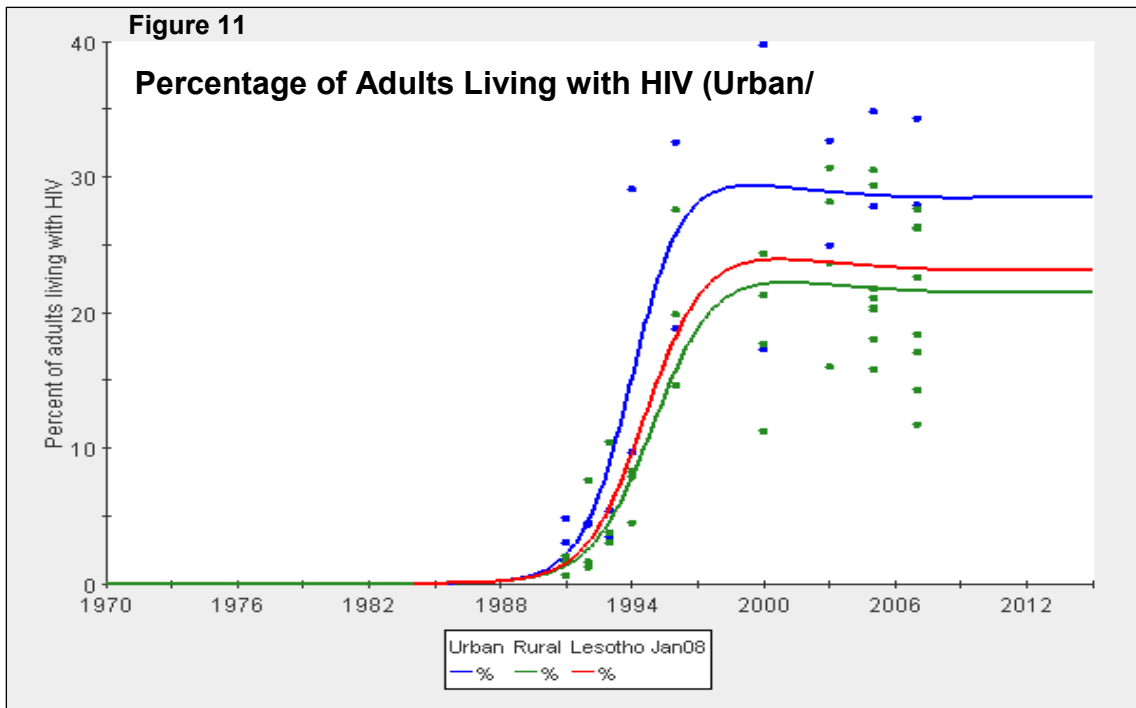
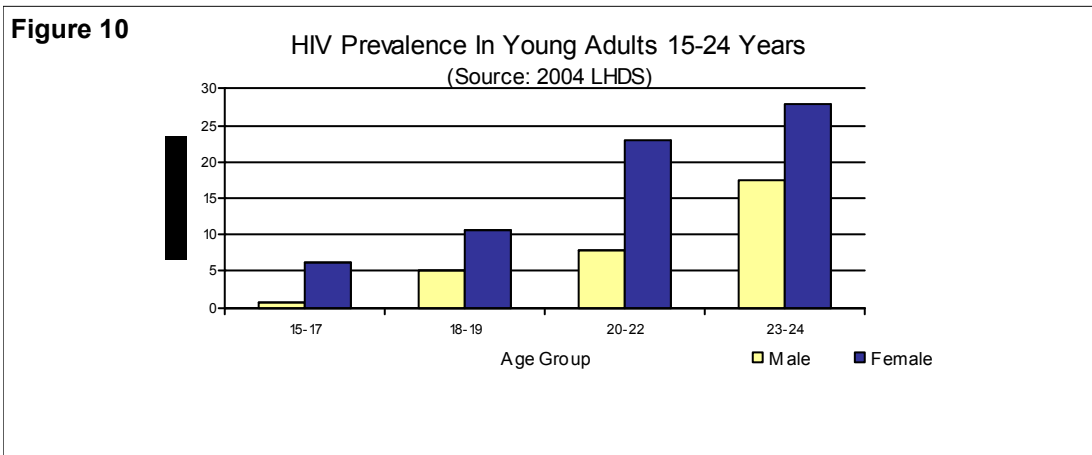
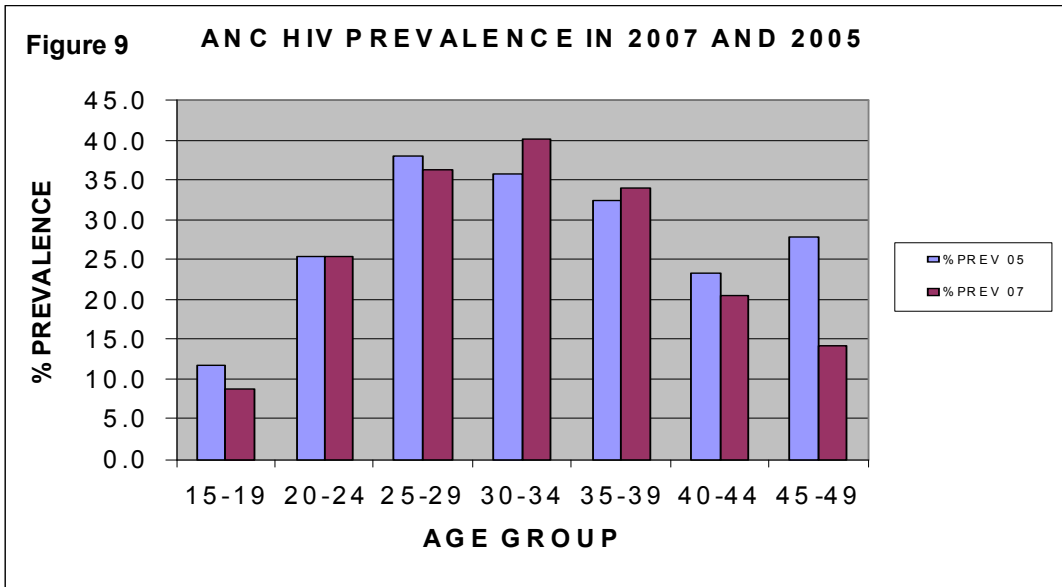
There has been significant progress in the roll out of antiretroviral therapy and food support to people put on treatment. At the end of 2007, an estimated 21,710 people were receiving anti-retroviral treatment. This has been nearly a three fold increase from 2005 where an estimated 8000 people were on treatment. However the percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy has gone down to 74.4% from about 82% reported in 2005.

It is estimated that 81,270 (63,100-98200) people are in need of ART at the end of 2007 of which 25% are currently receiving treatment.

This increase in the number of people needing ART is due to the new method of calculation as recommended by WHO/UNAIDS. This new estimate takes into account that the average survival period is now 11 years as opposed to 6 in the past and the fact that people have to start on treatment a year early than previously estimated. Consequently, the estimated number of people in need of treatment in 2005 is now recalculated to be 42,640 bringing the coverage to 10.2%.

At least 3,966 pregnant women with HIV received anti-retroviral treatment to prevent mother to child transmission of HIV in 2007. The coverage of PMTCT programmes has increased from an estimated 5% in 2005 to 31% in 2007, which is a six fold increase over the corresponding period.





National response to the AIDS epidemic

Lesotho has embarked on an accelerated programme to achieve universal access to HIV prevention, treatment, care and support by 2010 in line with commitments made at the United Nations General Assembly Special Session (UNGASS) High level meeting on HIV and AIDS in 2006. There has been significant progress on all aspects of the response. Between 2005 and 2007, there have been major advances in the field of policy development as well in increasing programme coverage. While the epidemic still continues to play a major impact on the country, the foundations for an effective response have been laid.

National commitment & programme implementation

There has been consistent political support for the response to HIV since 2000 when it was declared a national emergency. The political commitment from top leadership has been evident through their various actions in the field of implementing the “three ones” principles, review of legislation and the emergence of leadership from a wide range of civil society actors – significantly from the people living with HIV and Lesotho’s church leaders. HIV is seen as an exceptional issue which requires utmost commitment from all stakeholders in order to overcome the pandemic.

Policy environment- “the three ones” implementation

At an institutional level, Lesotho has embraced the “three ones” principles and in the last two years has crossed several milestones in the road towards its full implementation. Following an in-depth review of the national response in 2005 involving a range of internal and external stakeholders, an updated National HIV and AIDS Policy as well as the National HIV and AIDS Strategic Plan for 2006-2011 and the National Monitoring and Evaluation Plan were approved by the Government of Lesotho in November 2006. The National AIDS Commission (NAC) which was set up by an act of parliament in 2005 also became fully

functional in 2006. The National HIV and AIDS Policy and the National HIV and AIDS Strategic Plan have set ambitious targets with a view to achieve universal access by 2010. Based on the National HIV and AIDS Strategic Plan, a unified Operational Plan was made for 2007-2008 financial year. Significant progress was also made in securing resources for the implementation of the national strategic plan.

In order to coordinate the national HIV and AIDS response, the National AIDS Commission Act of 2005 provides for the establishment of a HIV and AIDS Forum consisting of representatives from all national stakeholders. The Forum has been established and one member of the Forum also serves as a commissioner of the NAC. For the purposes of information sharing, a wider- national partnership forum has been established and meets quarterly. The NAC has also developed a coordination framework which was adopted in June 2007. The Board of the NAC started functioning in April 2006 and since then has met consistently on ordinary meetings and special sittings when needed. In addition, the Cabinet Sub-Committee on HIV and AIDS under the chairmanship of the Deputy Prime Minister also receives updates from the NAC on key policy issues and programmatic progress on a regular basis.

However, there are still significant challenges in the full implementation of the “three ones”. Critical among these are the acceptance of NAC as the lead policy setting and coordinating body for the national response and the need for a multi-sectoral, yet coordinated response. The annual consolidated action plan for 2007-2008 was the first attempt to put together a complete picture of the national response and avoid duplication. There is also a further need to clarify roles and responsibilities between key sectors and ministries, umbrella organisations and implementers at various levels as well as among the development partners.

Leadership environment

Political leadership

Lesotho has shown consistent political leadership on HIV and AIDS. Since the declaration of AIDS as an emergency in 2000, the top political leadership has consistently spoken out and supported the AIDS response at the highest level. The Right Honourable, the Prime Minister has openly taken an HIV test along with other senior leaders in the

Table 1: Lesotho Universal access targets

Target description	Target date	Baseline	2007
% of recurrent national budget allocated to HIV by the GOL	2%(2008-2009) 5%(2010-2011)	0.8% (2005)	
% of recurrent nat. budget allocated to HIV by the GOL actually spent	70%(2008-2009) 90%(2010-2011)	43% (2005)	
% of HIV positive pregnant women receiving a complete course of ARV to reduce the risk of mother-to-child transmission	80%(2010-2011)	5% (2005)	31.1%
% of general population populations who received an HIV test in the past 12 months and were informed of the results	80%(2010-2011)	5.9%(2004)	8.5%
% of young men and women aged 15-24 reporting the use of a condom during last sexual intercourse with a non-regular partner	80%(2010-2011)	49%(2004)	Not Available
Percentage of young men and women aged 15-24 who have had sex before age 15	7.5%(F)(2010-2011) 13.5%(M)(2010-2011)	15%(F)(2004) 27%(M)(2004)	Not Available
Percent of women, men and children with advanced HIV infection receiving anti-retroviral combination therapy	80%(2010-2011)	15%(2005)	25%
Percentage of OVC (boy/girl) aged under 18 whose household has received a basic external support package	80%(2010-2011)	20% (2005)	32%
Reduction in number of new HIV infections	20,000(2010-2011)	23948 (2005)	22665

country in an attempt to promote the “Know your status” campaign and reduce stigma and discrimination. In Lesotho’s quest to achieve the Millennium Development Goals (MDG), tackling the HIV has been positioned as “the number one” MDG goal. HIV issues are regularly raised by top leaders and policy makers in their public statements.

Lesotho has a bicameral Parliament with both Houses taking responsibility for HIV & AIDS related issues. The sixth Parliament was convened in March 2007, and subsequently HIV and AIDS select committees were established in both the National Assembly and the Senate. The remit of the HIV and AIDS Select Committees is to “ensure a broad-based facilitation of Parliamentary advocacy, debate and discussion. To prepare occasional reports and to oversee and monitor policy and legislation on HIV and AIDS through a process of consultation, training and information exchange. The committee shall have power to call expert witnesses and to receive testimony and documentation through committee hearings.” Work undertaken by the Select Committees in 2007 included ‘Pitso’ (public gathering) outreach sessions with members of the public on the subject of HIV &

AIDS and training sessions for Parliamentarians on human rights issues and HIV & AIDS. Additionally, a delegation from the Lesotho Parliament attended the Inter-Parliamentary Union meeting on HIV & AIDS in Manila in November 2007 and presented their key recommendations to the Government.

Church Leadership

In 2007, 15 senior Christian church leaders belonging to various denominations got together and signed a Statement of Commitment on HIV and AIDS in the presence of His Majesty King Letsie III and the Rt. Honourable, the Prime Minister Pakalitha Mosisili. Since the signing of the Statement of Commitment, the church leaders have openly spoken about HIV prevention as well have developed a set of key messages to be promoted through the church. An inter-faith body to coordinate the faith based response to AIDS called Lesotho Inter-Religious AIDS Consortium has been established. Training of faith based leaders is integral part of the HIV prevention programmes and the faith based organisations play a vital role in HIV prevention, treatment, care and support as well as in care of orphans and vulnerable children.

People living with HIV

People living with HIV have come to the forefront of the national response to HIV. The Lesotho Network of People living with HIV and AIDS (LENEPWHA) formed in 2005 is increasingly taking a leadership role in coordinating the needs of people living with HIV and in spearheading the GIPA principles. People living with HIV are actively communicating about the epidemic. They are providing care and support for each other, sharing experiences, taking up responsibilities in addressing stigma and discrimination, and enjoying equal rights and opportunities regarding their livelihoods. Over the past two years, LENEPWHA has demonstrated leadership in establishing a strong network with a national executive committee, secretariat, and increasing its outreach to all districts and setting up district executive committees. They actively participated in the preparation of the National HIV and AIDS policy, Strategic Plan and M&E Plan as well in the consultation process for the drafting of the National HIV and AIDS Bill. Representatives of People living with HIV are well represented in national decision-making bodies like CCM, NAC HIV and AIDS Forum and the Multisectoral Partnership Forum. At the global level, LENEPWHA is also a member of NAP+, ICW and SafAIDS.

LENEPWHA is also increasingly involved in implementing programmes. They actively participate in promoting the “Know your status” campaign, promoting treatment literacy, nutrition support and supporting income generation activities for their members. LENEPWHA has been able to mobilize resources from international and local donors for support groups to enhance food security projects, OVC support towards education, health and food security.

Sectoral Policies

In line with the National HIV and AIDS Policy's recommendation of preparing sector specific policies where appropriate, several policies have been developed to support the national HIV and AIDS response. Many of these are in draft stage while a few have been approved. Prominent among the policies approved are the National OVC Policy and the Blood Transfusion Policy and HIV Testing and Counselling Policy. The table on the facing page, Table 2, has a list of milestones.

National OVC policy

The national OVC policy was approved in 2006. This policy aims to provide an enabling environment in which orphans and vulnerable children are adequately cared for, supported and protected in all respects, and enjoy their rights and fulfil their responsibilities. The GoL recognises that political support and pro-active leadership are fundamental to accelerate the national response to OVC issues. It has recognised the seriousness of the OVC situation in the country and has made commitments towards their protection and wellbeing.

The main principles enshrined in the policy are protection of the rights of the child in keeping with the best interests of the child. In addition, the policy calls for empowerment of communities and families, reduction of vulnerabilities, non-discrimination and gender equity and access to quality services, information and resources to reduce the impact on orphans and vulnerable children. A National OVC Coordination Committee has been established to oversee the implementation of the OVC programme and has representation from all key stakeholders.

Education Sector HIV and AIDS policy

The Education Sector Policy on HIV and AIDS was developed in 2007 following a consultative process involving key stakeholders in the delivery of education in Lesotho. This draft policy has been presented to the top management in the Ministry of Education and Training (MOET) and it is now being integrated into the overall Education strategy.

National HIV Testing and Counselling Policy

The Ministry of Health and Social Welfare (MOHSW) developed the *National HIV and AIDS Testing and Counselling Policy of the Kingdom of Lesotho* in April 2006. This policy though written prior to the release of the WHO/UNAIDS policy on providing initiated testing and counselling, is consistent with it. The policy provides for access to testing for young people aged 12 and above and to provider initiated testing and counselling.

Blood Transfusion Policy

Lesotho's cabinet approved the National Blood Transfusion Policy in 2006. The main goal of the policy is to ensure availability of safe blood in the country. Lesotho Blood Transfusion Services (LBTS) is the only centre in country tasked to collect, screen, store and distribute blood. LBTS is allocated its own budget.

Table 2: Key Milestones 2006-2007

Phase II of Round 2 Global fund grant approved	2006
Launch of National AIDS Commission	September 2005
Inauguration of the National AIDS Commission	December 2006
Labour Code amended to ensure non-discrimination	2006
National Blood Transfusion Policy adopted	2006
1 st anniversary of the formation of LENEPWHA	May 2006
Phase I of Round 5 Global fund grant approved (Scale-up of care and treatment)	Nov2006
HIV and AIDS Forum constituted with representation of all stakeholders	September 2005
Development partners pledge significant funds to support National AIDS response	November 2006
Launch of the National Action plan on Women, girls and HIV and AIDS	November 2006
Official Launch of National HIV and AIDS Strategic plan	December 2006
Official Launch of National HIV and AIDS Policy	December 2006
Official Launch of National M&E Framework	December 2006
National Coordination Framework adopted	May 2007
District level launch of National AIDS Policy, Action plan and M&E plan	August 2007
National Operational plan for 2007-2008 developed	May 2007
Phase I of Round 6 Global fund grant approved on the scale up of TB/HIV collaborative activities	June 2007
Plan to scale up PMTCT programme developed as a result of joint review of PMTCT programmes	May 2007
National HIV and AIDS Partnership Forum launched	March 2007
Church leaders sign statement of commitment to focus on HIV and AIDS	July 2007
Thematic working groups for Programme management, HIV prevention, Treatment, care and support and Impact mitigation formed	July 2007
EU grant for 12 million Euros for focusing on OVCs approved	August 2007
Launch of national consultations on preparation of AIDS Bill	September 2007
All 21 line ministries and Government departments trained on HIV and AIDS and develop action plans for mainstreaming HIV within their sectors	September/October 2007
Global Fund round 7 for US\$33 million approved to focus on OVC and PMTCT	November 2007
All 128 community councils in Lesotho prepare AIDS action plan to implement essential package of services on HIV and AIDS at community level	November 2007

Legal Environment

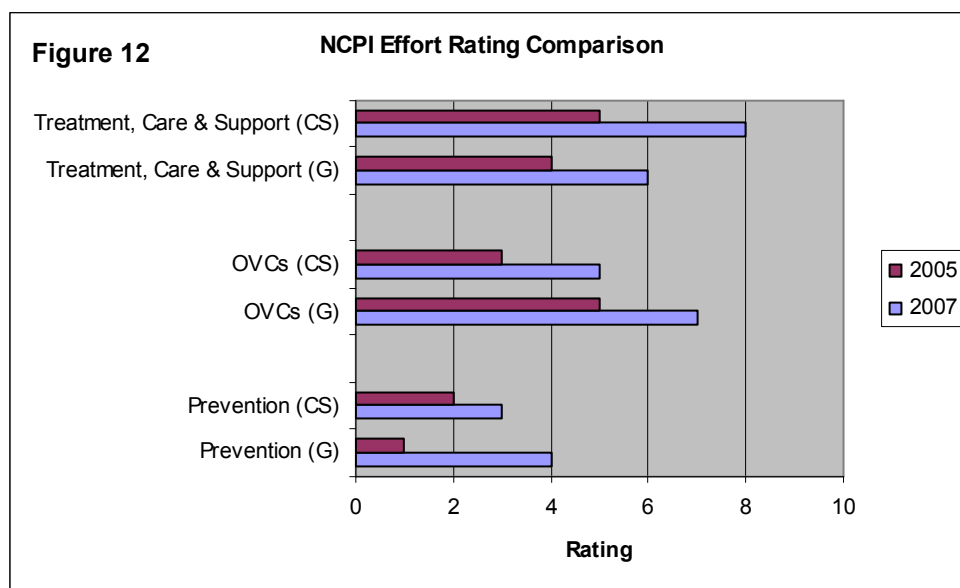
New laws/amendments that create an enabling environment for accelerating the national response to HIV

In 2006, Lesotho passed the Legal Capacity of Married People's Act providing equal status to women who had previously been considered minors under customary law. The enactment of this Act, along with full implementation of the Action Plan on Women, Girls and HIV, is considered key to removing barriers to access to HIV prevention, treatment, care and support services for women and girls.

The Labour Code was also amended in 2006 to stop discrimination at the workplace based on HIV status. The Constitution of Lesotho makes no specific reference to HIV & AIDS but does list non-justiciable and justiciable rights which are relevant to the field. The Labour Code (Amendment) Act, No. 5 of 2006 prohibits pre-employment testing, testing during employment, ensures confidentiality and non-disclosure and prohibits discrimination in employment. It is broad and follows human rights principles, providing protection to employees who are living with or presumed to be living with HIV or AIDS.

National HIV and AIDS Bill

Lesotho has started a process of developing a comprehensive HIV and AIDS Bill. In developing the Bill it adopted an inclusive process by setting in motion a series of discussions and consultations with a wide ranging group of key stakeholders including representatives from trade unions, people living with HIV and AIDS, NGOs, health professionals, educators, civil society, international donors, media, local government structures and government ministries. The Government of Lesotho and the National AIDS Commission intend to hold further in-depth consultations before the Bill is tabled in Parliament.



Other laws affecting AIDS programmes

The Public Health Order (1970) outlines various aspects to maintain public health in the country. The Act preceded the advent of HIV and AIDS epidemic. However, the definition of 'communicable disease' is broad enough to encompass HIV and AIDS.

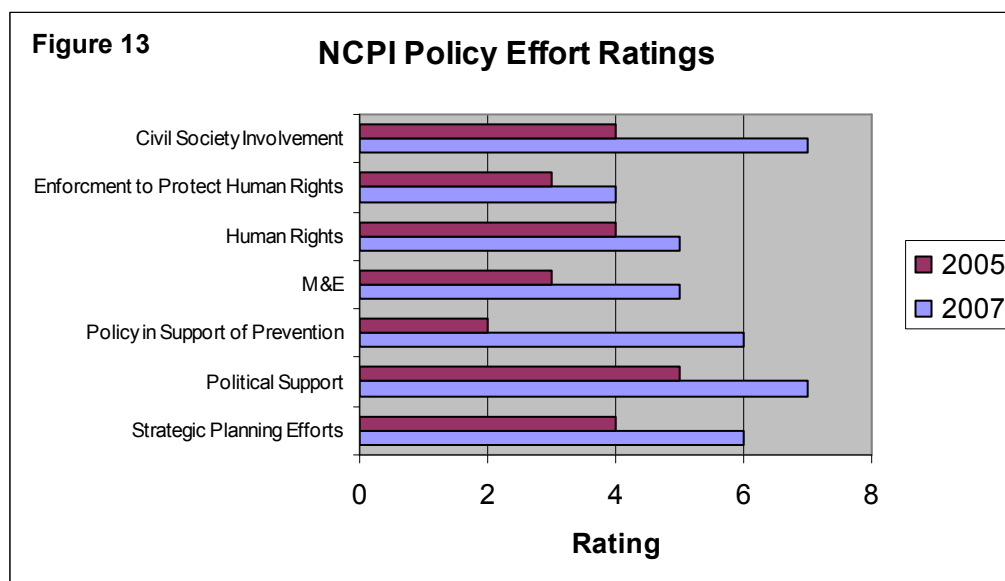
The Labour Code (Codes of Good Practice) Notice (2003) states that no one should be dismissed merely on the basis of HIV status, and should a person become incapacitated; the employer must endeavour to find alternative employment without prejudice to the employee's benefits. When an employee becomes too ill to continue, it is only then that the provisions of the Code on Termination based on incapacity apply.

The Sexual Offences Act (2003) contains several provisions that deal with HIV and AIDS including making it mandatory for an accused to undergo an HIV test within one week of being charged. The Act also provides for imprisonment of not less than ten years for a convicted person who had HIV at the time of the commission of the offence but had no knowledge or reasonable suspicion of his HIV status. However, if a person had "knowledge or reasonable suspicion" that they were infected with HIV at the time of commission, the penalty shall be the death penalty.

The Draft Children's Protection and Welfare Bill (2004) will for the first time give comprehensive protection to the rights of children in Lesotho including OVC. It generally requires the state to provide for amenities such as health care, education and the other basic necessities of life for OVC. The Bill has yet to be passed by Parliament.

The National AIDS Commission Act (2005) establishes the National AIDS Commission, Board, the HIV and AIDS Forum and Secretariat and outlines the functions of each of the bodies.

The Figures 12 and 13 show the progress made by Lesotho in the National Composite Policy Index (NCPI). The NCPI forms a part of the indicators of the UNGASS Reporting Mechanism. Figure 12 shows the rankings given by civil society (CS) and the government of Lesotho (G) for different thematic areas for the years 2005 and 2007. Both sectors have felt there has been an advancement in the rating.



Resources available for HIV and AIDS

The National HIV and AIDS Strategic Plan for 2006-2011 estimated a total need of 360 million US\$. Based on the resource needs model, a revised needs estimate was developed by the National AIDS Commission in 2007. It is estimated that a minimum of 547 million US\$ will be required for the period 2006-2011.

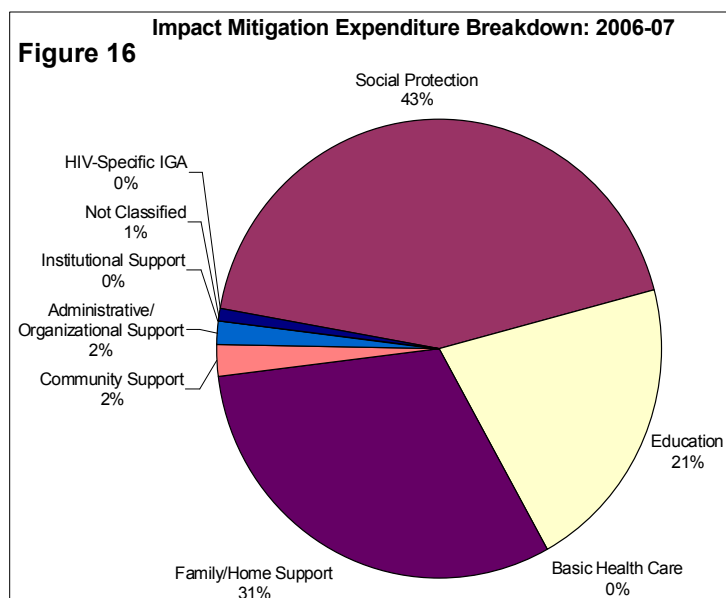
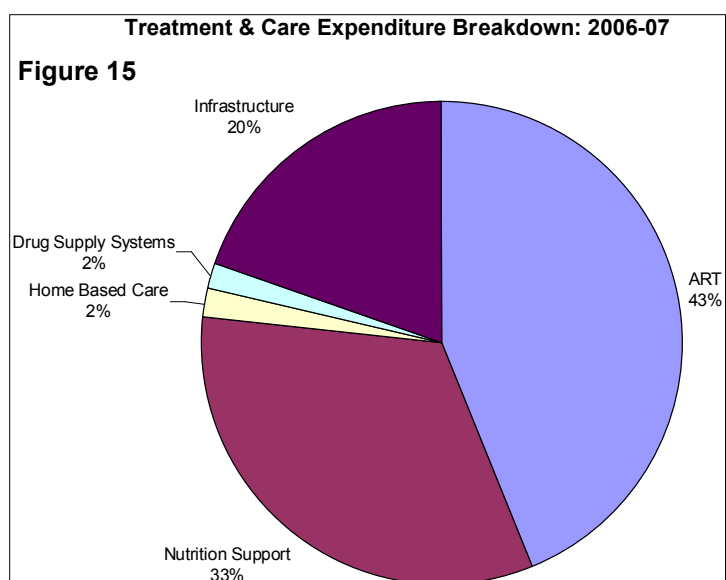
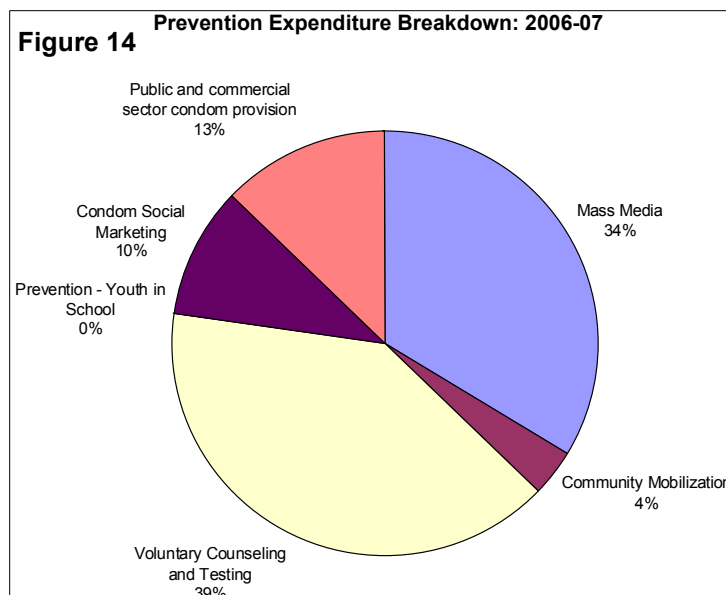
Domestic Funds

Five key ministries of the Government of Lesotho spent approximately US\$ 8.4 Million in 2005-06 and US\$ 8 million in 2006-07 fiscal years. In the fiscal year 2007-08, it has already spent around US\$ 3.6 million from its recurrent budget. The Ministry of Finance, Development and Planning issued a circular, advising each ministry that it could spend up to 2% of its allocated funds on HIV related issues. However, its use by various ministries is varied, and there is still little clarity on the issue of allocating and reporting on the 2% of the recurrent budget spent on HIV. Also the source of funding for the National AIDS Commission and STI/HIV Directorate in the Ministry of Health and Social Welfare has to be cleared in light of the 2% allocations. In the coming year, it is critical to clarify this issue and provide clear directions on the utilisation of these funds.

International Funds

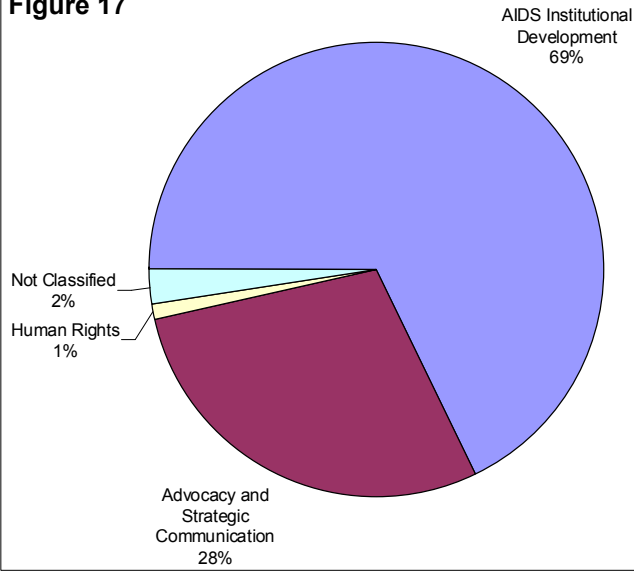
There has been a significant increase in the amount of resources pledged and available for the AIDS response in Lesotho. Following the 9th Donor Round Table Conference on Sustainable Economic Growth and Poverty Reduction, the development partners pledged to support the national AIDS response. Lesotho has been successful in getting a total of US\$ 114,473,978 from the Global Fund to Fight AIDS, TB and Malaria (GFATM). Of these US\$102,922,867 are for HIV related programmes. Other significant new grants for Lesotho are from the European Union- 12 million Euro for OVC, USG and Irish AID.

This page and the facing page have figures showing the breakdown of the expenditure on various thematic areas. Figure 19 gives the overall breakup of expenditure across the 8 programmatic areas.



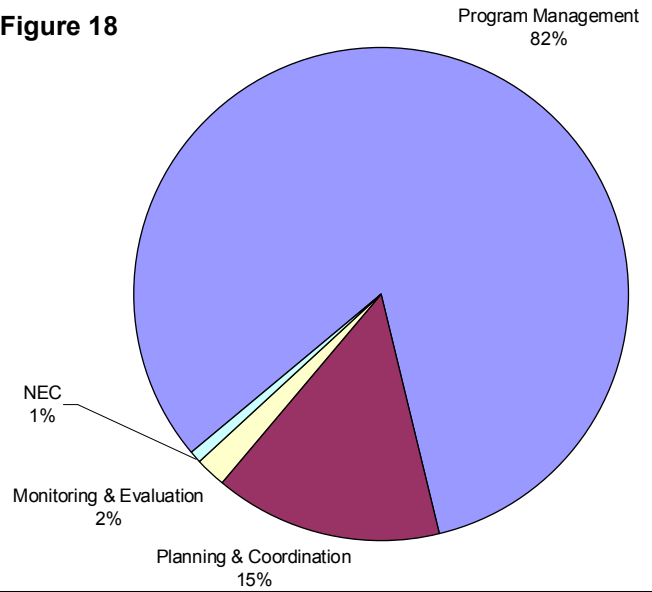
Enabling Environment Expenditure Breakdown: 2006-07

Figure 17



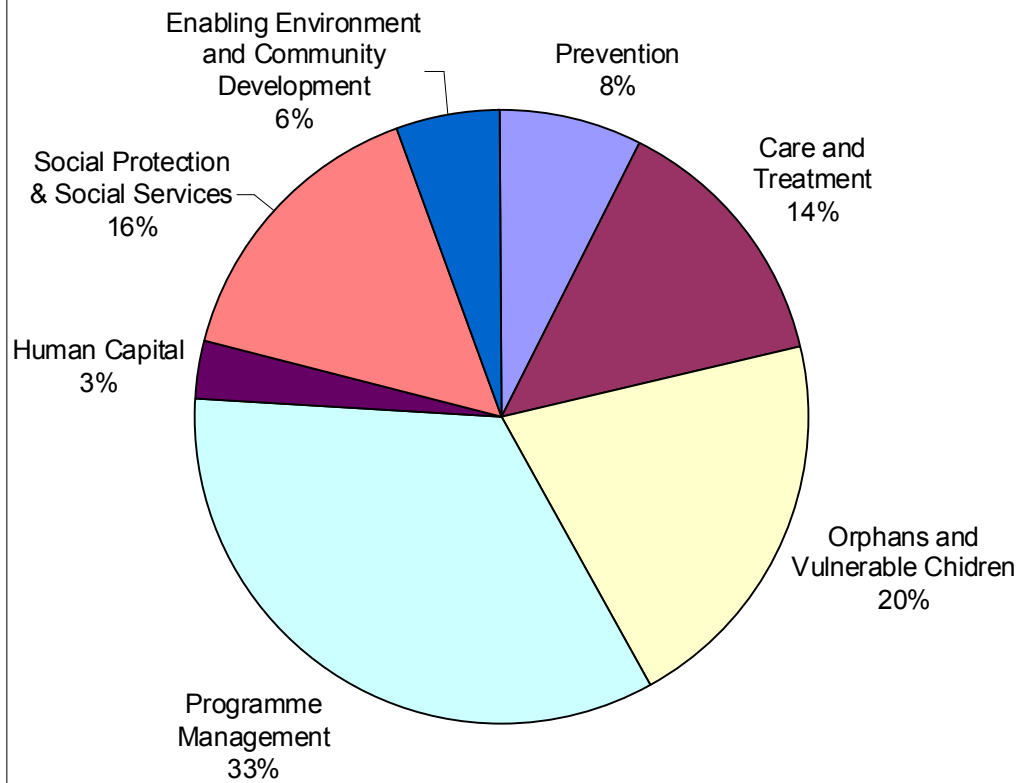
Program Management Expenditure Breakdown: 2006-07

Figure 18



Programmatic Expenditure: 2006-07

Figure 19



HIV Prevention

There are nearly 62 new HIV infections each day in Lesotho. HIV prevention efforts across the country are varied with a large number of organizations involved in promoting HIV prevention. The National HIV and AIDS Policy and the National HIV and AIDS Strategic Plan prioritize HIV prevention as one of key pillars of the national response. However, there is a need to develop a unified operational strategy to focus on HIV prevention, especially those related to prevention of sexual transmission of HIV. It is estimated that M 26.5 million was spent on HIV prevention in the year 2006-07, as depicted in Figure 14.

Prevention of Mother to Child Transmission of HIV

In 2007, Lesotho requested technical support to develop and roll out a plan for PMTCT programmes. A joint review of the PMTCT activities was conducted and a PMTCT scale up plan was developed in 2007. PMTCT uptake has increased from 5% in 2005 to 31% in 2007 with 19 hospitals and 117 health centres and private clinics out of 167 health facilities offering antenatal care (ANC), postnatal care (PNC) and maternity services (103).

In 2006, 9,277 pregnant women tested for HIV as compared to 5,459 in 2005. A total of 2592 were found to be HIV positive and of whom 2,224 (ARV prophylaxis – 2005 & 219 - HAART) received ART for PMTCT. Similarly in 2007, 23,965 pregnant were tested for HIV of whom

5,539 were found to have HIV and 3,966 were provided ART (ARV prophylaxis – 2,799 & 1,167 - HAART). These statistics are further illustrated in Figure 20, 21 and 22. The PMTCT policy guidelines and data collection instruments were finalised. A Joint Review by an Inter Agency Task Team in 2007 found that only 600 children (16.5%) were on ARV. A Scale Up Plan was developed to strengthen implementation. Partnership was strengthened through the ICAP, CHAI, EGPA, Baylor Centre of Excellence, PMTCT and Pediatric HIV Treatment Programmes.

There is an increase in the proportion of pregnant women who accepted to take the HIV test from 51% in 2005 to 91% in 2007. This is partly attributed to the shift in approach to the “opt-out” strategy. However, the proportion of mothers who were offered post-test counselling (and by inference, the test results) initially increased from 86% in 2004 to 90% in 2005 but dropped significantly to only 57% in 2006. This was mainly due to the fact that most of the new facilities were not reporting data on post test counselled women.

The Sentinel HIV/Syphilis survey of 2007 showed that 41.9% of those attending the ANC services had taken an HIV test previously and knew their HIV status. Of the 1549 women who had taken a test within the past three months, 9.1% who reported their status to be negative were found to be HIV positive, indicating that they may have become positive in the last three months. The fact that 24.4% of those who knew they were HIV positive got pregnant indicates either an unmet need for reproductive health services or the strong desire to have children, or both.

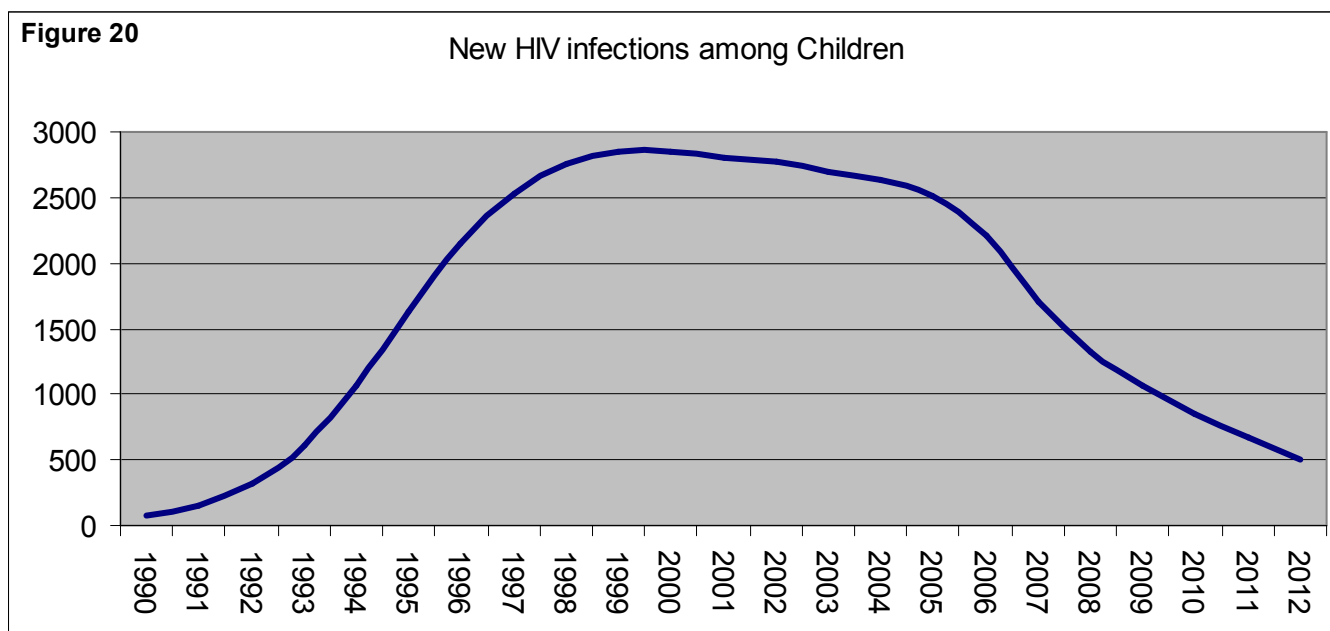


Figure 21

Number of pregnant women counselled and tested for HIV 2005-2007

(Source: MOHSW 2007)

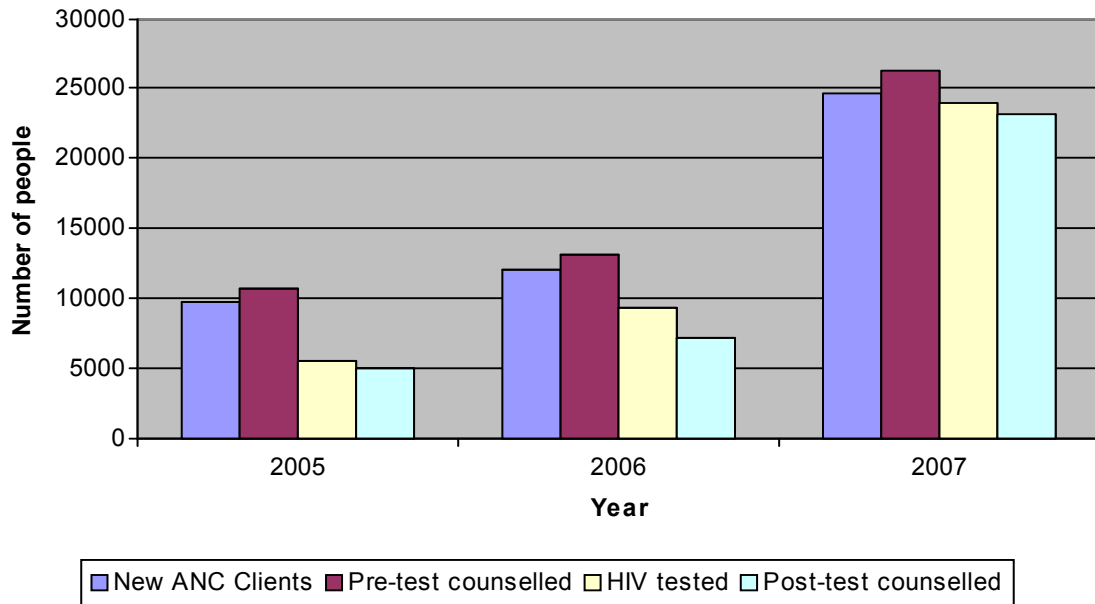


Figure 22

HIV positive pregnant women receiving ARV

(Source: MOHSW 2007)

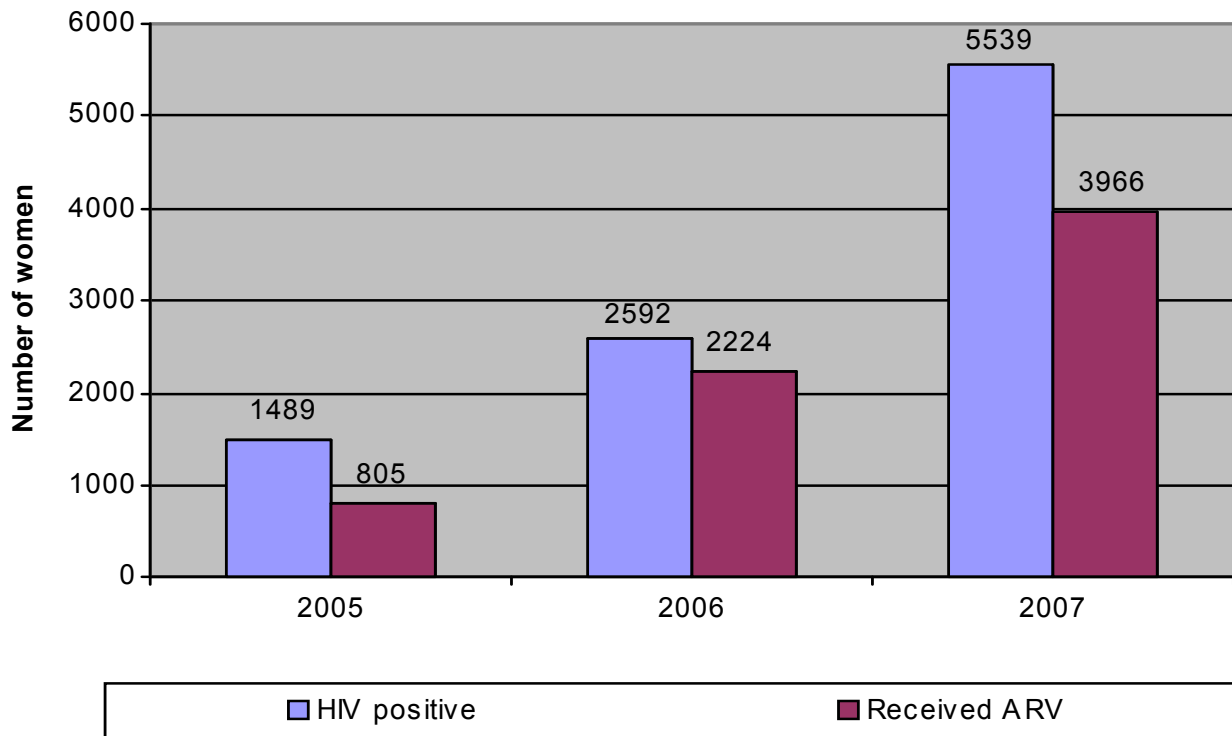
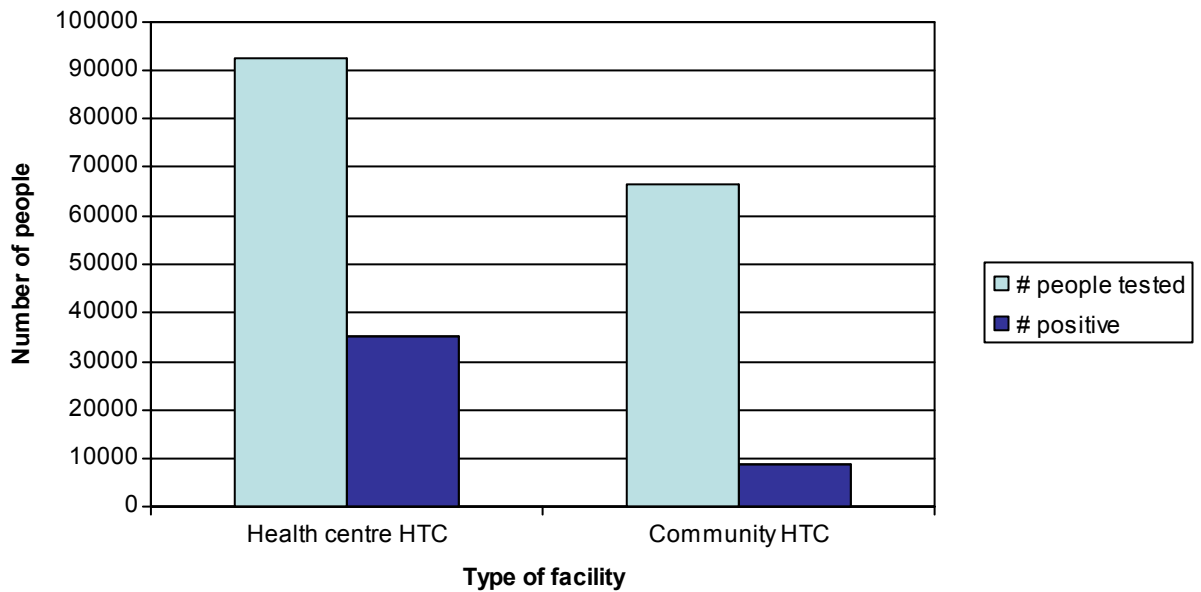


Figure 23

Health Facility and Community based HTC 2007

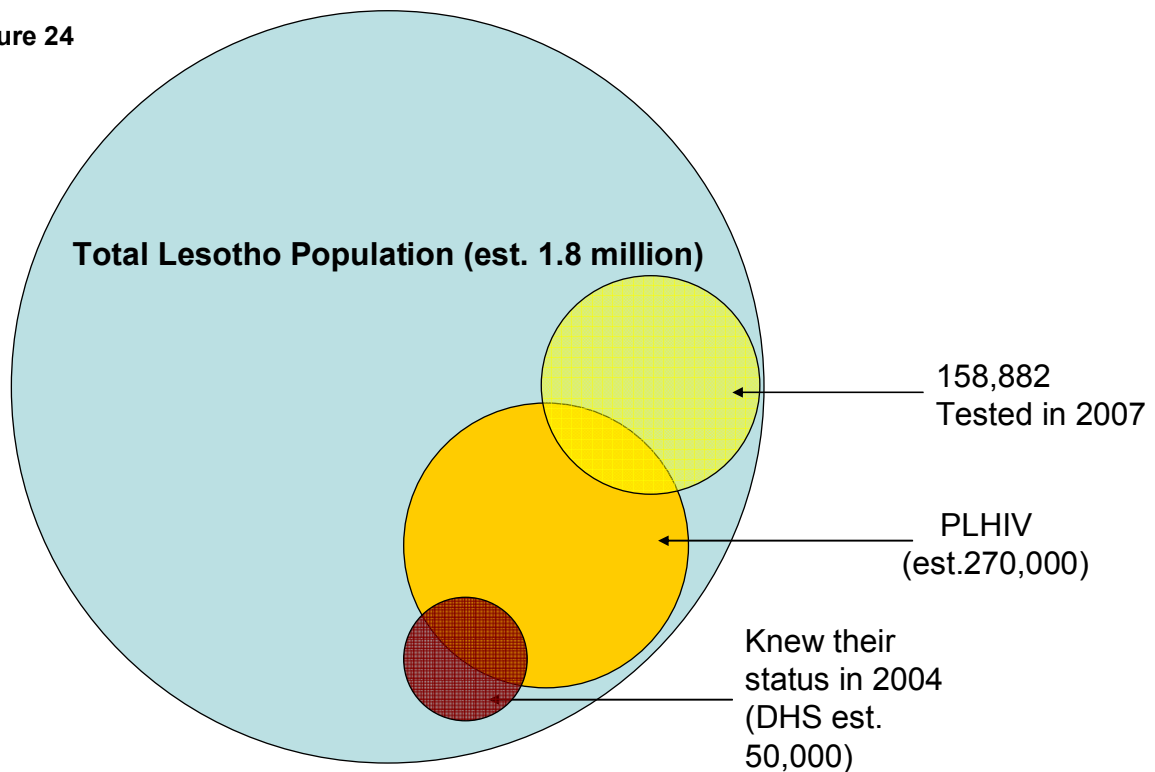
(Source: MOHSW 2007)



% of people knowing their HIV status in the past 12 months

(Source: KYS Statistics MoHSW)

Figure 24



HIV Testing and Counselling- Know Your Status

According to the 2004 LDHS only 6.3% of women and 4.8% of men (15-49) in the country received an HIV test and know their result in the last 12 months. While the next round of 2004 LDHS will be undertaken in 2009, Lesotho has made significant progress in this area.

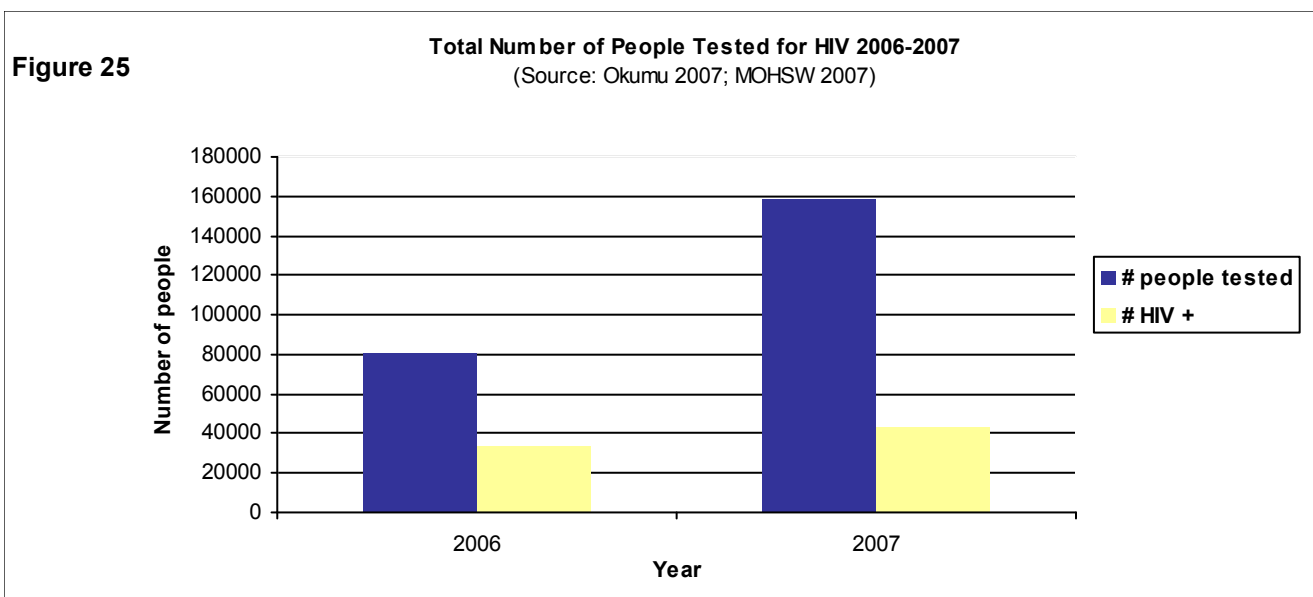
There is a clear trend of increased uptake of HIV Testing and Counselling in Lesotho. In 2007, the cumulative figure of people who ever received an HIV test in Lesotho was 229,092 or 12% of the population, refer to Figure 23. This represents an increase of nearly three times those tested in 2005.

The increased uptake in HTC may partly be attributed to the increased number of health centres now offering HTC. At the end of 2007, 161 health centres offering HIV testing and counselling. The HTC drive also received high political support from the top leadership of the government. More importantly, the GoL also launched the ambitious “Know Your Status” campaign at the end of 2005. The campaign aims to offer every Basotho over the age of 12 an HIV test, thus scaling up HIV Testing and Counselling to achieve Universal Access. With an innovative approach including community HIV Testing and Counselling through mobile services, door-to-door HTC and provider initiated HTC, the campaign was initially launched for a period of two years with a target of reaching 1 300 000 individuals.

However, the KYS campaign took some time to get off the ground, as the first year (2006) was spent building logistics and procurement systems and establishing efficient overall coordination of the campaign. Another reason for the delay in implementation of KYS was due to inadequate funding and lack of human resources. As part of the campaign, a total of 3,590 Community Based Care Givers (CBCG) were trained (out of the target 7,200) under the KYS banner, tasked with providing HIV prevention, treatment, support and care services.

Despite these hurdles, a major success of the KYS campaign was reaped during the month of August in 2007 when the Ministry of Health and Social Welfare implemented the Accelerated KYS campaign in the district of Mafeteng. During a period of two weeks 13,342 people (between the ages of 18 month to 50+) were tested, out of which 2,468 or 11% were found HIV positive. There were 13,750 individuals offered pre-test counselling giving an uptake rate of 97%. Out of the 4,291 adult females who tested for HIV during this period in Mafeteng, 16.1% were found to be HIV positive, whereas out of the 2,255 males 13.6% were found positive. The graph with the figures is also depicted in Figure 26 on the opposite page.

However the sentinel surveillance done in September 2007 in the district showed an HIV prevalence of 30% which was the same as in 2005.



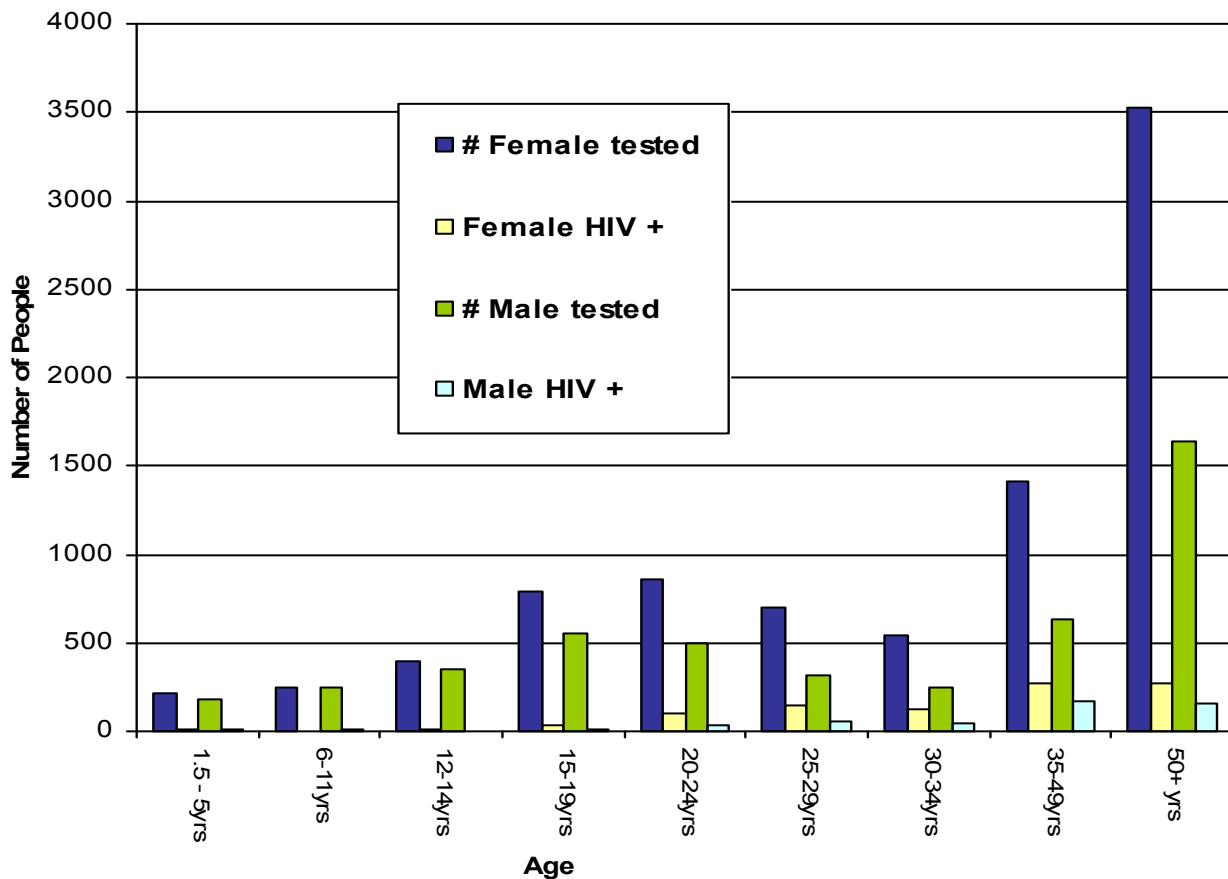
HIV Testing and Counselling uptake among females is considerably higher than among males with 19,816 (69% of total tested) females testing between December 2006 and November 2007 compared to 9,086 males (31% of total tested). This was also the case in the accelerated-KYS campaign in Mafeteng District where out of the 13,342 who were tested, just over two thirds were females.

Whenever there are public gatherings with testing sites provided people queue up spontaneously to test for HIV. An evaluation of the campaign is planned in the coming months as the country gears to further expand the provision of HIV Testing and Counselling services.

The Know Your Status campaign may not have achieved its targets as set out in the plan, but it has had great impact in changing Basotho's mindset towards HIV and AIDS. It has managed to create a social movement towards testing and has enabled people to talk easily about HIV between different age-groups, which was almost impossible before because of the conservative Basotho culture which considers sex and talk about it 'sacred' and therefore, unacceptable to discuss in public.

Figure 26

Accelerated KYS Campaign Mafeteng HTC uptake by age
(Source: Okumu 2007)



Condom promotion

Condom use among those reporting more than one sexual partner in the past two months was 48.6% for men and 41.9% for women aged 15-49. According to the resource needs model, Lesotho will require about 24 million condoms in 2008. In 2006, the MOHSW procured 12 million condoms, while the other organisations such as PSI, Red Cross, LPPA and Lebone Consultants contributed to the remaining 5 million. PSI is the leading agency in terms of social marketing and it distributed 1.48 million condoms in 2006 and 3.6 million in 2007. Furthermore, there has been a modest attempt to introduce female condoms in the country. 25,372 were distributed in 2006. In 2007, MOHSW procured 12 million condoms most of which came through UNFPA. However, half of the consignment was stuck at Maseru Bridge for 6 months because of communication problems between UNFPA and NDSO. There were sporadic shortages of condoms in 2006 due to logistic problems. The information system on condom procurement and distribution need to be strengthened through the National Condom Management Strategy.

An inter-agency condom promotion task force/committee has been established to monitor the condom promotion programme in Lesotho. The condom promotion strategy used in Lesotho includes free distribution and social marketing of condoms. At national level, it is estimated that at least 17 million male condoms were procured in 2006, refer to Figure 27.

Male Circumcision

A technical working group to develop a plan for rolling out Male Circumcision (MC) in the country has been set up. Technical presentations on the role of male circumcision in HIV prevention has been made to key policy makers and programme implementers. Several studies are being planned to help prepare a comprehensive plan to provide male circumcision services in the country.

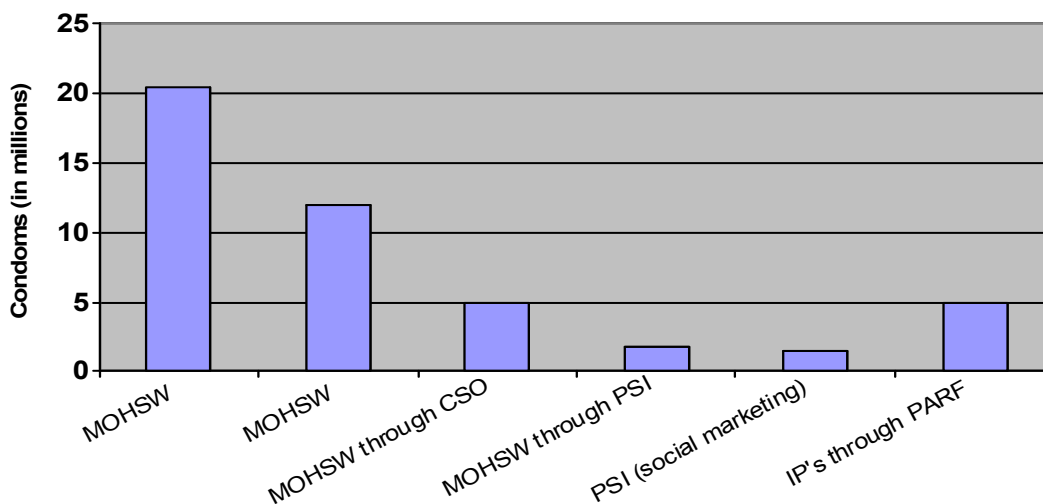
In 2007, a study was conducted on the Implication for the Cost-Effectiveness of Circumcision as an HIV intervention was conducted. The main aims were to explore the social and policy context of male circumcision, to assess the cost of providing adult male circumcision and to evaluate the implication of scaling up MC for cost effectiveness. It is expected that a full strategy will be developed in 2008.

A costing study on male circumcision was carried out. The main findings were that the unit cost of a comprehensive package of Male Circumcision services was estimated at \$56.35 (about M412). The largest proportion was surgical costs (81%), followed by communications (13%), testing (3%) and pre and post counselling. This does not include training, community mobilization, and policy analysis and formulation costs.

Based on the cost analysis, the epidemiological impact and cost effectiveness it was projected that MC among males (ages 15-49) be scaled up to 52.5% coverage between 2008 and 2020. It is estimated that one HIV infection will be averted for

Figure 27

Condom distribution (2006)
(Source: AJR MOHSW 2006)



every 6.1 male circumcisions performed, and that the cost per infection averted is US\$292 (about M2,136). This is potentially cost effective relative to other HIV prevention interventions.

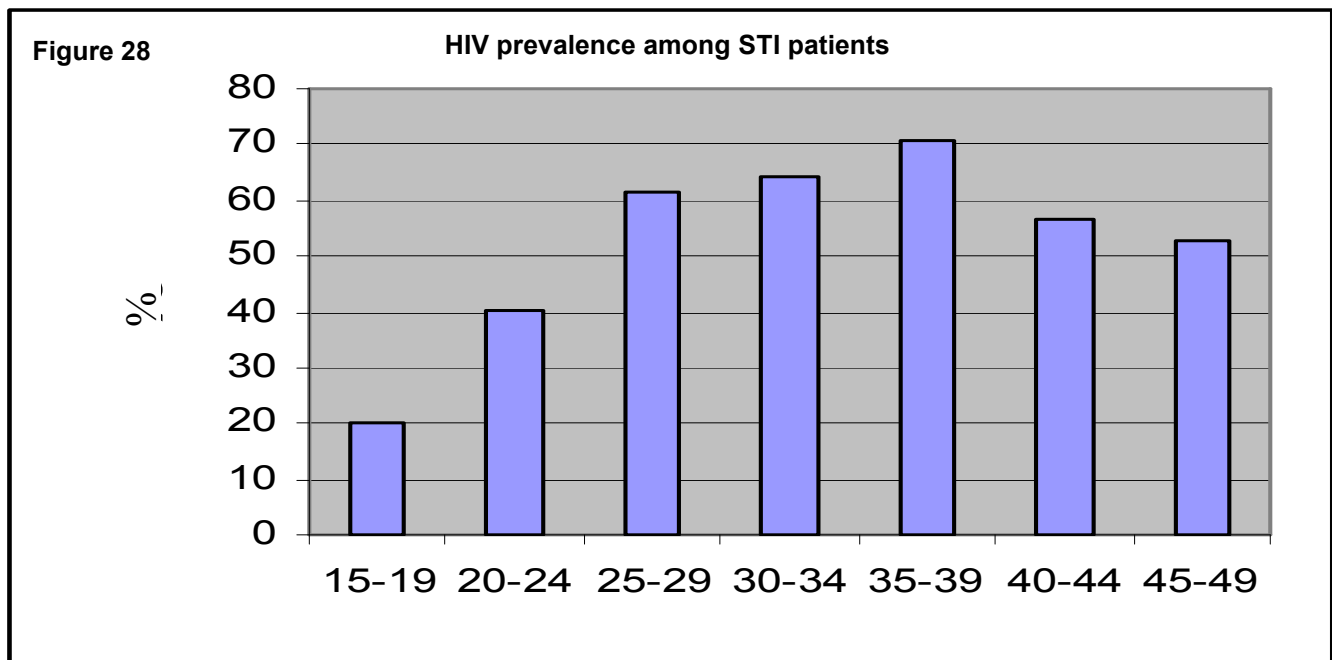
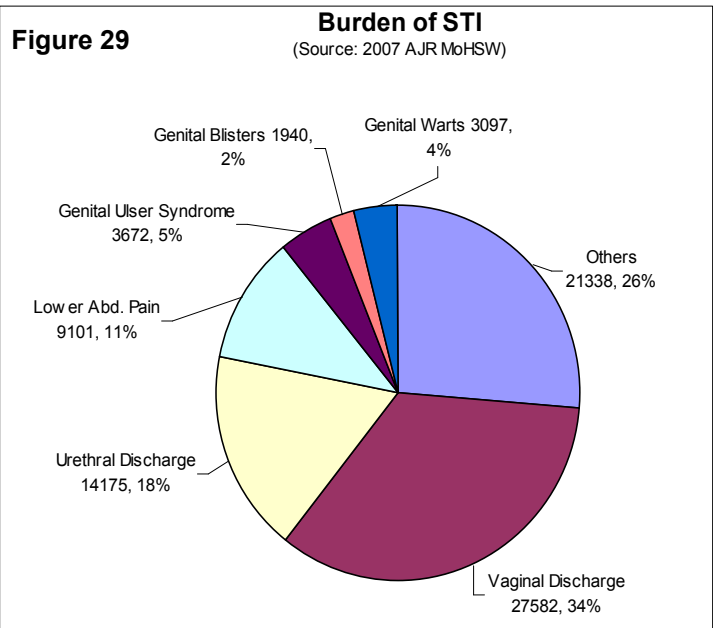
The scaling up of MC requires approx. 34,798 male circumcisions in 2008, increasing to 44,164 in 2015. This is an annual number of 27,473 circumcisions, or a daily average of 114 circumcisions for the next 10 years to achieve and maintain 52.5% coverage. This will require on average 9.1 surgical nurses and 10.9 physicians to be dedicated full time to male circumcison over the period 2008 to 2020.

Behaviour change communication

Lesotho is currently developing a Behaviour Change Communication (BCC) strategy. In 2007, a communication strategy was developed to support the KYS campaign. Current BCC activities are fragmented and it is hoped the new BCC strategy will endorse an integrated approach to promoting behaviour change in the country. An assessment of existing HIV and AIDS educational material for young people was undertaken in 2007 involving 15 organisations. This assessment found that there are inadequate materials on HIV prevention aimed at adolescents.

The Information Education Communication (IEC) materials are produced mostly by MOHSW and a few NGOs (national and international) and are distributed in the districts by different implementers to the community members. The

graph shows that the majority of these materials were distributed in Maseru (8,200) followed by Mafeteng (6,880) and Butha-Buthe (6,155). Qacha's Nek had the lowest (71) followed by Berea (1107). Printing of IEC materials for most NGO's remains a challenges due to reasons related to limited capacity and funding. Therefore in most cases NGO's distribute more IEC materials that were received from other sources than they produced themselves. A full analysis of the communication materials and HIV preventions responses will be undertaken in early 2008.



STI Treatment

The sentinel HIV/Surveillance of 2007 shows that 1.4% of ANC clients and 2.3% of STI clients had syphilis. The prevalence of HIV among STI patients was high at 56.2%, indicating a need for accelerating STI treatment along side other prevention measures, refer Figure 28.

STIs were among the top ten causes of frequent OPD consultations at health facilities in 2006. Of the 1,091,752 OPD new contacts in 2006, 74,520 (7%) were attended for STI complaints. This number rose to 80,905 in 2007. In 2006 about 51% of the consultations were on account of genital discharges – 18% in males and 33% in females. In a sample of 820 STI clients drawn from Maseru and Motebang STI sentinel sites in 2007, 56.2% were HIV positive. The overall trend of Syphilis is decreasing. According to the ANC Sentinel Surveys, there was a 38.9% HIV prevalence and a 2.9% Syphilis prevalence in 2003. By 2007, the prevalence of HIV was 25.7% and the prevalence of Syphilis was 1.4% among STI clients.

In the course of 2006 and 2007, consensus on integrated data collection tools were established and to date STI data is collected as part of the overall general OPD data collection systems. A draft update of the STI management guidelines was produced but will be finalized after the results of the ongoing STI Etiological Study are out. STI awareness and supply of medicines was strengthened. The STI and AIDS Directorate in the MOHSW also conducted a Drug Sensitivity Survey through support from Irish Aid. Data collection is complete and data analysis is ongoing. STI surveillance was integrated into the routine data HMIS as from April 2006 and the figure below show the summary of data collected up to December 2006. Figure 29 shows the breakup of the STI OPD visits for 2006.

Reaching most at risk populations

A literature review indicates the presence of sex work in several locations in Lesotho. Around 1.7% of men reported having had paid sex in the last 12 months (2004 LDHS). Out of those, 58% responded that they had used a condom in the most recent encounter. There is also anecdotal evidence about the presence of males who have sex with males. There has not been any

systematic effort to estimate the size of these populations or measure HIV prevalence among them. Dedicated services or outreach programmes to reach these populations are currently not available, though most of them have access to STI services, condoms and ART through the facilities available to the general public. There are no known injecting drug users in the country. There is also no data on the percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission or have taken an HIV test and received their results in the last 12 months. More studies need to be conducted in this area. Intergenerational relationships seem to be an important phenomenon: the 2004 LDHS found that 7.2% of young women (15-19) who had sexual intercourse with a non-married, non-cohabiting partner in the last 12 months did so with someone who was 10 years or older than themselves. There is also anecdotal evidence suggesting that this figure might be an underestimation.

However, even though knowledge and data is scarce about these most at risk populations, progress has been made in Lesotho though the adoption of *the National HIV and AIDS Policy (2006-2011)* and the *National HIV & AIDS Strategic Plan (2006-2011)* recognizes the need to address vulnerable populations such as sex workers, migrant populations, people with disabilities and heard boys. The National HIV and AIDS policy stipulates that the state should take steps for the establishment of user friendly services, improve access to information and ensure a participatory approach to the development of these programmes. In addition, the *National Action Plan on Women, Girls and HIV and AIDS: Facing the Future Together 2007-2010* commits to promote the equitable access to treatment for HIV and AIDS by women and girls, including sex workers. It also aims to design targeted programs to address violence against women sex workers (and all women).

During the reporting period there was only one programme in Lesotho which targeted at sex workers: the Sexual Health and Rights Promotion, "SHARP!" implemented by CARE Lesotho. It was launched in 2001, and worked mainly through training peer educators (including sex workers), capacity-building of community-based organisations, addressing gender based violence, establishing community resource centres. The main targets were border towns with South Africa,

and the programme, in addition to sex workers, targeted truck and taxi drivers, low-income women, mineworkers, youth and factory workers. The programme ended in 2006.

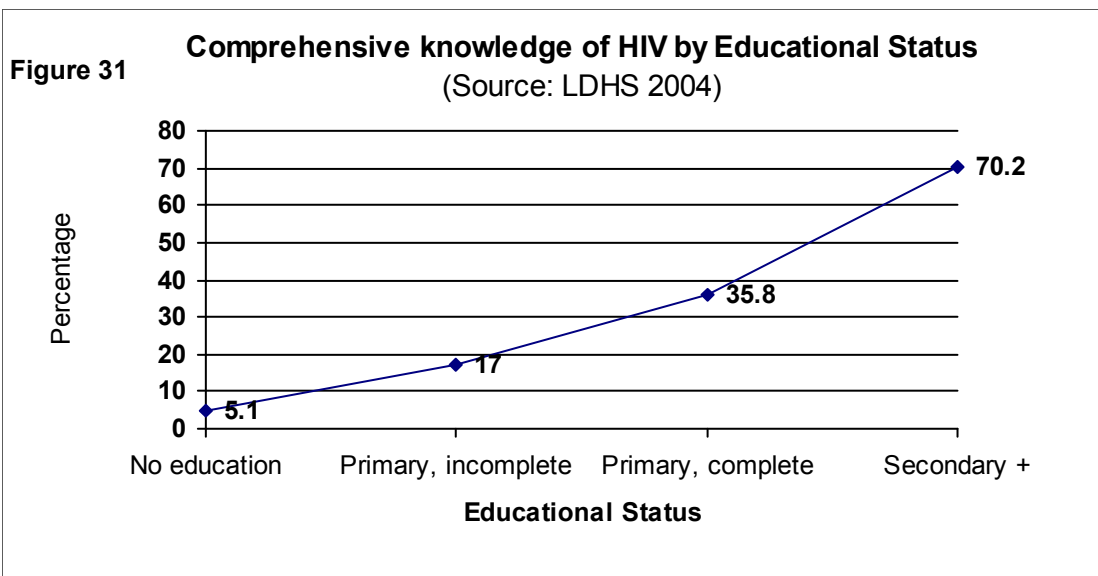
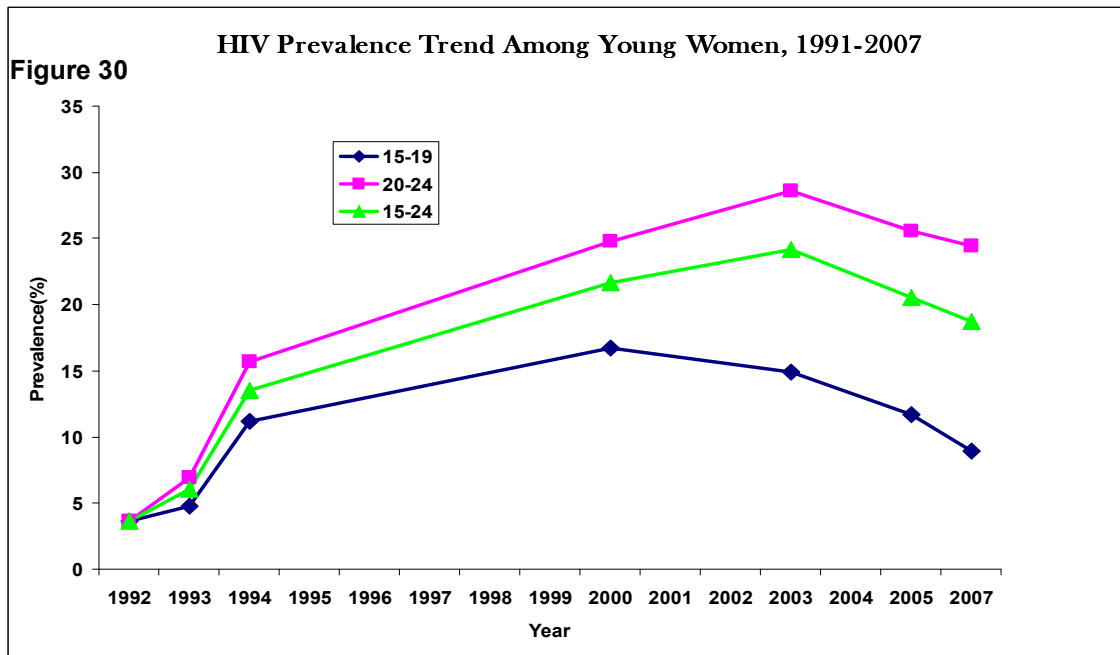
The number of orphans supported through MOET with DSW and NGOs has increased by 70% from 11,502 in 2005 to 19,607 in 2007. This is expected to increase with the EU-supported OVC programme. The Lesotho Planned Parenthood Association (LPPA) has also provided *ad hoc* demonstration of female condoms and provided free condoms through outreach activities towards sex workers on a small scale from 2001 onwards.

HIV Prevention among Young People

Knowledge levels among young people

In Lesotho, 18.4% of 15-24 year old males and 25.8% 15-24 year old females have a comprehensive knowledge about AIDS. However, comprehensive knowledge in the adult population (15-49) varies between the 10 districts, with the lowest being 11% of women and 6% of men with comprehensive knowledge in the district of Mokhotlong to the highest being Maseru with 33% of women and 26% of men with comprehensive knowledge.

Knowledge levels are correlated with education. Only 5.1% of the adult population (15-49) with no primary education has comprehensive knowledge about AIDS compared to 70.2% of those with



secondary or higher education as shown in Figure 31. However, even though comprehensive knowledge increases with the highest education attained, the relationship between HIV prevalence and education is not linear. A regression analysis of the 2004 LDHS data showed that education is strongly correlated with condom use, abstaining until marriage, delayed sexual onset, and accessing HTC.

Sexual behaviour among young people

In Lesotho, 27% of young men and 15% of young women had sexual intercourse before the

age of 15, as shown in Figure 33. Additionally, according to the Lesotho Youth Identity Study conducted in 2005, over 20% of young people, both male and female, over the age of 20 expressed that they would have more than one partner if given a chance, as depicted in Figure 32.

Furthermore, Corno and DeWalque in their regression analysis of the 2004 LDHS found that the reported age of first sexual intercourse is at the age of 19 for women and 16 for males. However, the 2004 LDHS shows that 14.8% of female and 27.2% of males are already sexually active at the age of 14.

Percentage of young people who would like to have more than one lover if they had the opportunity

Figure 32

(Source: Lesotho Youth Identity Survey 2005)

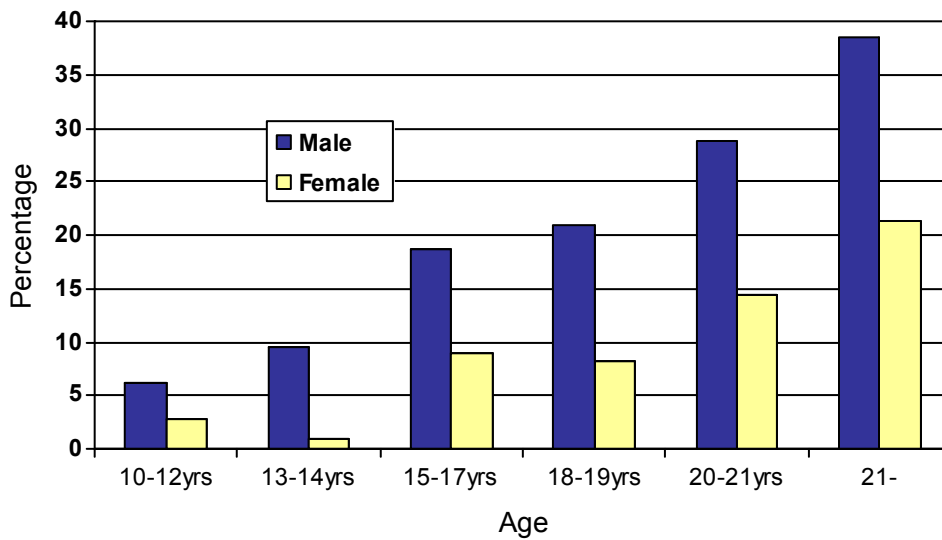
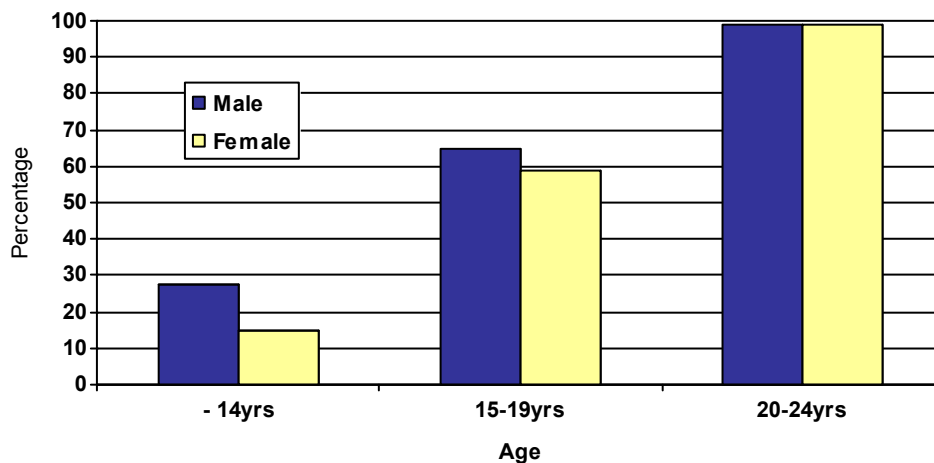


Figure 33

Percentage of Young People Sexually Active

(Source: LDHS 2004)



Furthermore, one in every five adolescent girls (15-19) are either pregnant or have had one birth (2004 LDHS).

The study also demonstrates that females growing up in urban areas are more likely to delay sexual debut – there was no similar relationship for males. In addition the analysis showed that age of first sex increases with socio-economic status for females, but found no such correlation for males.

The data on youth sexual behaviour and knowledge is unfortunately scarce in Lesotho. However, a needs assessment and situation analysis on sexual and reproductive health and related issues on young people (12-24) is being undertaken by the Ministry of Gender, Youth, Sports and Recreation in collaboration with UNICEF and UNFPA.

HIV interventions to reach young people

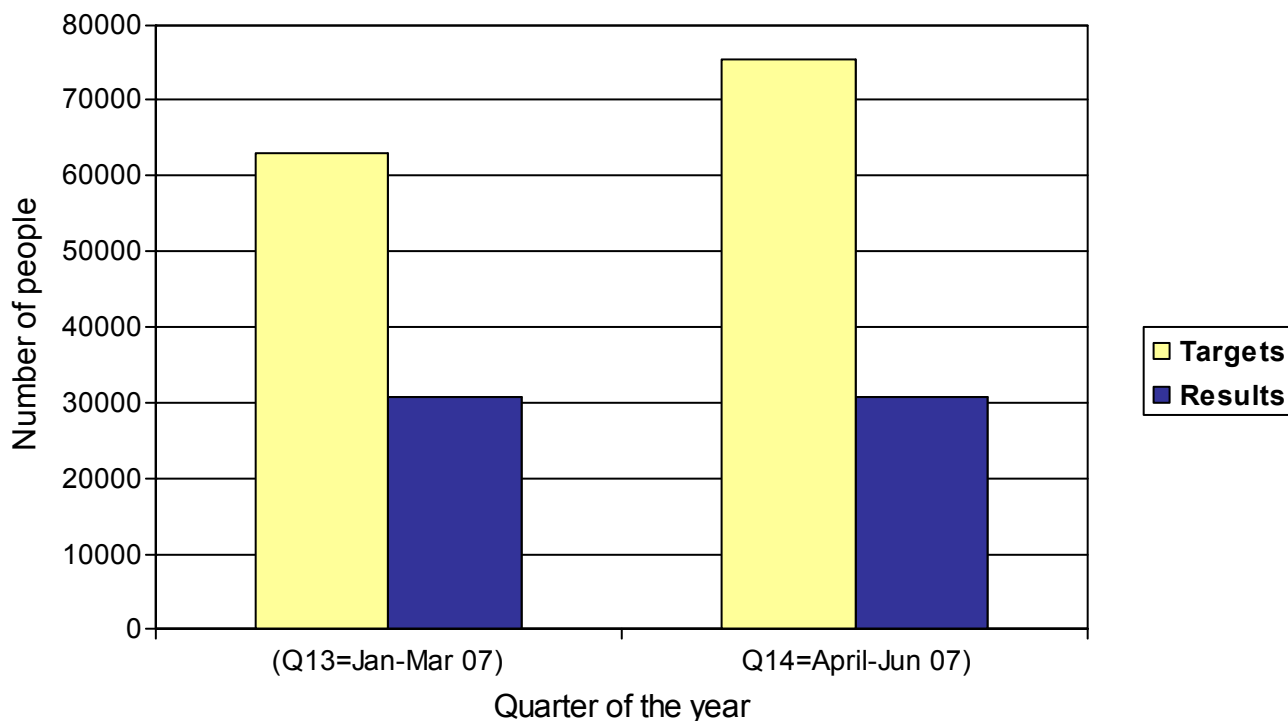
Training in life-skills and peer education is offered to youths, both the in-school and out-of school. The MOET through support of GFATM is in the process of revising the school curriculum to include issues of reproductive health and HIV and AIDS. Over 3500 teachers have been

trained on how to provide life-skills.

In addition, a separate programme exists for the out-school where NGO's and FBO's have been funded also mainly through Global Fund to promote various activities related to peer pressure including road shows, youth clubs and abstinence pledges. A cumulative total of 376,318 young people out of school were taught life-skills in 2006 and 388,741 by June 2007. The organizations that were involved in this undertaking were Red Cross, Scripture Union, World Vision and the MGYSR. The number of young people out of school reached with life-skills education by far exceeds the target of 228,438 set for 2006; making this undertaking extremely successful.

The MGYSR implemented the UNICEF developed "string game" in all the districts in Lesotho. In 2007, string game interventions reached 60,000 young people with HIV prevention messages. An independent evaluation of string game intervention showed that while the approach was an effective one, specific behavioural change objectives and indicators must be built into the programme. In order to standardise the interventions for outreach to young people, the MGYSR in collaboration with implementing partners has developed a minimum

Figure 34 **Lifeskills Education for Youth at School**
(Source: Global Fund Coordination Unit, Ministry of Finance 2007)



package of interventions to be used across the country.

To ensure meaningful child participation and empowerment on issues that affect them, 60 peer educators, from the Girls and Boys Education Movement (GBEM), were trained on HIV and AIDS, gender, children's rights and life skills. This assisted the young people to gain useful knowledge which they will be passed on to their peers during peer education activities in their schools. A total of 10,000 copies of HIV and AIDS learner's books and 500 copies of teachers' books were printed and distributed to Non-Formal Education (NFE) learning posts in an effort to mainstream HIV and AIDS within the education system, and among the most vulnerable groups of children.

HIV prevention at the workplace

Lesotho has developed national guidelines for the implementation of workplace programmes for HIV. BCC strategies for specific target groups have been developed. A major HIV prevention programme is carried out in the textile industry, which is one of the largest employers in Lesotho. A total of 36 labour inspectors have been trained on promoting HIV issues at the workplace. The labour code was amended in 2006 to take into account HIV and AIDS in the workplace. The amended code prohibits pre-employment testing, testing during employments, ensures confidentiality and non-disclosure and prohibits discrimination in employment, amongst others. However this law only applies to private employers and parastatals and does not apply to civil servants. The Government of Lesotho is one of the biggest employers in the country and it is important that similar provisions ensuring non-discriminations at the workplace also apply to civil servants.

Several workplace programmes have been initiated in Lesotho. Prominent among them is the workplace programme at the Apparel Industry, one of the biggest employers in the private sector accounting for nearly 80% of the workforce. The Apparel Lesotho Alliance to Fight AIDS (ALAFA) was formally launched in Maseru on 16 May 2006 by development activist and musician Bono. ALAFA started with a pilot implementation in one factory with 4,500 workers in Maseru. Since December 2006, more than 20 factories have been included in the prevention programme,

giving 30,000 workers access to at least basic prevention interventions. Out of these factories, 9 have established workplace clinics, giving their employees access to medical services funded through ALAFA. At the end of November 2007, 17,000 workers had access to the complete ALAFA workplace HIV Programme. ALAFA seeks to reach out on the entire textile workers, currently estimated to over 48 000. The programme caters for both female and male workers, based in Maseru textiles, with intent to expand to Maputsoe industrial sites in the district of Leribe before the end of 2008 (also see best practice section for more details).

The Ministry of Trade, Industry, Cooperatives and Marketing (MTICM) is also in the process of developing IEC materials for use among the medium and small scale industries.

The Association of Lesotho Employers has also initiated several workplace programmes and undertaken advocacy with employers.

Blood Safety

All blood used for transfusion purposes in Lesotho is screened for HIV. Lesotho Blood Transfusion Services (LBTS) is the only centre in the country which recruits blood donors. LBTS is also the only centre in country tasked to collect, screen, store and distribute blood. Therefore it is the only centre in which screening of donated blood takes place. The LBTS screens 100% of donated blood units. All units are screened for ABO (cell and serum) and RhD grouping, HIV Ag/Ab Combo through ELISA, HBsAg through ELISA, HCV using ELISA, and Syphilis through RPR. Donors are selected based on a physical examination and medical history which is collected through a standard questionnaire.

All staff working in the LBTS receive training on quality management. An External Quality Assessment Scheme for HIV screening is in place. Samples are periodically sent to the National Institute for Communicable Diseases, South Africa for quality assurance.

To collect blood, the centre organizes blood collection clinics (mobile clinics). In 2006, the mobile clinics made 146 site visits and in 2007 they made 136 visits. From these sites together with the LBTS a total of 2,892 and 2,308 units of blood were collected in 2006 and 2007 respectively. The donation centres were set up at secondary schools and colleges (52.0%), in government offices and in the private sector (25.1%) in all 10 districts of

Lesotho. In 2007, the mobile clinics made 136 visits, from which 2,308 units collected (67.1%). An additional 727 units were collected at LBTS (24.0%). The total number of units collected in 2007 was 3,035. The clinics were set up at secondary schools (47.3%), colleges and training institutes (17.4%), and in offices and public gatherings (11.3%) in the 10 districts. About 22.9% of the blood units were collected at LBTS centre in 2006 and 24% in 2007. Out of the 2,892 units collected in 2006, 16.9% came from regular voluntary donors. Only 0.8% donors were collected by family replacement donor, with the remaining units collected on a voluntary basis; there were no autologous donors in 2006. Out of the 3,035 units collected in 2007, 2.5% were family replacement donors and 16.3% came from regular voluntary donors; there were no autologous donors. The remaining 81.1% units came from first time voluntary donors. The HIV prevalence among blood donors was 4.6% in 2006 and 4.5% in 2007.

During 2007, HIV prevalence among blood donors was 4.5%. It is interesting to note that the LBTS specifically aims at recruiting blood donors from the young population given the higher HIV prevalence in older age groups (for more information see *indicator 22*).

In terms of the blood transfusion requirement (Figure 35), the target in 2006 for LTBS was 4,000, and the estimated need according to the WHO Guidelines on Blood Transfusion was 6,000 units. As such, the LTBS reached 72% of its target, and 48.2% of its need of blood units

for the year 2006. In 2007, the target and the need remained the same, but the total number of units collected increased slightly to 3,035 (resulting in the LBTS reaching 75.9% of its target and 50.6% of its estimated need in 2007).

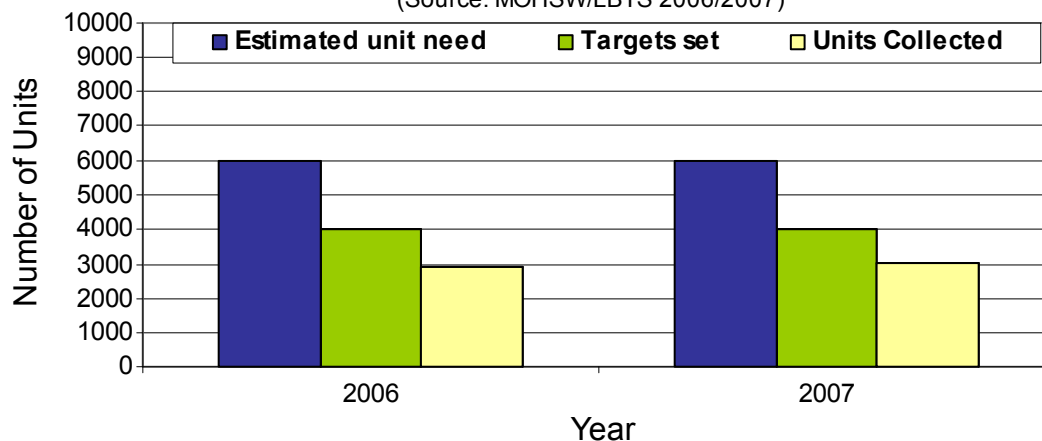
The reasons suggested for not meeting targets was according to the Annual Joint Review report 2006/2007 from the Ministry of Health and Social Welfare was due to the absence of a blood donor recruiter.

However, the LBTS has since March 2007 received funds for recruiting a blood donor recruiter from the *Safe Blood for Africa Foundation*. The main focus for this staff member is donor recruitment and public education; consequently, the target for 2008 has been raised to 5,000 units. Additional constraints for the LBTS as stated in the National Policy document are the lack of organized and planned blood collecting campaigns and not having a qualified medical doctor as permanent staff.

Figure 35

Blood Transfusion Requirements

(Source: MOHSW/LBTS 2006/2007)



Care, Treatment, and Support

Lesotho has made significant progress in the area of care, treatment and support. Treatment is now available in remote parts of the country. It is estimated that M 48.8 million was spent on treatment, care and support in the year 2006-07.

ART Access

In 2005, 77,986 men and women in Lesotho were in need of ART according to the revised GoL/UNAIDS 2007 estimates, but only 8,000 people had access to ART resulting in coverage of 10.2%. Furthermore, the estimates showed an increase in the number of people in need of ART rising to 81,270 (63,100-98,200) in 2007. Currently, 21,710 have access to ART, meaning that approximately 25% of those in need are accessing ART in Lesotho. Projection of treatment requirements vs. ART access is further illustrated in Figure 38.

The first ART site in Lesotho was established in 2002 in the capital district of Maseru. Since then, the GoL/WHO adopted a scale up plan in 2004 to decentralize ART service delivery, and ART is now available in a total of 104 sites which include hospitals, health centres and private practitioners. In 2007, the GoL revised its ART guidelines, to be in with the WHO

2007:Numbers Adults (15+) needing ART: 81,270 (63,100 – 98,200)

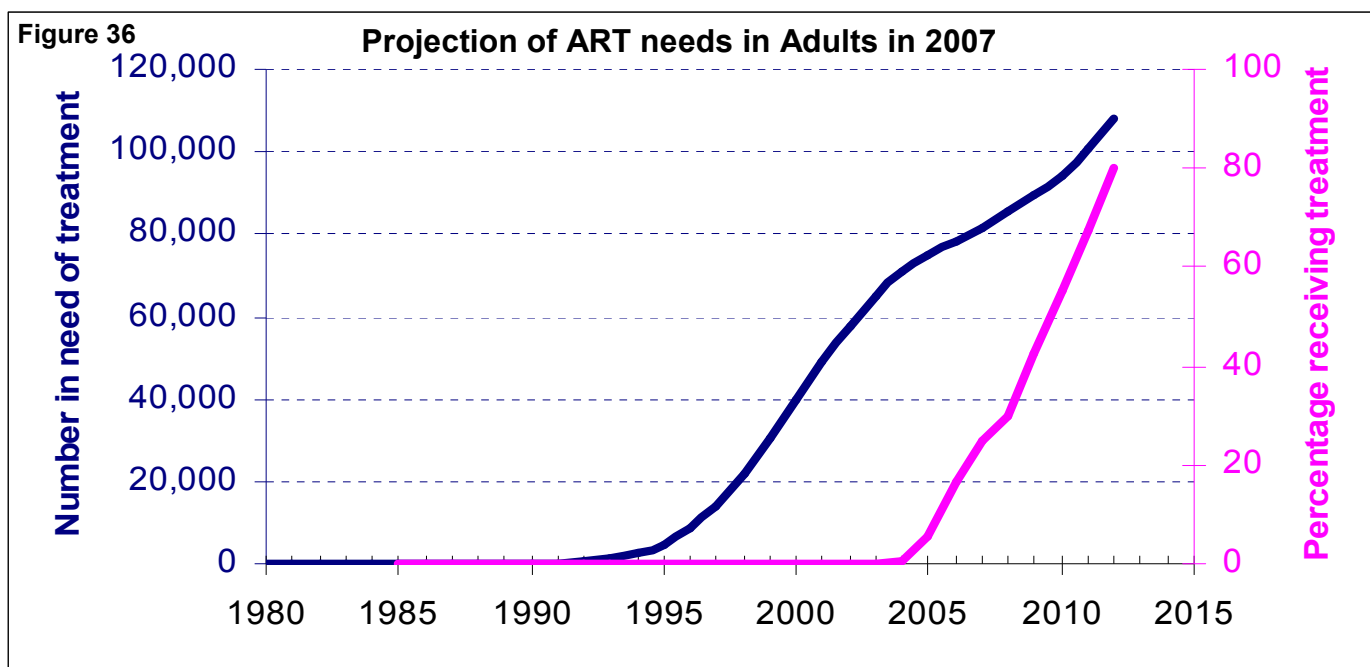
2008:Numbers Adults (15+) receiving ART: 21,710 (Source: MoHSW)

guidelines.

It is now recommended that people with CD4 count below 350 are eligible for treatment, whereas previously ART was recommended when CD4 count was below 200.

MOHSW ART coverage report indicates that in the month of November 2007, 21,710 people were on antiretroviral treatment. Out of this total, 7.2% (1,553) were children below the age of 15, and 92.8% (21,157) were adults. Adult women make up just over 2/3 of those accessing treatment (13,275), whereas females under the age of 15 make up half of the children on treatment. In addition, 49,192 people were enrolled on chronic care up to March 2007.

WFP is currently providing nutritional support to approximately 5,510 households infected with and affected with HIV with a total of about 25,158 beneficiaries. The food support is distributed via health centres once a month. An additional, 350 children on ART are given food support through Queen II Hospital and Baylor Clinic. WFP is also providing food assistance in 10 health centres out of which 2 are for paediatric AIDS. The food aid is currently given for the first 9 months after which the clients are transferred to ongoing food for work/asset programs.



Paediatric AIDS

The estimated number of children needing ART treatment is 3520 and the coverage was about 931 (26%) in November 2007 as per Figure 40.

The Baylor Centre of Excellence's outreach program was supported by UNICEF to deliver Paediatric HIV care and treatment mentoring and training to 5 hospitals and staff from filter clinics in 5 districts. In-service training of staff from all hospitals on DNA-PCR testing has been undertaken by UNICEF in collaboration with Clinton Foundation and Baylor College. DNA-PCR testing has been rolled out from 5 hospitals in 2006 to all the 17 hospitals in 2007 and will be expanding to all the 165 health centres in 2008. DNA-PCR testing for over 3,437 HIV exposed children in 2007 and 1,400 HIV exposed children in 2006 was undertaken. UNICEF has also provided PMTCT and Paediatric HIV supplies, namely: a) 200 Haemoglobino-meters for the implementation of the new PMTCT and Paediatric HIV regiments and for use in all ANC clinics. b) A total of 65,000 HIV rapid testing kits for HIV testing of pregnant women in all ANC clinics; c) 1,000 midwifery kits and 50 sterilization kits to expand safe delivery services to 50 additional maternity sites.

TB-HIV co-infection

Lesotho is committed to achieving the MDG of reducing the TB burden by 50% of 1990 prevalence, and reversing the trend by 2015. It

is the main agenda of the National TB Control Programme. Lesotho revised its *TB Control Policy* and adopted a *National TB/HIV Strategic Plan for 2007-2010*. The focus of the Stop TB Strategy is to ensure high quality DOTS expansion, address TB and HIV and MDR and TB, improve the health system, expand Public-Private Mix, empower people with TB and communities and to create an enabling environment for TB research. It is estimated that 76% of patient suffering from TB in the country are also infected with HIV according to the WHO TB Global Report (2006). In 2006, only 1907 HIV positive people with TB were identified. However was a three fold increase in the first three quarters of 2007 with nearly 4,500 people with TB found to be HIV positive and put on treatment.

By the end of 2007, a total of 12,201 cases of TB of all forms were noted. Of these cases, 5,767 (47%) accepted HIV testing after counselling. Of those 5,101 (88%) were found to be HIV positive. Post test services were offered to 80% of those who tested positive.

TB control received more resources as ten district TB Officers were appointed to coordinate the process of the decentralisation of TB services with closer linkage to HIV and AIDS control. In addition, technical assistance was received from WHO, KNCV, PIH, URC, and CDC Atlanta. The Global Drug Facility provided two years first line anti TB drugs.

Details of TB/HIV patients are further illustrated in Figure 38 and 39.

Total number of people on ART in November 2007

Figure 37

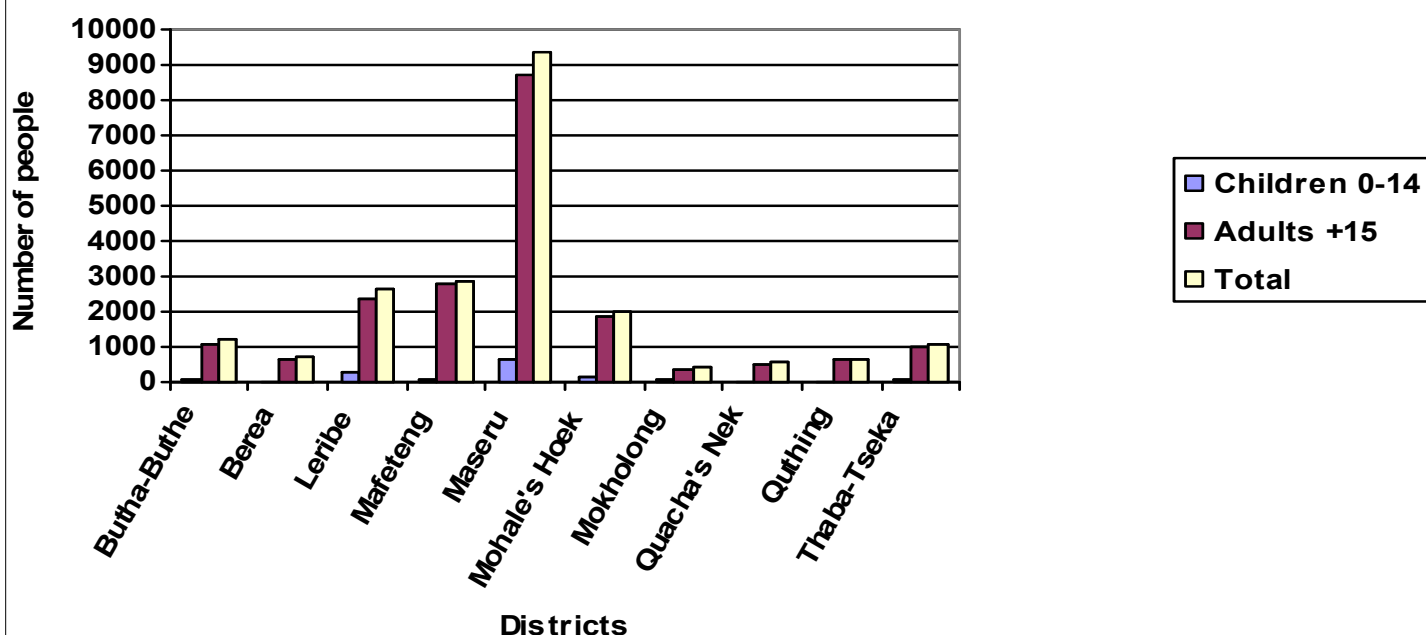
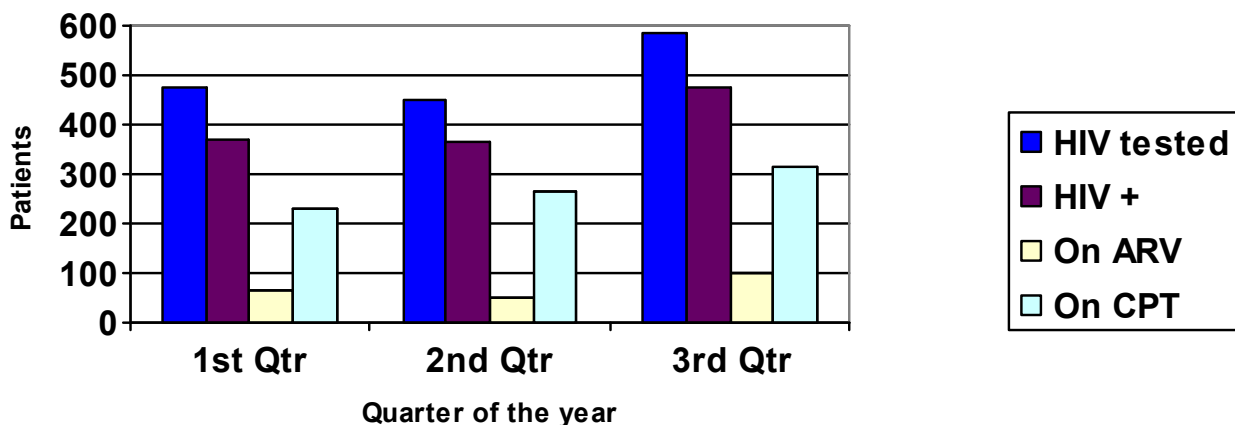


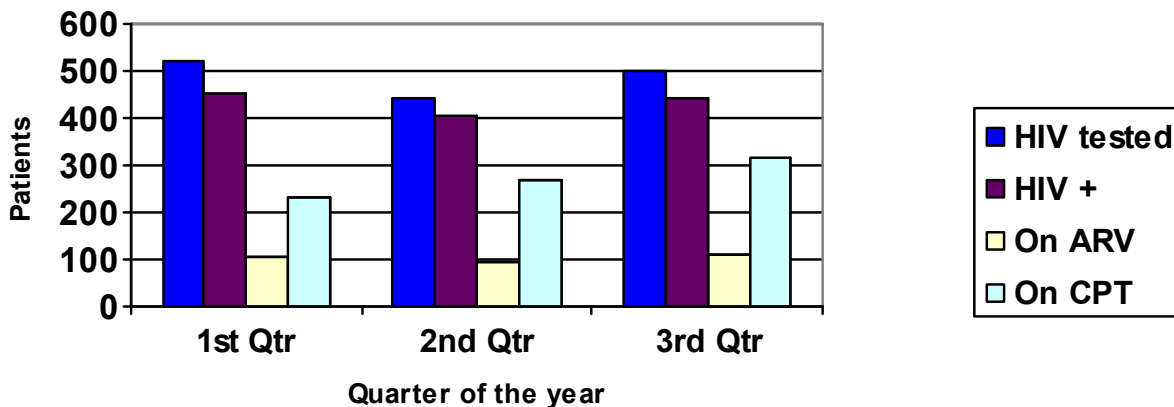
Figure 38

Male TB patients on HIV treatment



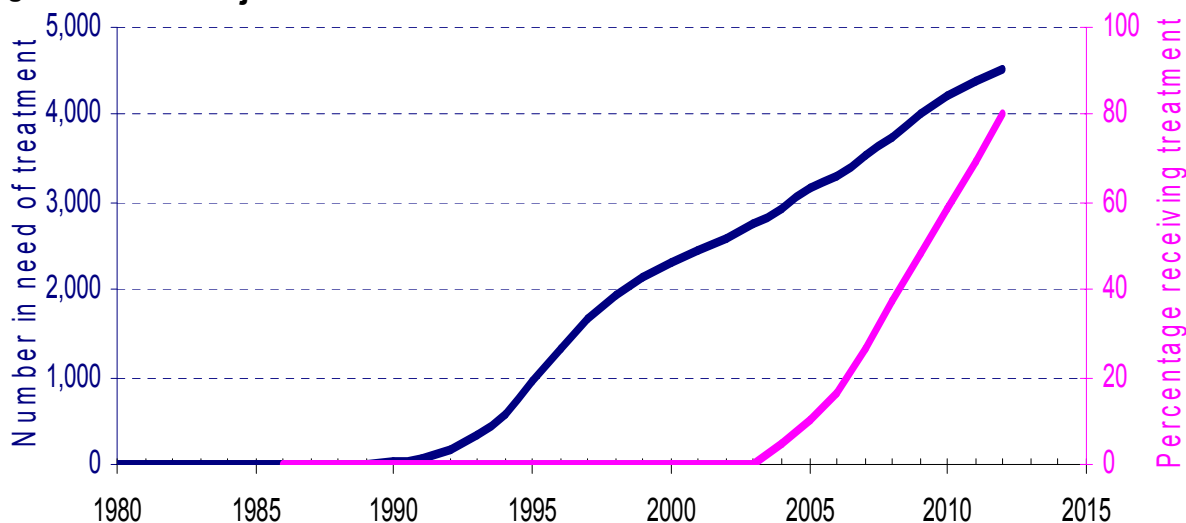
Female TB patient on HIV treatment

Figure 39



2007: Numbers Children needing ART: 3520 & Numbers receiving ART: 931

Figure 40 Projection of ART needs in Children in 2007



Impact Mitigation

The adoption of the National OVC policy in 2006, helped poise OVC programmes in Lesotho to scale up. Several programmes are also now being initiated to alleviate the impact among people living with HIV and those affected by HIV. It is estimated that M 56.1 million was spent on impact mitigation in the year 2006-07. The total number of children orphaned due to AIDS is estimated at 108,700, as shown in Figure 41. This number has increased from 2005 where an estimated 88500 were orphaned due to AIDS². The estimated number of dual orphans is around 46,600, while there are around 73,000 paternal orphans and 77,000 maternal orphans at the end of 2007.

The ratio of school attendance among orphans and non-orphans aged 10-14, was estimated as 1:1 according to the 2004 LDHS. This has been maintained through making primary education free as of 2005 and the provision of bursaries for those in secondary schools. Programmatic data indicates that roughly 32% of OVC are receiving free basic support. Furthermore, the GoL has been able to mobilize funds from the European Commission and The Global Fund to fight AIDS, TB and Malaria for implementing the OVC component in the national response. This will significantly increase services to approximately 100.000 OVC in the next few years. In addition, a national OVC registration system is being developed by the GoL and it is also considering providing cash transfers to households caring for OVC. Another milestone was the adoption of the *National Policy on Orphans and Vulnerable Children* in 2006.

The National OVC Coordinating Committee (NOCC) has been established, which is responsible for the coordination of the OVC

National Action Plan (NAP – whose development was also supported by UNICEF together with the development of the National OVC Policy). The NOCC also fosters linkages among implementing partners and the District Child Protection Teams, that ensure implementation and coordination of the OVC NAP at district and community level.

To address the vast disparities in orphan related data, an orphan registration system has been integrated into the Government's vital birth and death registration system. Progress has been significant in identifying and registering orphans in a standardized manner. The release of a circular instructing the relevant authorities in the Ministry of Local Government and Chieftainship to implement the orphan registration led to the printing and use of 600 orphan registration books and subsequent training of implementing structures.

In an effort to strengthen skills of service providers and ensure quality in the practice and provision of psychosocial support (PSS), UNICEF has supported training in play therapy, a form of psychosocial support and trauma alleviation method which is carried out through play, since 2003. In 2007, training of trainers was conducted for 23 trainees who were provided with play therapy teaching and learning materials to enhance their skills as trainers on play therapy. These trainers will roll-out the training at district and community level in 2008. The practice will be monitored by the newly established and registered Lesotho Association of Play Therapy.

The process of establishing a child helpline commenced in 2007, which will be formally launched in 2008. The child helpline will not only be a tool for addressing issues around abuse, neglect and exploitation of children, but also a channel in which children can access information on HIV and AIDS.

The OVC livelihood project (Supported by Food

Lesotho's operational definition for an OVC:

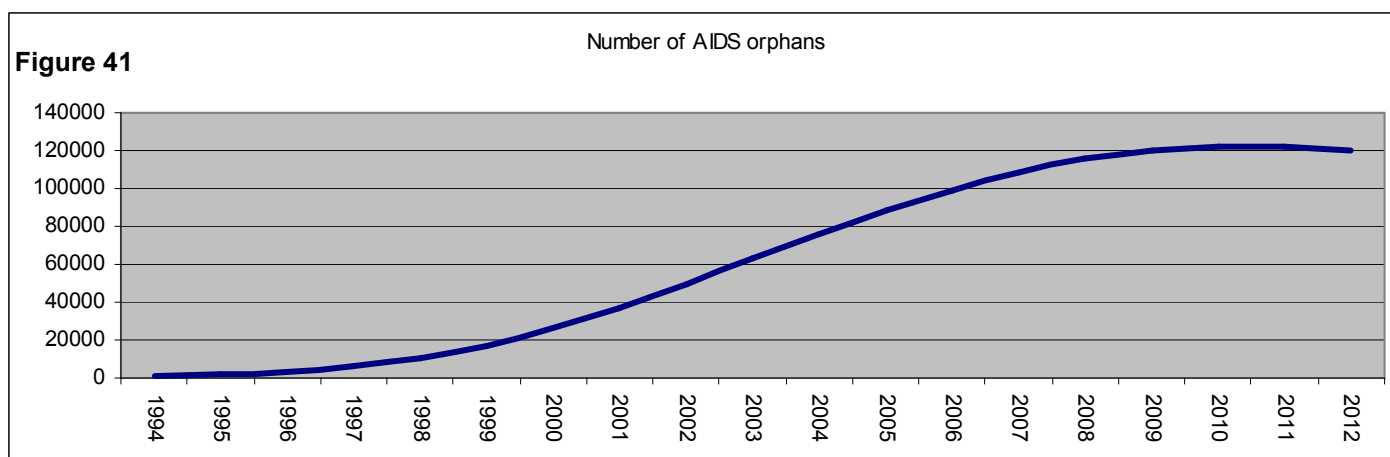
“An Orphan is any person who is below the age of 18, who has lost one or both parents due to death. A vulnerable child is any person who is below the age of 18, who has one or both parents who have deserted or neglected him/her to the extent that he/she has no means of survival and as such is exposed to dangers of abuse, exploitation and/or criminalisation and is, therefore, in need of care and protection. Vulnerable children include orphans, children living on the streets, children with challenging behaviour, children in need of legal and other forms of protection, children who have been or are physically, psychologically, emotionally, or sexually abused, neglected children, children who behave in a manner that may harm them, children involved in child labour, children with disabilities, children involved in commercial sex work, children who frequent the company of immoral persons, children infected or affected by HIV/AIDS and other chronic diseases, children whose parents are delinquent and/or children who cannot be supervised by their parents or guardians and children who by virtue of their age are vulnerable (under 5).”

and Agriculture Organization) on the other hand aims to improve household food security and nutrition for orphaned and vulnerable children (OVC). Activities under the two programmes include:

- Input Fairs - a voucher system (with a monetary value) that enables vulnerable households to purchase seeds and other farm inputs at locally staged input trade fairs. These fairs strengthen local market mechanisms, retain money in the local economy and provide a market outlet for local produce. FAO and its implementing partners use these fairs as a platform for introducing improved inputs into the farming system and raising HIV/AIDS awareness in participating communities.
- Widening the scope of the voucher system to enable vulnerable households to acquire dual purpose chickens to improve backyard poultry production in order enhance household food and nutrition security.
- Promoting awareness and understanding about the importance of nutrition in boosting the immune system for HIV-infected individuals and other household members;
- Promoting homestead vegetable production for vulnerable and HIV/AIDS affected communities using innovative technologies.
- Promoting labour saving technologies and practices to overcome labour shortages and labour peaks associated with farming. These technologies include conservation agriculture which employs the principles of minimum tillage. The technology does not only save labour but also reduces the rate of soil erosion which is largely to blame for the declining agricultural productivity and food security in Lesotho.
- Reducing the burden of daily household tasks through promoting simple technologies such as water control, keyhole gardens, roofwater harvesting and simple, small scale irrigation systems such as drip irrigation.
- Supporting the livelihoods of HIV/AIDS affected households and encouraging livelihoods diversification through introduction of low-labour input enterprises such as dual purpose poultry and other small livestock.

Table 3: GOL and NGO support to school going orphans

Institution	2005/06	2006/07	2007/08
Ministry of Education	10,625 (92.4%)	12,000 (94.3%)	18,000 (91.8%)
Lesotho Red Cross	200 (1.7%)	340 (2.7%)	124 (6.4%)
Lesotho Save the Children	127 (1.1%)	179 (1.4%)	186 (0.9%)
Maseru	485 (4.0%)	161 (1.3%)	133 (0.7%)
Quthing	72 (0.6%)	43 (0.3%)	35 (0.2%)
Thaba Tseka	20 (0.2%)	7 (0.05%)	6 (0.03%)
Total	11,502	12,730	19,607



Major challenges and remedial actions

Although Lesotho has made significant progress since the last UNGASS reporting period, the country has been faced with a number of major challenges towards the implementation of the national response, as shown in Table 4.

The response is still largely fragmented at the national and district level. The institutionalization of the National AIDS Commission (NAC) in Lesotho is a key achievement towards addressing and coordinating HIV efforts in Lesotho.

Some of the main challenges reported in the 2005 UNGASS were improved coordination of efforts at all levels, better mainstreaming of HIV and AIDS and a unified M&E plan. Although the NAC was established in 2005 and key personnel such as the Chief Executive appointed, this institution was not fully functional during its first year as technical staff had not been recruited. This has since changed, with the NAC fully assuming its coordinating role of the national response to HIV and AIDS. Its major achievements have been the development and dissemination of the National HIV and AIDS Strategic Plan 2006-2011, National HIV/AIDS Policy as well as the National Monitoring and Evaluation Framework.

Table 4: Major Challenges to the National Response and Remedial Actions

Thematic Area	Progress since 2005	Challenge	Remedial Action
Prevention	Scale up of HIV Testing and Counselling through the KYS campaign Scaling up of PMTCT programmes	Slow progress in achieving behaviour change. Low coverage of prevention programmes for main target populations Limited number of targeted interventions e.g. herd boys, sex workers, and males who have sex with males	Undertake a prevention review to gain understanding of prevention efforts in place Targeted prevention efforts implemented in 2008-09
Treatment and Care	Massive scale up of ART (10.2 % in 2005; 25% in 2007).	Limited human resources Adherence to treatment Limited access to health facilitated and drugs National support and food security	Train and retain health professionals Increase capacity of family and community health members to deal with adherence of ART Improve procurement process of drugs Review of duration of food support to people on ART/TB
Impact Mitigation	School feeding programme and take home ration for orphans	No proper mechanisms in place to make sustainable and appropriate programmes to mitigate the economic and social impact of HIV/AIDS Increased number of OVC but no clear registration process in place	Ensure proper registration of OVC in place Avail resources towards impact mitigation
Management and Co-ordination	A fully functional decentralized NAC established Development and to some extent implementation of the National Strategic Plan (2006-2011) Increase in allocation of funding towards the national response	Lack of timely data collection and dissemination Stakeholders not collaborating and coordinating at district and community level Lack of clarity of roles and responsibilities at all levels and acceptance of NAC as the lead organization to lead the national AIDS response	Standardization of data collection tools Put policy in place on timely release of good quality data GoL support to facilitate NAC coordination and stakeholder collaboration

Monitoring & Evaluation Environment

Overview of the current M&E system

Prior to 2004, there was no country-specific HIV and AIDS M&E plan for Lesotho and activities were largely integrated with the on-going Health Sector Reform programme M&E strategy. The set up and functioning of the NAC in 2005 was instrumental in the development of a National HIV and AIDS Strategic Plan (2006-2011) with a costed Monitoring and Evaluation Framework (2006 – 2011). The development process of the M&E plan was very consultative and was endorsed by key partners in M&E such as development partners, local and international NGOs, government ministries and civil society organizations.

Progress on alignment and harmonization of M&E activities of key partners to the M&E framework indicates that some partners have done so whilst others have not yet. The main reason for the latter is that some of the key partners had already developed their M&E plans prior to the National M&E framework and hence were unable to re-align with it immediately.

The M&E plan clearly stipulates the National Core Indicators with core out-put indicators that address clinical and non-clinical HIV data. Implementation of this plan is underway with the main achievements thus far being: establishment of a functional M&E unit at NAC, setting up of a central HIV data base – the Country Response Information System (CRIS) within government, setting up of data collection mechanisms and data flow systems,

decentralization of the M&E system, Health Management Information System (HMIS) in place and establishment of a functional M&E technical working group, which includes representation from civil society including PLWHA and serves as an advisory body to the M&E system.

NAC and the Ministry of Health have placed data officers in each of the districts to collect data on coverage of HIV and AIDS programmes. These officers have been trained on using CRIS as well in data management. In the coming years there is a need to establish strong district level linkages between the two to promote district level analysis of data to feed into the implementation of the activities at the district level. Training of civil society organizations involved in the implementation of HIV programmes on M&E is planned in 2008.

Challenges faced with implementation and remedial actions

The main challenges faced with implementation of a comprehensive M&E system are mainly in the area of harmonization of M&E activities, data flow mechanisms, data collection and use, as summarized in Table 5.

Table 5: Major M&E Challenges and Remedial Actions

<i>Major challenges identified</i>	<i>Remedial actions</i>
Poor stakeholder collaboration and coordination of M&E activities at	Top government support to NAC to facilitate stakeholder collaboration and coordination of M&E activities.
Some of the key partner's M&E plans are not aligned with the National M&E plan.	High level advocacy with key partners and training of M&E focal points
Data flow mechanisms not working well, some due to limited stakeholder collaboration and inconsistency in reporting.	Clear definition of roles and responsibilities of M&E personnel at district level
Limited data use due to planning cycle not being synchronized with the reporting cycle.	Synchronization of planning cycle to take place when strategic information is produced.
Limited advocacy using strategic information	Providing regular updates (preferably monthly) to top leadership on progress made on Key indicators(e.g. number of people tested, number of people put on ARV, PMTCT, orphans registered and receiving basic support)

Support from the country's development partners

Key support received from development partners

Support to implementation of "three ones"

The main development partners involved with the HIV and AIDS response in Lesotho are Irish AID, United States Government-PEPFAR, European Union, GTZ, DFID, the GFATM, World Bank and the UN system. The development partners are committed to the implementation of the "three ones principles" and have used the various platforms provided to them to reiterate their support for the principles. The United Nations has established a Joint UN Team on AIDS (JUNTA) and developed a management arrangements framework outlining the roles of the different agencies and designated thematic team leads for different technical areas. The United Nations Development Assistance Framework (UNDAF) for 2008-2012 is in line with the National Strategic Plans and indicators used are consistent with the National M&E plan.

Financial support to the National HIV and AIDS response

Over 80% of the national HIV and AIDS response is funded through the development partners. In addition the development partners also provide technical support for the implementation of the national AIDS response. Most of the funding is project based, though discussion on providing budget support is currently underway (see also section on Resources available on HIV from development partners)

Coordination

Currently there is no AID coordination framework for HIV and resources are channelled to multiple ministries and civil society organizations by the different development partners. Following the launch of the National HIV and AIDS Policy and Strategic plan, development partners have taken steps to align their programmes to fit the national strategic plan.

The development partners fully participate in the CCM and are also invited to the National HIV and AIDS Partnership Forums. In addition, the

Expanded UN Theme Group on HIV and AIDS co-chaired by the UN and bilateral development partners brings together the implementing partners (including government and civil society organizations) on a monthly basis to discuss key HIV related issues. Following the establishment of the National HIV and AIDS Partnership Forum which has similar objectives as the Expanded UN Theme Group on HIV/AIDS, discussions are underway with NAC on developing synergies and avoiding duplication and a possible merger of the two forums.

Technical support

The development partners participated actively in the Joint Review of the National HIV and AIDS programme in 2005 and the subsequent development of the National HIV and AIDS Policy, National HIV and AIDS Strategic Plan, National HIV and AIDS M&E plan, revision of the national costings, and development of the draft HIV and AIDS Bill. In addition technical support was provided to develop the scale up plans for the Know Your Status campaign, PMTCT, Care and Support and OVC plans. Regular technical assistance is sourced through the development partners based on the demand. Training was organized in 2007 by the Technical Resource Facility of UNAIDS for key ministries to help assess their technical support needs and plan the technical assistance required. A significant portion of the UN resources are aimed at providing technical assistance and capacity building. The development partners have also supported the capacity building of key civil society organizations in implementing the AIDS response. Support was also provided for programme management issues such as CCM member role clarification, role clarity with the National AIDS Commission, institutional building support for umbrella bodies such as LENEPWHA and LIRAC.

Actions that need to be taken to ensure achievement of the UNGASS targets

One of the major challenges identified by the development partners is fragmented coordination of HIV related activities in the country. The main reason for this is that the coordination role of NAC is not yet recognized by some of the stakeholders in the country. The development partners need to improve coordination amongst themselves as well as continue to advocate for the implementation of the "three ones" principles.

Another area identified as being crucial to the measurement of the implementation status of the national response is the regular production of strategic information. Data flow mechanisms are rather weak and as a result, there is inadequate information flow. Support from development partners in this area is vital to ensure regular production of good quality strategic information, which informs the planning process as well.

Highlights of different agencies support to the National AIDS response

Irish AID has been supporting the roll out of ARVs in remote mountains in partnership with the MOHSW and Clinton Foundation since 2006. Within the context of that partnership support was also provided to strengthen ARV management and supply, facilitate clinical mentoring and training to facilitate management of patients on ART and pre-ART. To address the need for human resources in the context of scaling up the roll out of ART, support was provided to recruit an additional 100 nurses, the majority of whom will come from Kenya. In 2006, Irish Aid supported the NAC to develop the National HIV and AIDS Strategic Plan, policies and Monitoring and Evaluation framework. Irish Aid supports nine civil society organizations and two international NGOs (PSI and ALAFA) around activities related to HIV treatment, prevention and mitigation. Through Irish Aid support to the education sector, 3,600 OVC have benefitted from school bursaries in addition to a book loaning scheme to ensure that all children especially those most vulnerable can access text books. More recently Irish Aid has committed to strengthening the Joint UN team on AIDS in Lesotho by supporting a capacity assessment study and undertaking strategic information assessment around male circumcision. Technical support was also provided to the Government of Lesotho to write the GFATM Round 7 proposal which secured in excess of USD30 million for OVC.

USG/PEPFAR. The US President's Emergency Plan for AIDS Relief (PEPFAR) has prioritized the following program areas:

- prevention of sexual transmission of HIV
- prevention of mother to child transmission

- integration of TB and HIV service delivery including laboratory services
- universal access to counseling and testing
- helping to address the human resources crisis in Lesotho

PEPFAR is also supporting the roll-out of the National Monitoring and Evaluation Framework at both district and central levels, as well as helping to develop more coordinated procurement and supply chain management systems. Now that the USG Millennium Challenge Corporation (MCC) Compact has been signed, PEPFAR and MCC will work closely on coordination of the health component of MCC along with other stakeholders.

DFID supports Lesotho through grants provided to the GFATM, The World Bank, European Commission, UNAIDS and UNICEF. In addition DFID Lesotho Country office funds the ALAFA programme (see section on workplace and best practices for results) with Irish Aid and the EC locally. The Programme is providing a comprehensive prevention and treatment regime to the garment sector workers. DFID Lesotho has with Irish and UNDP supported the governments "Know Your status Campaign"(see section on HIV testing for results).

The **European Commission** is financing OVC, through a Euro 12 million project implemented by UNICEF and the Ministry of Health and Social Welfare. This project started mid-2007 and will continue for four years, providing assistance to OVC through a holistic approach: access to education, health care, food security, cash transfers, etc. Moreover, the EU will support the ALAFA project with half a million Euro grant for a three years period starting from 2008. In addition to those two projects, the European Commission has supported and still supports the German and Lesotho Red Cross, especially on home-based care for OVC and HIV infected households, for a total amount of Euro 1.9 millions.

Within the 10th European Development Fund (which covers the period 2008-2013), the European Commission has earmarked Euro 27.2 millions for Human Development.

The **German Development Corporation** is supporting Decentralized Rural Development including facilitating Local Authorities in their role as the Gateway to services, especially HIV and AIDS interventions, at the community level. This includes capacitating national and community stakeholders around the Gateway approach and the implementation of the National HIV and AIDS Coordination Framework. GTZ is also providing technical advisors and financial resources to assist the Ministry of Local Government and Chieftainship and the Local Government Councils with HIV and AIDS competency, development planning and accessing funds to implement these plans. Plans include HIV and AIDS action plans, the Essential HIV and AIDS Services Package developed by all 128 Community Councils, as well as the mainstreaming of HIV and AIDS into all development plans. GTZ consults with ministries and national bodies such as the National AIDS Commission on the structure and implementation of the decentralised response to HIV and AIDS. GTZ supports the training of Public Servants in HIV&AIDS mainstreaming and other HIV and AIDS-related issues. Further, GTZ assists with connecting communities through Local Authorities to competent HIV and AIDS service providers.

Joint UN team on AIDS

The United Nations has formed the Joint UN Team on AIDS (JUNTA) with the aim of consolidating its HIV resources and delivering a harmonized programme of support to the national response. A management arrangements framework has been agreed upon and has been shared with the National AIDS Commission, development partners and key stakeholders. The United Nations Development Assistance Framework for 2008-2012 prioritizes HIV as a key area of support. The JUNTA through its various constituents has been active in the area of care and support; Know Your Status campaign, acceleration of PMTCT, HIV prevention, food and nutrition support and supporting strategic information.

UNDP supported the operationalisation of the National AIDS Commission through the recruitment of Technical Assistants to support the Secretariat in the development of organisational and management systems in terms of the NAC Operational Business Plan to:

- facilitate an effective and transparent system for donor coordination and management of resources to support the functioning of NAC
- development of NAC Financial Management Systems
- development of human resources management systems.

Support was also provided to implement the process of the finalising the Joint Review of the national HIV & AIDS response and coordinating the collaborative establishment of a new National HIV and AIDS Policy and Strategic Plan in line with the 'Three Ones' principle. UNDP further supported the compilation and engendering the mission of the National HIV & AIDS Policy, National AIDS Strategic Plan, and National Coordination Framework for utilization and improved coordination of HIV & AIDS activities and initiatives in Lesotho, and capacity building for the NAC Board of Commissioners.

A critical mass of economic planners and key focal persons from some line ministries have been trained in HIV & AIDS Mainstreaming; complemented by the joint effort between LIPAM and UNDP, which led to the publication of a booklet on the roles of the Public Service in the response to HIV & AIDS in Lesotho. UNDP supported the "Know Your Status" Campaign in 2007 Their achievements include the training of Community health workers and PLWHA support group members as 3 600 have been trained in HIV & AIDS and HIV testing and counselling in all the districts of the country and are continuously supporting and implementing components of the campaign; further strengthening HIV testing and Counselling; HIV Prevention; Psychosocial support; and Treatment and Adherence education at the local health centres throughout the country.

A national GIEPA action plan was prepared based on supportive policy environment to ensure the fulfilment of the rights of people living with HIV; as well as a Training Manual for capacitating the District Executive Committees (DEC) of the LENEPWHA and affiliate support groups. Through the food security component, seeds, irrigation kits, and garden implements were provided and transported through LENEPWHA to 4 communities, complemented by capacity building in that area in collaboration with the District Agriculture Officers. Support was also provided to the NAC in developing the draft HIV and AIDS Bill.

UNICEF's support to the national response to HIV and AIDS is addressed as a crosscutting issue in all its programme areas. UNICEF supported the PMTCT scaling up efforts, through training of health workers in all 17 hospitals and 165 health centres in all 10 districts. UNICEF also supports the initiative to provide Paediatric AIDS care for children. UNICEF also supported the social mobilization component of the "Know Your Status" (KYS) campaign which included HIV and AIDS related transit advertising, dissemination of IEC materials, community seminars and the development of the KYS communication strategy.

Jointly with UNESCO and UNAIDS, UNICEF supported the MOET to develop an HIV and AIDS Education Sector Policy that consolidated the existing draft education policies into one comprehensive policy document. The HIV and AIDS Education Sector Policy is informed by the National HIV and AIDS Policy and Strategy. UNICEF, in collaboration with UNESCO and UNFPA, supported the development of the life skills education curriculum, which includes issues of HIV and AIDS and gender, for grades 4 to 7 and forms A to C. The finalization and roll out of the curriculum has been delayed by lack of consensus among partners in relation to the content of the curriculum with respect to HIV prevention and risk reduction. UNICEF will continue to support MOET in engaging with key stakeholders. UNICEF supported the MGYSR to raise awareness among young people on HIV prevention and other related issues through carrying out the String Game Story in all 10 districts during the period of 2005 – 2007. In 2006, UNICEF supported the MOHSW to develop and finalize the National Plan on Drug and Substance abuse among Youth and Adolescents. HIV prevention in the context of drug and substance abuse is a key component of this plan. UNICEF supported sports based life skills activities for HIV prevention during 2005 – 2006. This contributed to strengthening the capacity of national sports associations to implement HIV prevention interventions with and for young people. More than 30 schools have been involved in the programme. Moreover, UNICEF has supported capacity development of peer leaders in the adolescent friendly health corners on sexual and reproductive health

issues with a particular emphasis on HIV prevention. UNICEF also contributed to the

development of a minimum package of interventions for HIV prevention among young people. This process is being lead by the MOHSW and MGYSR, with inputs from MOET and relevant civil society partners. In 2007, UNICEF contributed to the country's national response to HIV and AIDS through leveraging resources to support GoL in the impact mitigation mainly focusing on OVC. The result was the signing of an agreement between GoL, EC and UNICEF for 11.3 Million Euros which aims at uplifting the livelihoods of orphans and their communities. It also contributes to institutional capacity building of GoL.

The EC grant has contributed to setting up crucial structures, systems and processes for implementing the OVC programme. These include, the National OVC Coordinating Committee (NOCC), which is responsible for the coordination of the OVC National Action Plan (NAP) – whose development was also supported by UNICEF together with the development of the National OVC Policy. The NOCC also fosters linkages among implementing partners and the District Child Protection Teams (DCPT – another UNICEF supported initiative), that ensure implementation and coordination of the OVC NAP at district and community level. Technical support from UNICEF's four programmes sections was provided to GoL in the development of the Global Fund Round 7 proposal on OVC. This was to ensure an integrated approach and multi-sectoral collaboration that enforces complementarities of donor funded OVC programmes to avoid duplication, gaps and to coherently ensure coverage in the hard to reach areas.

UNFPA offered technical support to GoL in assisting them in the development of the National BCC Strategy that is being conducted by - Medical Care Development International (MCDI) and Academy for Educational Development (AED). UNFPA together with UNAIDS will be exploring an area of joint collaboration with regards to Sex Work in Lesotho. It is hoped that a Strategy will be developed to put in place intervention addressing the issues around Prevention of HIV Infections. UNFPA together with UNICEF is undertaking a rapid situation analysis and needs assessment of young people between the ages of 10-24 in Lesotho. UNFPA also supported the MOHSW with reproductive health commodities including male and female condoms for dual protection against unintended pregnancies, and sexually transmitted infection including HIV infection. UNFPA has conducted training of key stakeholders in condom programming to ensure consistent availability of quality condoms and helped form the

thematic working group on condoms under the NAC technical working group on HIV prevention. UNFPA has also provided support in the development of Policies and strategies for SRH, HIV and Gender Equality legal framework and provided technical support for the enactment of the Legal Capacity of Married People's Act of 2006; for finalization of the RH Policy, development and costing of PMTCT scale-up plan.

WFP's support to vulnerable people included nutritional support as a household ration to 2,600 patients on TB medicines. WFP also provided support to households affected by HIV as its contribution towards the mitigation of HIV and AIDS in the country. This included 4,258 families hosting OVC, 7,184 people living with HIV including those on ART, 659 patients on home based care and 25 women enrolled under the Government PMTCT programme. In collaboration with Ministry of Education & Training, the school-feeding programme has provided rations to 115,000 children in 585 primary schools. Orphans and vulnerable children have been provided take-home rations through schools. Further to these interventions, WFP consistently provides food relief in the face of emergencies such the 2006/7 drought. As a part of deliberations conducted about draft HIV and AIDS Bill, WFP contacted 15 stake holders to capture and consolidate their views about the draft bill.

During the period 2006 **World Health Organization's** support in the area of HIV focused in strengthening the health sector response to HIV through building its capacity for scaling up cost effective interventions such as ART, PMTCT, HCT, Safe Blood transfusion and Management of STI. The MOHSW has been supported to implement innovative approaches such as integrated management of adult, adolescent and child illnesses (IMAI & IMCI); "Know Your Status" Campaign, Syndromic management of STI and community home-based care. These approaches strengthen health systems towards the universal access to HIV prevention, treatment and care services. Technical support continued to be provided to strengthen the Health Information Management System including the disease surveillance system to adequately respond to the needs of HIV programme and epidemic monitoring in the country.

The **Food and Agriculture organization** has

two main programmes which provide vital entry points to addressing HIV and AIDS: the Agricultural Emergency Relief and Rehabilitation Programme and OVC livelihood project. The two programmes provide timely insights and valuable lessons for identifying suitable approaches to alleviate negative effects of the HIV and AIDS epidemic. Under the Emergency Programme, FAO is integrating a rehabilitation dimension into the emergency activities, providing vulnerable households with access to seeds and other essential farm inputs. (See impact mitigation section for more details)

ILO has been working with the Ministry of Labour in providing technical support to training of all the labour officers and supporting development of workplace programmes and polices.

UNESCO has supported the Ministry of Education and Training in development of the Education sector AIDS policy as well as in the development of curriculum and training of teachers through the EDUCAIDS programme.

UNAIDS Country Office in Lesotho has taken the lead in coordination of the United Nations' response to HIV as well as bringing together development partners. It has provided policy support to the National AIDS Commission and other GoL ministries and departments as well as civil society organizations. It has helped the NAC in finalizing the National HIV and AIDS Policy, Strategic Plan and Monitoring and Evaluation plan. The office has also provided support to costing of the National HIV and AIDS Strategic Plan as well as in review of the national prevention response. It has furthermore supported the Ministry of Youth, Gender, Sport and Recreations in the development of the National Action plan for Women, Girls and HIV&AIDS. In the area of strategic information it has supported NAC and other organizations in increasing understanding of the epidemic, capacity building of implementing organizations on M&E and supporting the development of key information to support programme implementation. It has provided technical assistance to NAC on developing a partnership forum, supporting the establishment of LIRAC, development of the draft National AIDS Bill. UNAIDS has also collaborated with several civil society organization and helped develop partnerships with the faith based sector and organizations of people living with HIV. It has also supported NAC in rolling out a decentralized programme at the community level to implement a basic package of services at the grassroots level.

HIGHLIGHTS OF BEST PRACTISES ON HIV AND AIDS IN LESOTHO

1.0 INTRODUCTION

For many years countries have been implementing various programmes and projects in responding to the HIV and AIDS pandemic. It has become apparent that these interventions need to be documented and shared so that countries can benefit and learn from each other's experiences. This document presents highlights of some best practices in Lesotho. A total of seven best practices have been identified in the country and three of them will be highlighted for inclusion in the UNGASS report. However, it should be noted that because of the lengthy nature of each best practice the selected best practices are just highlights which will form part of the report.

2.0 BEST PRACTICES

The following are the criteria that was used to identify and select best practices:

- Ethical soundness
- Effective
- Relevant
- Cost effective
- Sustainable
- Replicable
- Innovative

The following best practices have been documented and are presented in detail below:

- Know Your Status Campaign
- Decentralization of ART services by the Ministry of Health and Social Welfare and Partners in Health
- ALAFA HIV and AIDS workplace programme

2.1 KNOW YOUR STATUS (KYS) CAMPAIGN

Background

The Know Your Status (KYS) Campaign is a national programme to access counseling and testing services. The goal of the campaign is to contribute to halting and reversing the spread of HIV in Lesotho, in the context of comprehensive HIV and AIDS prevention, care, treatment and support.

The campaign's operational plan which was launched by His Majesty King Letsie III in December 2005, ensures that the Ministry of Health and Social Welfare (MOHSW) and its many partners in Lesotho put in place all the necessary components to allow all men, women and adolescents to know their HIV status and access HIV prevention, care, treatment and support services.

The campaign aims at reaching all Basotho above the age of 12 years living in Lesotho to know their HIV status. This caters for people from all sectors of the community being men, women and adolescents.

Purpose

The purpose of this campaign is to ensure uptake of HIV testing and counseling as an entry point to accessing HIV prevention, care and treatment. The campaign also aims at creating awareness of the benefits of HIV testing and counseling and the benefits of knowledge of sero status can outweigh the cost, thereby provoking and supporting the decision making process.

ELEMENTS OF THE BEST PRACTICE

Effectiveness

The KYS campaign programme's broad objective is that all Basotho above the age of 12 years know their HIV status so that those who are negative remain and those who are positive live longer productive lives. In March 2007 about 160,277 people with national coverage of 12% compared to the target of 1.3 million people were tested. The KYS team has adopted an alternate plan to support the on going campaign and implementing the HTC by the use of mass campaign model. The national support team provides necessary technical support strengthening the district capacity in planning and implementing the accelerated mass campaign ensuring increased access and utilization of HIV testing and counseling services at Health facilities and community level.

Ethical soundness

In respect of human rights and confidentiality, all community counselors, support groups and health personnel were trained and there are guidelines in place. Pretest counseling is provided to facilitate informed decision and consent prior to testing. For children below 12 years the parent's consent applies. There is group or individual pre-test counseling then informed consent is asked from participating parties and make an informed decision to test, then the HIV test is performed. If the test result is HIV negative post-test counseling is provided and a client is advised to test again after three months. In the case of HIV positive result the second test using double check is done and if the result is positive post-test counseling is provided followed by confirmation test and the client is referred and monitored closely depending on the CD4 count results. PLHIV are playing a critical role in the implementation of this campaign.

Cost Effectiveness

The counseling and testing services during the campaign are done for free and if a client is found to be HIV positive and need to be enrolled on ARV's immediately, the drugs are provided free of charge by both government facilities and private practice. There are minimum costs involved in the provision of services, the service providers are from within the same community, therefore there are no transport costs for both the implementers and the communities served.

Relevance

The campaign has received tremendous support and acceptance from the government and the community. This campaign is an opportunity to accelerate prevention and scaling-up ART, it addresses the challenges and other issues related to HIV and AIDS. Further, the campaign's objectives are aligned to the national strategic plan on HIV and AIDS. The campaign has been initiated at a critical time when HIV has matured in this country and there is a need to scale up all relevant services.

Replicability

KYS campaign applies simple but effective activities and processes that can easily be replicated in SADC member states and even beyond. The campaign has used locally available resources in an effective manner and its initiative requires transparent and accountability in the manner the resources are utilized.

Innovativeness

The idea of accelerating HTC was conceptualized in this country, MOHSW designed the project with technical and financial assistance from development partners. The campaign was launched by the Honourable the Prime Minister who took a step further and took up testing and counselling. KYS is a unique project which has taken services to the door steps of the communities and has strengthened community participation in health services.

Sustainability

The STI/HIV and AIDS Directorate within the Ministry is directly responsible for the implementation, coordination and monitoring of the campaign. The policy environment that enables people to know their status has been created, there is a widespread national support and community ownership of the campaign also the human resource capacity to conduct HIV testing, counseling and education at the district, health centre and community level have been achieved.

2.2 DECENTRALIZATION OF ART SERVICES THROUGH MINISTRY OF HEALTH AND SOCIAL WELFARE (MOHSW) AND PARTNERS IN HEALTH (PIH)

Background

In March 2006, the Ministry of Health and Social Welfare (MOHSW) launched its Rural Initiative in the mountain clinics of Lesotho with the support of Irish Aid, Clinton Foundation and Partners in Health. The initiative's objective is to expand access to HIV and AIDS care, treatment and support services in Lesotho, with focus on patients living in the remote areas. Partners in Health is the implementing agent in partnership with Ministry of Health and Social Welfare in this initiative.

The initiative has been able to increase awareness of the availability of treatment at the Lesotho Flying Doctors Service (LFDS) health centres, encouraging those who did not already know their HIV status and to link them with the local health centre to get tested and learn more about HIV and AIDS and start the positive response and acceptance of the PIH model with the surrounding communities.

PIH initiative was to provide overall improvement in primary health care services, thus services for men, women and children, persons with tuberculosis and those with sexually transmitted infections in Lesotho's most hard to reach places.

Purpose

The main purpose of this initiative is to expand access to HIV and AIDS care, treatment and support services in Lesotho, with a focus on patients living in the remote and hard to reach areas.

ELEMENTS OF THE BEST PRACTICE

Effectiveness

The implementation of this initiative is based on PIH's successful models of service provision and focuses on health and illness in the socioeconomic context in which they occur. Due to this, PIH approach not only provides medical care, but also aims at directly addressing the root causes of disease including poverty, malnutrition and gender inequality. As a result, this approach advocates for strong collaboration among government, civil society organizations, including media and corporate entities.

Cost Effectiveness

Within this project Basotho doctors are employed to provide care and treatment services in the remote areas of the country and with the assistance from trained village health workers, who volunteer on counseling, testing, home based care services and follow-ups of patients on antiretroviral treatment with no traveling costs implications because the services are locally available.

Relevance

In its one year of operation in Lesotho the rural initiative has helped to enroll over 550 patients on ARV's, 1,500 HIV positive patients in follow-up care, and trained about 300 Village Health Workers (VHW's). Therefore, with the available local support of VHW's, and support group of people living with HIV, patients are treated and cared for in their homes by PIH doctors with the assistance from VHW's.

Replicability

PIH project applies simple but effective activities and processes that can easily be replicated in the SADC region and even beyond. The project has used locally available resources in an effective manner and its impact has been felt by community members. With Doctors from PIH, comprehensive HIV and AIDS care and treatment services now available at Nohana, Nkau and Bobete Health Centres. In line with the goals of partnership, PIH is now rolling-out to seven (7) more sites. It is very possible to be replicated in other areas.

Innovativeness

The rural initiative provides access to increased HIV testing as well as comprehensive HIV care, including antiretroviral therapy, prophylaxis for and treatment of opportunistic infections. Development of the systems required for comprehensive HIV and AIDS care also serves as a vehicle for overall improvement in primary health care services, services for women and children, persons with tuberculosis and those with sexually transmitted infections in Lesotho's most hard to reach places.

Sustainability

The Ministry of Health and Social Welfare as an overseer of the project will absorb all the responsibilities that are carried out

by PIH including the staff when the project phases out. The LFDS staff at the clinics that have rolled out ART have been trained to deliver HIV and AIDS care and treatment. Additional nurses have been brought into the health care system and almost 300 Village Health Workers have been trained to identify patients that need care and support those who have been enrolled into treatment.

2.3 APPAREL LESOTHO ALLIANCE TO FIGHT AIDS (ALAFA) APPAREL INDUSTRY HIV AND AIDS WORKPLACE PROGRAMME

Background

The Lesotho Apparel Industry currently employs about 46 000 Lesotho citizens and is the country's largest private sector employer, accounting for around 80% of private sector employment in Lesotho. By providing employment for poor and relatively unskilled workers, the majority of whom are women, this industry is combating two of the key long-term "drivers" of the HIV and AIDS epidemic, namely poverty and gender inequity. However, at present, it is precisely this sector of the community, young women, who have the highest prevalence of HIV infection. A baseline seroprevalence survey conducted during the first quarter of 2007 for ALAFA showed HIV prevalence rates of 44.2% for female employees and 35.6% for male employees.

The project has been branded as "ALAFA" and was formally launched at Precious Garments in Maseru on 16 May 2006 by development activist and musician Bono. ALAFA started with a pilot implementation in one factory with 4,500 workers in Maseru. Lessons learned from this implementation are being used to continuously improve the original programme layout. Since December 2006, more than 20 factories have been included in the prevention programme, giving 30,000 workers access to at least basic prevention interventions. Out of these factories, 9 have established workplace clinics, giving their employees access to medical services funded through ALAFA. At the end of November 2007, 17,000 workers had access to the complete ALAFA workplace HIV programme.

ALAFA seeks to reach out to the entire textile workers, currently estimated to over 46 000. The programme caters for both female and male workers, based in Maseru textiles, with intent to expand to Maputsoe industrial sites before the end of 2008.

Purpose

The overall purpose of the programme is to reduce new HIV infections, morbidity and mortality among the workforce of Lesotho's apparel industry and their dependents and to minimize the impact of HIV & AIDS on factory competitiveness, thereby ensuring ongoing jobs for the large employee base of the industry and indirectly supporting over 220 000 Basotho.

In order to achieve the broader goal, a comprehensive prevention and treatment programme will reduce the number of new infections in the workforce and prolong the lives of those already infected with HIV. It is believed that if the ALAFA treatment component is rolled out to all employees and dependents, nearly 2 000 lives could be saved each year.

ELEMENTS OF THE BEST PRACTICE

Effectiveness

The ALAFA programme is a new intervention that has proved to have a positive impact in the lives of Basotho men and women working in the textile industry. The intervention has improved the lives of people employed in this sector through ac-

cess to basic prevention and care and treatment interventions. To date 9 workplace clinics have been established, giving employees access to medical services funded through ALAFA.

Ethical soundness

The programme reaches out to the textile industry, a sector which was given little attention in terms of HIV and AIDS interventions. Employees in this sector are now able to have access to basic HIV and AIDS programmes coming to them at their workplace. Confidentiality is a norm, with employers only getting statistics not bearing names.

Cost effectiveness

Implementation of the ALAFA programme is the total responsibility of ALAFA through donated funds. HIV and AIDS services given to the textile industry are brought to them through established clinics, and the employees pay a minimal fee to see the Health professionals, with the rest of the cost handled by ALAFA.

Relevance

A very relevant intervention targeting the group that did not have prior access to the services. The programme offers a variety of essential services ranging from IEC materials, condom distribution, peer education, HIV Testing and counseling, PMTCT, patient registration and monitoring, as well as treatment of HIV related illnesses.

Replicability

In similar circumstances, the programme can be replicated because it has a clear target group.

Innovativeness

The ALAFA HIV and AIDS workplace programme is the first of its kind and has never been practiced in any country.

Sustainability

The programme promises to be sustainable. It is also likely to attract even more funding from other donors as well as its ability to expand to factories outside Maseru.

Appendix I: National Composite Policy Index

Part A

(This section was filled in by informants from government institutions)

Section I: Strategic plan

1. **Has the country developed a national multi-sectoral strategy/action framework to combat AIDS? - Yes, National Strategic plan 2006-2011**
 - 1.1. **How long has the country had a multi-sectoral strategy/action framework? Number of years: 6 years, 1st plan was for 2002/3-2004/5 and 2nd plan 2006/7-2010/11**
 - 1.2. **Which sectors are included in the multi-sectoral strategy/action framework with a specific HIV budget for their activities:**

Sectors included	Strategy/Action framework	Earmarked budget
Health	Yes	Yes
Education	Yes	Yes
Labour	Yes	Yes
Transportation	Yes	Yes
Military/Police	Yes	Yes
Women	Yes	Yes
Young people	Yes	Yes
Agriculture	Yes	Yes
Finance	Yes	Yes
Human Resources	Yes	Yes
Justice	Yes	Yes
Minerals and Energy	Yes	Yes
Planning	Yes	Yes
Public Works	Yes	Yes
Tourism	Yes	Yes
Trade and Industry	Yes	Yes
Other: Local Government	Yes	Yes

1.3. Does the multi-sectoral strategy/action framework address the following target populations, settings and cross-cutting issues?

Target populations	Response
a) Women and girls	Yes
b) Young women/young men	Yes
c) Specific vulnerable sub-populations	Yes
d) Orphans and other vulnerable children	Yes
Settings	Response
e) Workplace	Yes
f) Schools	Yes
g) Prisons	Yes
Cross-cutting issues	Response
h) HIV/AIDS and poverty	Yes
i) Human rights protection	Yes
j) Involvement of people living with HIV	Yes
k) Addressing stigma and discrimination	Yes
l) Gender empowerment and/or gender equality	Yes

1.4. Were target populations identified through a process of a needs assessment or needs analysis? – Yes

If yes, when was this needs assessment/analysis conducted? Year: 2005

1.5. What are the target populations in the country?

- Women and girls
- Vulnerable populations – sex workers, migrant populations, herd-boys, people with disability, PLHIV, men who have sex with men
- OVCs
- Uniformed forces
- Young & Adolescent people
- Pregnant women
- Adult men

1.6. Does the multi-sectoral strategy/action framework include an operational plan? – Yes, this is developed separately on an annual basis. The first annual operational plan was developed for 2007-2008.

1.7. Does the multi-sectoral strategy/action framework or operational plan include:

The multisectoral strategy includes:	Response
a) Formal programme goals?	Yes
b) Clear targets and/or milestones?	Yes
c) Detailed budget of costs per programmatic area?	Yes
d) Indications of funding sources?	No
e) Monitoring and evaluation framework?	Yes

1.8. Has the country ensured “full involvement and participation” of civil society in the development of the multi-sectoral strategy/action framework? – *Active involvement*

If active involvement, briefly explain how this was done: *Involved during the joint review of the national response and preparation of the strategic plan. Involved in setting targets, discussing strategies in targeted groups, thematic areas and in the validation of the plan. The civil society is currently represented on all thematic working groups set up to operationalise the strategic plan. They were also involved in the development of the operational plan for 2007-08.*

1.9. Has the multi-sectoral strategy/action framework been endorsed by most external development partners (bi-laterals, multi-laterals)? – Yes

1.10. Have external development partners (bi-laterals, multi-laterals) aligned and harmonized their HIV and AIDS programmes to the national multi-sectoral strategy/action framework? – *Yes, some partners.*

If some or no, briefly explain: *Most partners are now involved with the alignment and harmonisation process as many of the programmes cycles of partners did not co-incide with strategic plan period. Most development partners in Lesotho have new programme cycles starting 2008 and these plans are aligned to the national strategic plan. For example the UN Development Assistance Framework for 2008-2012 has been aligned to the national strategic plan’s priority areas.*

2. Has the country integrated HIV and AIDS into its general development plans such as: a) National Development Plans, b) Common Country Assessments/United Nations Development Assistance Framework, c) Poverty Reduction Strategy Papers, d) Sector Wide Approach? - Yes

Plans:	Response
a) National Development Plans?	Yes
b) Common Country Assessments/United Nations Development Assistance	Yes
c) Poverty Reduction Strategy Papers?	Yes
d) Sector Wide Approach?	No

2.1. If yes, in which development plans is policy support for HIV and AIDS integrated?

HIV and AIDS has been integrated into the National Vision 2020 and the Poverty Reduction Strategy (PRS) as a cross-cutting issue. It is also accorded its own chapter for purposes of costing the required resources for its mitigation and control. It forms an integral part of the CCA, UNDAF as well as the Country Programme documents and Action Plans. SWAPs are still in their infancy in Lesotho and as such, efforts are still being made to integrate HIV issues into these. Another critical issue has been to translate the vision and objectives in these documents into a practical reality. There is a strong need to operationalise these policy commitment into action.

2.2. If yes, which policy areas below are included in these development plans?

Policy Area	Development Plans				
	a)	b)	c)	d)	e)
HIV Prevention	Yes	Yes	Yes	No	
Treatment for opportunistic infections	Yes	Yes	Yes	No	
Antiretroviral therapy	Yes	Yes	Yes	No	
Care and support (including social security or	Yes	Yes	Yes	No	
AIDS impact alleviation	Yes	Yes	Yes	No	
Reduction of gender inequalities as they relate to	Yes	Yes	Yes	No	
Reduction of income inequalities as they relate	Yes	Yes	Yes	No	
Reduction of stigma and discrimination	Yes	Yes	Yes	No	
Women's economic empowerment (e.g. access	Yes	Yes	Yes	No	
Other					

3. Has the country evaluated the impact of HIV and AIDS on its socio-economic development for planning purposes? - No
4. Does the country have a strategy/action framework for addressing HIV and AIDS issues among its national uniformed services such as military, police, peacekeepers, prison staff, etc? – Yes
- 4.1. If yes, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of one or more uniformed services?

Behavioural change communication	Yes(to a limited	Military, prison staff
Condom provision	Yes	Military, Prison
HIV testing and Counselling	Yes	Military, Prison
STI services	Yes	Military
Treatment	Yes	Military
Care and support	Yes	
Others		

What is the approach taken to HIV testing and counseling? Is HIV testing voluntary or mandatory (e.g. at enrolment)? Briefly explain:

Voluntary, but actively promoted as part of the “know your status” campaign. However, HIV testing for troops being contributed to peace keeping is mandatory as per UN peace keeping guidelines. New recruits to the Lesotho Defence Force are tested at enrollment stage as part of the comprehensive medical examination.

5. **Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?** – Yes
- 5.1. **Has the National Strategic Plan/operational plan and national AIDS budget been revised accordingly?**
– Yes
- 5.2. **Have the estimates of the size of the main target population sub-groups been up-dated?** – Yes
- 5.3. **Are there reliable estimates and projected future needs of the number of adults and children requiring antiretroviral therapy?** – Yes. *Estimates and projected needs*
- 5.4. **Is HIV and AIDS programme coverage being monitored?** – Yes
- a) **IF YES, is coverage monitored by sex (male, female)?** – Yes *and by age*
- b) **IF YES, is coverage monitored by population sub-groups?** – Yes
- IF YES, which population sub-groups?**
- *Young People*
 - *Adults*
 - *People on Treatment*
 - *Pregnant Women &*
 - *OVCs*
- c) **IF YES, is coverage monitored by geographical area?** – Yes
- IF YES, at which levels (provincial, district, other)?**
- *District*
 - *Rural and urban*
- 5.5. **Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?** – Yes, *plans exist for human resources and strengthening supply chain management.*

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?

4 out of 10 in 2005

6 out of 10 in 2007 with 0 being poor and 10 being good

Comments on progress made in strategy planning efforts since 2005:

- *New strategic plan for 2006-2011 developed*
- *Annual operational plan for 2007-2008 developed*
- *National OVC Policy & Plan developed*

Section II: Political Support

Strong political support includes government and political leaders who speak out often about AIDS and regularly chair important meetings, allocation of national budgets to support the AIDS programmes and effective use of governmental and civil society organizations and process to support effective AIDS programmes.

1. Do high officials speak publicly and favourably about AIDS efforts in major domestic fora at least twice a year?

Official:	Response
a) President/Head of government?	Yes
b) Other high officials?	Yes
c) Other officials in regions and/or districts	Yes

2. Does the country have an officially recognized national multi-sectoral AIDS management/coordination body? (National AIDS Council or equivalent)? – Yes

2.1. IF YES, when was it created? Year: 2005 by NAC ACT 2005, effective from September 2005

2.2. IF YES, who is the Chair? Advocate Thabo Makeka, Chairperson, NAC Board of Commissioners

2.3. IF YES, does it:

Have terms of reference?	Yes
Have active Government leadership and participation?	Yes
Have a defined membership?	Yes
Include civil society representatives? (*)	Yes
IF YES, what percentage? – 80% (calculated based on commissioner strength)	Yes
Include people living with HIV?	Yes
Include the private sector?	Yes
Have an action plan?	Yes
Have a functional secretariat?	Yes
Meet at least quarterly?	Yes
Review actions on policy decisions regularly?	Yes
Actively promote policy decisions?	Yes
Provide opportunity for civil society to influence decision-making?	Yes
Strengthen donor and coordination to avoid parallel funding and duplication of effort in programming and reporting?	No

(*) If it does include civil society representatives, what percentage? - 80%

3. Does the country have a national AIDS body or other mechanism that promotes interaction between government, people living with HIV, civil society and the private sector for implementing HIV and AIDS strategies/programmes? – Yes, A national partnership forum for HIV exists.

3.1. IF YES, does it include?

Terms of reference	Yes
Defined membership	Yes
Action plan	Yes
Functional secretariat	Yes
Regular meetings (*)	Yes

(*) If it does include regular meetings, what is the frequency of the meetings: *Quarterly Partnerships Forum*

IF YES, what are the achievements?

- Joint development of the annual operational plan
- Quarterly progress reports presented to all stakeholders & key issues regarding implementation discussed.

IF YES, what are the main challenges for the work of this body?

- Reports are not submitted on time by implementing organizations.
- Poor coordination during implementation among stakeholders.
- Reliability of information/data.
- Duplication of efforts.

4. What percentage of the national HIV and AIDS budget was spent on activities implemented by civil society in the past year? – M 12 million was given by NAC to civil society organizations out of its M33 million budget.
5. What kind of support does the NAC (or equivalent) provide to implementing partners of the national programme, particularly to civil society organizations?

Information on priority needs and services	Yes
Technical guidance/materials	Yes
Drugs/supplies procurement and distribution	No
Coordination with other implementing partners	Yes
Capacity building	Yes

6. Has the country reviewed national policies and legislation to determine which, if any, are inconsistent with the National AIDS Control policies? – Yes

- 6.1. IF YES, were policies and legislation amended to be consistent with the National AIDS Control policies? – Yes

6.2. IF YES, which policies and legislation were amended and when?

Labour Code amended to ensure nondiscrimination	2006
National Blood Transfusion Policy	2006
National HIV Testing & Counseling Policy	2006
National OVC Policy	2006
Legal Capacity of Married Persons Act	2006

Overall, how would you rate strategy planning efforts in the HIV and AIDS programmes in 2007 and in 2005?

3 out of 10 in 2005

5 out of 10 in 2007, with 0 being poor and 10 being good

Comments on progress made in political support since 2005:

- *National Strategic Plan 2006-2011.*
- *National AIDS Policy & National OVC Policy approved by cabinet.*
- *Development of the action plans at each community council level by elected leaders.*
- *Labour Code amendment passed by parliament.*
- *Legal Capacity of Married Persons Act of 2006 enacted by parliament.*

Section III: Prevention

1. Does the country have a policy or strategy that promotes information, education and communication on HIV to the general population? - Yes

1.1. IF YES, what key messages are explicitly promoted?

Be sexually abstinent	Yes
Delay sexual debut	Yes
Be faithful	Yes
Reduce the number of sexual partners	Yes
Use condoms consistently	Yes
Engage in safe(r) sex	Yes
Avoid commercial sex	No
Abstain from injecting drug use	No
Use clean needles or syringes (policy focuses on health facilities rather than IDUs)	Yes
Fight against violence against women	Yes
Greater acceptance and involvement of people living with HIV	Yes
Greater involvement of men in reproductive health programmes	Yes
Other; HIV Testing & Counseling, Blood safety, PMTCT, PEP, management of	Yes

1.2. In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media? - Yes

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people? Yes – *Adolescent Policy and reproductive health policy*

2.1. Is HIV part of the curriculum in:

Primary Schools?	Yes
Secondary Schools?	Yes
Teacher Training?	Yes

2.2. Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women? - Yes

2.3. **Does the country have an HIV education strategy for out-of-school young people?** - Yes. A basis minimum package of interventions for reaching young people has been defined for use by organization working with young people.

3. **Does the country have a policy or strategy to promote information, education and communication and other preventive health intervention for vulnerable sub-populations?** – Yes, the national aids policy has specific policy statements on the role of the state in promoting access to services for vulnerable populations.

3.1. **IF YES, which sub-populations and what elements of HIV Prevention do the policy/strategy address?**

	IDU	MSM	Sex Work-ers	Clients of sex workers	Prison inmates	Other subpopulations: Women and girls, people with disabilities, people who abuse alcohol and drugs.
Targeted information on risk reduction and HIV education	No	Yes	Yes	No	Yes	Yes
Stigma and discrimination reduction	No	Yes	Yes	No	Yes	Yes
Condom promotion	No	Yes	Yes	No	Yes	Yes
HIV testing and Counselling	No	Yes	Yes	No	Yes	Yes
Reproductive health, including STI prevention and treatment	No	Yes	Yes	No	Yes	Yes
Vulnerability reduction (e.g. income generation)	N/A	N/A	Yes	N/A	N/A	Yes
Drug substitution therapy	No	N/A	N/A	N/A	N/A	No
Needle and syringe exchange	No	N/A	N/A	N/A	N/A	No

Overall, how would you rate policy efforts in support of HIV prevention in 2007 and in 2005?

2 out of 10 in 2005 (mainly because most programmes had just started)

6 out of 10 in 2007 (with 0 being poor and 10 good)

Comments made on progress made in policy efforts in support of HIV prevention since 2005:

The National AIDS policy has made specific recommendations for reaching out to vulnerable groups. There is no legal barrier to stop access to HIV related services.

4. **Has the country identified the districts (or equivalent geographical/decentralized level) in need of HIV prevention programmes?** – Yes, all districts

IF YES, to what extent have the following HIV prevention programmes been implemented in identified districts* in need?

HIV prevention programmes	The activity available in			
	<i>All districts in need</i>	<i>Most districts in need</i>	<i>Some districts in need</i>	<i>N/A</i>
Blood safety	Yes			
Universal precautions in health care settings	Yes			
Prevention of mother-to-child transmission of HIV	Yes			
IEC on risk reduction	Yes			
IEC on stigma and discrimination		Yes		
Condom promotion	Yes			
HIV testing and Counselling	Yes			
Harm redetection for IDUs				N/A
Risk reduction for MSM	None			
Risk reduction for sex workers			Yes	
Programmes for other vulnerable sub-			Yes	
Reproductive health services including STI prevention and treatment	Yes			
School-based AIDS education for young people		Yes		
Programmes for out-of-school young people		Yes		
HIV prevention in the workplace			Yes	

*** Districts or equivalent geographical/de-centralized level in urban and rural areas**

Over all, how would you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?

1 out of 10 in 2005 and

4 out of 10 in 2007 (with 0 being poor and 10 good)

Comments on progress made in the implementation of HIV prevention programmes since 2005:

Significant progress has been made in rolling out the Know Your Status campaign with nearly 12.7% of the total population tested for HIV in the last 24 months. In 2007, 158,882 people got tested for HIV representing 8.5% of the total population. The coverage of PMTCT programmes has increased six times since 2005. Leadership of faith-based organisations has openly started to prioritize HIV prevention.

Section IV: Treatment, care and support

1. **Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care) – Yes**
 - 1.1. **If yes, does it give sufficient attention to barriers for women, children and most-at-risk populations? – Yes, but not all most at risk populations get attention especially sex workers.**
2. **Has the country identified the districts (or equivalent geographic /decentralized level) in need of HIV and AIDS treatment, care and support? - Yes.**

If Yes, to what extent have the following HIV and AIDS treatment, care and support services been implemented in

HIV treatment, care and support services	The service is available in		
	All districts in need	Most districts in need	Some districts in need
Antiretroviral Therapy	Yes		
Nutritional care	Yes		
Pediatric AIDS treatment	Yes		
STI management	Yes		
Psychosocial support for people living with HIV and their families	Yes		
Home-based care	Yes		
Palliative care and treatment of common HIV-related infections	Yes (*)		
HIV testing and counseling for TB patients	Yes		
TB screening for HIV infected people	Yes		
TB preventive therapy for HIV-infected people	No		
TB infection control in HIV treatment and care facilities	No		
Cotrimoxazole prophylaxis in HIV infected people	Yes		
Post exposure prophylaxis (e.g. occupational exposure to HIV, rape)	Yes		
HIV treatment services in the workplace or treatment referral system through the workplace			Yes
HIV care and support in the workplace (including alternative working arrangements)			Yes
Other programmes	N/A	N/A	N.A

the identified districts in need?

(*) for common HIV related infections

Comments:

- *All districts in need have not reached target of 80% access;*
 - *Pediatric AIDS treatment available in all districts but some more than others;*
 - *Not providing TB preventive therapy for HIV-infected for fear of resistance.*
3. **Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV? - Yes**
4. **Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral drugs, condoms, and substitution drugs? - Yes**
- 4.1 **If yes, which commodities? – All health products including ART, STI and OI drugs and Condoms**

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support services in 2007 and in 2005?

4 out of 10 in 2005

6 out of 10 in 2007 (with 0 being poor and 10 good)

Comments on progress made since 2005:

Scale up in ART up-take.

5. **Does the country have a policy or strategy to address the additional HIV-or AIDS-related needs of orphans and other vulnerable children (OVC)? - Yes.**
- 5.1 **If yes, is there an operational definition for OVC in the country? - Yes**
- 5.2 **If yes, does the country have a national action plan specifically for OVC? - Yes**
- 5.3 **If yes, does the country have an estimate of OVC being reached by existing interventions? - Yes**

If Yes, what percentage is being reached? - 32%

Overall how do you rate the efforts to meet the needs of OVC?

5 out of 10 for 2005

7 out of 10 for 2007 (with 0 being poor and 10 being good)

Section V: Monitoring and Evaluation

1. Does the country have one national M&E plan? - Yes

If Yes, Years covered: - 2006-2011

1.1 If Yes, was the M&E plan endorsed by key partners in M&E? – Yes

1.2 If Yes, was the M&E developed in consultation with civil society, including PLHIV? - Yes

1.3 If Yes, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan? - Yes, but only some partners

2. Does the M&E plan include?

A data collection and analysis strategy?	Yes
Behavioural surveillance?	Yes
HIV surveillance?	Yes
A well-defined standardized set of indicators?	Yes
Guidelines on tools for data collection?	Yes
A strategy for assessing quality and accuracy of data?	Yes
A data dissemination and use strategy?	Yes

3. Is there a budget for the M&E plan? - Yes

3.1 If Yes, has funding been secured? - Yes some funding secured

4. Is there a functional M&E Unit or Department? - Yes

4.1 If Yes, is the M&E unit/department based

In the NAC? - Yes

In the MoH? - Yes

4.2 If Yes, how many and what type of permanent and temporary professional staff are working in the M&E Unit/Department?

Position	Type	Since When?
NAC		
M&E Manager	Full Time	2006
Research Officer	Full Time	Vacant since Jan 08
M&E Officer	Full Time	Vacant since Jan 08
Data Officers (District Staff - 10 Nos.)	Full Time	2006
Ministry of Health		
Research Officer	Full Time	
Data Clerk	Full Time	
HIV/AIDS Officer	Full Time	
Epidemiologist	Part Time	

4.3 If Yes, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E UNIT /Department for review and consideration in the country's national response? - Yes

If Yes, does this mechanism work? What are the major challenges?

The mechanism is not working very well with the main challenges being:

- *Data flow mechanisms not working well.*
- *Mechanisms not all inclusive i.e. not used by major implementing partners.*
- *Mechanisms not cost effective.*
- *Lack of harmonized systems.*
- *Lack of decentralisation of key institutions.*
- *Poor coordination at the district level.*
- *NAC not being recognized as the main coordinating body and hence some partners do not feel the need to submit data to them.*

4.4 If Yes, to what degree do UN, bi-laterals, and other institutions share their M&E results? - 2 out of 5, with 0 being low and 5 being high

5. Is there an M&E Committee or Working Group that meets regularly to coordinate M&E activities? - Yes, but meets irregularly

If Yes, data of last meeting? - 02/11/2007

5.1 Does it include representation from civil society, including people living with HIV? – Yes, the larger M&E group has, but not the core working team.

If Yes, describe the role of civil society representatives and people living with HIV in the working group.

The civil society representation is in the expanded larger M&E technical working group but not with the core group that meets more regularly than the expanded larger group. There are no clear roles defined for members of the civil society organisations as they are not part of the core team.

6. Does the M&E Unit/department manage a central national data base? - Yes

6.1 **If Yes, what type is it? – Country Response information system (CRIS) & NASA RTS (National AIDS Spending Assessment Resource Tracking System)**

6.2 **If Yes, does it include information about the content, target populations and geographical coverage of programmatic activities as well as their implementing organizations? - Yes**

6.3 **Is there a functional Health Information Systems (HIS)?**

National level? - Yes

Sub-national level (*)? - Yes

(*) If there is a functional sub-national HIS, at what level(s) does it function? - District level

6.4 **Does the country publish at least once a year an M&E report on HIV, including HIV surveillance data? – No, work in progress.**

7. To what extent is M&E data used in planning and implementation?

1 out of 5 with 0 being low and 5 being high.

What are the main challenges to data use?

- *Planning cycle has gaps, not synchronized with reporting*
- *Inconsistency in data figures & data flow*
- *No advocacy around data use*
- *Reports not translated into the local language (Sesotho)*
- *Untimely dissemination of reports*

8. In the last year, was training in M&E conducted?

At national level? Yes, 10 people trained

At sub-national level? Yes, 20 people trained

Including civil society. Yes, 30 people trained

Overall, how would you rate the M&E effort of the AIDS programme in 2007 and 2005?

3 out of 10 in 2005 and

5 out of 10 in 2007 (with 0 being poor and 10 good)

Comments on progress made in M&E since 2005?

- *Functional M&E Technical Working Group*
- *Decentralized M&E system*
- *Health Management Information System in place*
- *M&E plan developed*
- *NASA training for NGOs*

Part B

(This section was filled in by informants from NGOs and CSOs)

Section I: Human rights

1. **Does the country have laws and regulations that protect people living with HIV against discrimination? (such as general non-discrimination provision or provision that specifically mention HIV, focus on schooling, housing, employment, health care etc.) – Yes, refer to Part A, Section II, 6.2**
2. **Does the country have non-discrimination laws or regulations which specify protection of vulnerable sub-populations? - Yes**

2.1 If Yes, for which sub-populations?

Women	Yes
Young people	Yes
Injecting Drug User (IDUs)	No
Men who have sex with men (MSM)	No
Sex workers	No
Prison inmate	Yes
Migrants/mobile populations	Yes

If Yes, briefly explain what mechanisms are in place to ensure these laws are implemented:

- *Raising awareness in the communities through NGOs like FIDA*
- *Establishments of units, such as the Child and Gender Protection Unit (CGPU) within the Police, to look specifically at issues of women and child abuse*
- *Gender task force established*
- *Mainstreaming of HIV issues into laws such as marriage, property rights, land and rights of children.*

If Yes, describe any systems of redress put in place to ensure the laws are having their desired effect: - Child and Gender Protection Unit established in the police, Master of the High Court

3. **Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for vulnerable sub-populations? - No**
4. **Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy? - Yes**
5. **Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV and/or most-at-risk populations? – Yes, but not addressing most at risk populations. No case has been brought to courts on grounds of discrimination.**

If yes, briefly describe this mechanism:

Yes but not addressing most at risk populations. No case has been brought to courts on grounds of discrimination. NGOs such as FIDA, and the Child and Gender Protection Unit are in place to assist with this.

6. **Has the government, through political and financial support, involved most-at-risk populations in governmental HIV-policy design and programme implementation? - No**

7. Does the country have a policy of free services for the following?

HIV prevention services	Yes
Anti-retroviral treatment	Yes
HIV-related care and support interventions	Yes

If yes, given resource constraints, briefly describe what steps are in place to implement these policies:

- Scale up of ART access
- Scale up HIV testing & Counseling
- Provision of Condoms & STI Treatment
- Free Primary Education

8. Does the country have a policy to ensure equal access for women and men, to prevention, treatment, care and support? In particular, to ensure access for women outside the context of pregnancy and child birth? - Yes

9. Does the country have a policy to ensure equal access for most-at-risk populations to prevention, treatment, care and support? - Yes

9.1. Are there differences in approaches for different most-at-risk populations? - No

10. Does the country have a policy prohibiting HIV screening for general employment purposes (recruitments, assignment/relocations, appointment, promotion, termination)? - Yes, the labour law

11. Does the country have a policy to ensure that AIDS research protocols involving human subjects are reviewed and approved by a national/local ethical review committee? - Yes

11.1 IF YES, does the ethical review committee include representatives of civil society and people living with HIV? - No

12. Does the country have the following human rights monitoring and enforcement mechanisms? If yes, on any of the above questions, describe some examples:

Existence of independent national institutions for the promotion and protection of Human Rights, human right commissions, laws reform commission, watchdogs and ombudspersons	No
Focal Points within governmental health and other departments to monitor HIV related human rights abuses and HIV related discrimination in areas such as housing and employment	No
Performance Indicators or benchmarks for compliance with human rights standards in health and other sectors	No
Performance Indicators or benchmarks for reduction of HIV stigma and discrimination	No

13. Have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV and AIDS and human rights issues that may come up in the context of their work? - Yes

14. Are the following legal support services available in the country?

- Legal aid system for HIV and AIDS casework – Yes , but it is not HIV/AIDS specific
- Private sector law firms or university based centers to provide free or reduced cost legal services to

PLHIV? - Yes, e.g. FIDA, WILSA, Legal AID

- Programmes to educate, raise awareness among people living with HIV concerning their rights? - Yes
15. Are there programmes designed to change societal attitudes of stigmatization associated with HIV and AIDS to understanding and acceptance? - Yes

If yes, what types of programmes?

Media	Yes
School education	Yes
Personalities regularly speaking out, people living with HIV	Yes
Other; out of school education	Yes

Overall, how would you rate the polices, laws and regulations in place to promote and protect human rights in relation to HIV and AIDS in 2005 and in 2007?

4 out of 10 in 2005

5 out of 10 in 2007 (with 0 being poor and 10 being good.)

Overall, how would you rate the effort to enforce the existing policies, laws and regulations in 2007 and in 2005?

3 out of 10 in 2005

4 out of 10 in 2007 (with 0 being poor and 10 being good.)

Section II: Civil society participation

(The scale for the following questions is 0-5 with 0 being low and 5 being high.)

1. **To what extent has civil society contributed to strengthening the political commitment of top leaders and national policy formulations?** - 4
2. **To what extent has civil society representatives been involved in the planning and budgeting process for the NSP on AIDS or for the current activity plan (e.g. attended planning meetings and reviewed drafts)?** - 4
3. **To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included**
 - a. **In both the NSP and national response?** - 5
 - b. **In the national budget?** - 2
4. **Has the country included civil society in national Review of the NSP? – Yes**

IF YES, when was the Review conducted? Year: - 2005

5. **To what extent is the civil society sector representation on HIV-related efforts inclusive of its diversity?** - 3

List the types of organization s representing civil society in HIV and AIDS response:

- *Community based organization*
- *Faith based organizations*
- *Private Sector*
- *Women's organizations*
- *Youth clubs*
- *International NGOs*
- *National NGOs*
- *Umbrella bodies and networks*
- *Associations of people living with HIV*

6. **To what extend is civil society able to access**
 - a. **Adequate financial support to implement its HIV activities?** - 4
 - b. **Adequate technical support to implement its HIV activities?** - 3

Overall, how would you rate the efforts to increase civil society participation in 2007 and in 2005?

4 out of 10 in 2005

7 out of 10 in 2007, (with 0 being poor and 10 being good.)

Section III: Prevention

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV prevention programmes? – Yes

If yes, to what extent have the following HIV prevention programme been implemented in identified districts in need?

HIV prevention programmes	The service is available in			
	All districts in need	Most districts in	Some districts in	N/A
Blood safety		Yes		
Universal precaution in health care settings		Yes		
Prevention of mother-to-child transmission of HIV			Yes	
IEC on risk reduction			Yes	
IEC on stigma and discrimination reduction		Yes		
Condom promotion			Yes	
HIV testing and Counseling		Yes		
Harm reduction for injecting drug users			Yes	
Risk reduction for men who have sex with men		Yes		
Risk reduction for sex workers			Yes	
Programmes for other vulnerable sub-groups			Yes	
Reproductive health services including STI prevention treatment			Yes	
School-based AIDS education for young people			Yes	
Programmes for out-of-school young people			Yes	
HIV prevention in the workplace		Yes		
Other programmes:				N/A

Overall, how do you rate the efforts in the implementation of HIV prevention programmes in 2007 and in 2005?

2 out of 10 in 2005 and

3 out of 10 in 2007, (with 0 being poor and 10 being good.)

Comments on progress made since 2005:

- *Door-to-door Know Your Status campaign made great impact. However, in many places service delivery was bogged down by failure to provide resources.*
- *Livelihoods strategies could have been emphasized and reflected everywhere.*
- *No control over availability of untested & unapproved health products such as herbal medication that are said to cure HIV; also condom brand control non-existent.*

Section IV: Treatment, care and support

1. Has the country identified the districts (or equivalent geographical/ decentralized level) in need of HIV and AIDS treatment, care and support services? - Yes

If Yes, to what extent have the following HIV and AIDS treatment, care and support services been implemented in the identified districts in need?

HIV and AIDS treatment, care and support services	The service is available in			
	All districts in need	Most districts in need	Some districts in need	N/A
Antiretroviral therapy	Yes			
Nutritional Care	Yes			
Pediatric AIDS treatment	Yes			
Sexually transmitted infection management	Yes			
Psychosocial support for people living with HIV	Yes			
Home-based care	Yes			
Palliative care and treatment of common HIV – related opportunistic infections			Yes	
HIV testing and counseling for TB patients	Yes			
TB screening for HIV-infected people	Yes			
TB preventative therapy for HIV-infected people	Yes			
TB infection control in HIV treatment and care facilities	Yes			
Cotrimoxazole prophylaxis in HIV-infected people	Yes			
Post exposure prophylaxis (e.g. occupational exposure)	Yes			
HIV treatment services in the workplace or treatment facilities		Yes		
HIV care and support in the workplace (including treatment facilities)		Yes		
Other programmes				N/A

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2007 and in 2005?

5 out of 10 in 2005

8 out of 10 in 2007, (with 0 being poor and 10 being good.)

Comments on progress made since 2005:

- IMAI training have capacitated health personal on acute and chronic care of adults and adolescents.
- More interventions that focus on pediatric care.

2. What percentage of the following HIV programmes or service is estimated to be provided by civil society?

Prevention for Youth	25-50%
Prevention for Sex Workers	<25%
Counselling and Testing	51-75%
Clinical Services (OI/ART)*	51-75%
Home-based Care	51-75%
Programmes for OVC**	51-75%

3. Does the country have a policy or strategy to address the additional HIV- and AIDS-related need of orphans and other vulnerable children (OVC)? - Yes

3.1 If Yes, is there an operational definition of OVC in the country? – Yes

3.2 If Yes, does the country have a national action plan specifically for OVC? - Yes

3.3 If Yes, does the country have an estimate of OVCs being reached by existing interventions? - Yes

If yes, what percentage of OVC is begin reached? - 40%

Overall, how would you rate the efforts to meet the needs of orphans and other vulnerable children?

3 out of 10 in 2005

5 out of 10 in 2007, (with 0 being poor and 10 being good.)

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