US Government
Rapid Appraisal for HIV/AIDS
Program Expansion

Lesotho

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TABLE OF CONTENTS

List of Abbreviations	Page 4
Executive Summary	Page 6
Background	Page 11
Prevention	Page 19
Laboratory Services	Page 29
HIV Counseling and Testing (HCT)	Page 32
Palliative Care	Page 33
Home and Community Based Care (HCBC)	Page 37
Prevention of Mother to Child Transmission (PMTCT)	Page 41
Orphans and Other Vulnerable Children (OVC0	Page 43
Treatment	Page 49
Nutrition	Page 56
People Living with HIV/AIDS (PLWHA)	Page 57
Next Steps	Page 59
References	Page 60

Annexes

1: Scope of Work for Rapid Appraisal	Page 62
2: Organizations and Individuals Interviewed	Page 67

ABBREVIATIONS

ABC	Abstinence, Being faithful and correct and consistent use of Condoms
ADB	African Development Bank
AED	Academy for Educational Development
AFB	Acid-Fast Bacillus
AMICAAL	Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa
ANC	Antenatal Care/Clinic
APCA	African Palliative Care Association
ART	Antiretroviral Therapy/Treatment
ARV	Antiretroviral
BCC	Behavioral Change Communications
BSS	Behavioral Surveillance Survey
BMS	Bristol-Myers Squibb
CARE	Cooperative for Assistance and Relief Everywhere
CBOs	Community-Based Organizations
CDC	Centers for Disease Control and Prevention
CHAL	Christian Health Association of Lesotho
CHCW	Community Health Care Workers
DATF	District AIDS Task Force
DCI	Development Cooperation of Ireland
DSW	Department of Social Work
DFID	Department for International Development
DHS	Demographic Health Survey
DOD	Department of Defense
DOTS	Directly Observed Therapy – Short-course
DS	District Secretary
DSW	Department of Social Welfare
EGPAF	Elisabeth Glazer Pediatric AIDS Foundation
ELISA	Enzyme-Linked Immunosorbent Assay
ENA	Essential Nutrition Activities
FAO	Food and Agriculture Organization
FBO	Faith-Based Organizations
FY	Fiscal Year
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GPA	Global Program on AIDS
GoL	Government of Lesotho
HAHPCO	HIV/AIDS Health Products Coordination Unit
HCBC	Home- and Community- Based Care
HCD	Human Capacity Development
HCW	Health Care Worker
HMIS	Health Management Information System
HR	Human Resources
HRDSP	Human Resources Development Strategic Plan
HSA	Health Service Area
HTC	HIV Testing and Counseling
IDU	Injection Drug Use

IEC	Information, Education and Communication
IGAs	Income-Generation Activities
IMCI	Integrated Management of Childhood Illness
ITNs	Insecticide-Treated Nets
LAPCA	Lesotho AIDS Program Coordinating Authority
LCN	Lesotho Council of NGOs
LPPA	Lesotho Planned Parenthood Association
NAC	National AIDS Commission
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MOFDP	Ministry of Finance and Development Planning
MOHSW	Ministry of Health and Social Welfare
MSM	Men who have Sex with Men
NHTC	National Health Training College
NAPCP	National HIV/AIDS Prevention and Control Program
NASP	National AIDS Strategic Plan
NDSO	National Drug Supply Organization
NGO	Non-Governmental Organization
OGAC	U.S. Office of the Global AIDS Coordinator
OHA	Office of HIV/AIDS
OI	Opportunistic Infection
OVCs	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PLOHA	People Living Openly with HIV/AIDS
PLWHA	Person Living with HIV or AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
PPP	Public-Private Partnerships
PR	Principal Recipient
PSCAAL	Private Sector Coalition Against AIDS in Lesotho
RHAP	Regional HIV/AIDS Program
RTK	Rapid Test Kit
QA	Quality Assurance
SG	Support Group
SHARP!	Sexual Health and Rights Promotion Program
SI	Strategic Information
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infection
TA	Technical Assistance
TOT	Training the Trainers
TB	Tuberculosis
TBA	Traditional Birth Attendant
UNAIDS	Joint U.N. Program on HIV/AIDS
UNDP	U.N. Development Program
UNFPA	U.N. Population Fund

UNGASS	U.N. General Assembly Special Session
UNHCR	U.N. High Commissioner for Refugees
UNICEF	U.N. Children's Fund
UPE	Universal Primary Education
USAID	U.S. Agency for International Development
USG	U.S. Government
VCT	Voluntary Counseling and Testing
WFP	World Food Program
WHO	World Health Organization

Executive Summary

Background: Lesotho currently does not have either a USAID or CDC-Global AIDS Program (GAP) office and is a non-focus country for the President's Emergency Plan for AIDS Relief (PEPFAR). In recent years, through the Corridors of Hope Initiative, the Ambassador's initiative on HIV/AIDS and other support to non-government organizations, the United States Government (USG), primarily through the regional offices of CDC and USAID, has emphasized prevention of HIV/AIDS among high risk groups such as migrant men, low income women, women working in the textile industry, truck drivers, taxi drivers, and female sex workers. Additionally, VCT and BCC projects have been supported. Anticipating increased funding for Lesotho for fiscal year 2005, a rapid appraisal of the USG strategy was conducted from September 5th to September 13th with a team comprising USAID, CDC and FHI technical staff from both Washington and the regional offices and a Senior Health Consultant from Lesotho. The major objectives of the rapid appraisal were to plan a joint USG strategy for Lesotho and to make recommendations for reorientation of the program within the context of a generalized epidemic. In addition, although Lesotho is not a focus country for the President's Emergency Plan, it is receiving financial support through this initiative and can clearly contribute to and benefit from aligning itself with the Emergency Plan goals of treating 2 million PLWHA, preventing 7 million HIV infections and caring for 10 million PLWHA and orphans and vulnerable children by 2008. The rapid appraisal was not designed to be a formal evaluation of interventions previously or currently supported by the USG or other donors.

Findings: The findings of the rapid appraisal team are presented in detail below. The team noted substantial opportunities for rapid expansion of HIV/AIDS activities. The people of Lesotho, referred to as Basotho, have a strong traditional system comprised of principle, area and local chiefs whom community members will first approach on social issues. They have a very solid cultural foundation of mutual assistance. They have survived numerous challenges with remarkable resilience and dignity. Lesotho is a small country with a homogenous population with one major ethnic group and language (Sesotho). Literacy rates are high (93.4 percent) among women and relatively high (72.6 percent) among men. Despite the mountainous geography of Lesotho, a relatively good transportation system and health care infrastructure provide a solid foundation upon which to build. Lesotho is also currently seeking opportunities to utilize its strong community structures and networks to even greater advantage. A cadre of community health care workers (CHCWs) was established in the 1970s and is being revitalized. In addition, an emerging model of support groups is showing great promise.

The Government of Lesotho (GoL) has made commendable achievements, particularly in the last year, in scaling up the national response through the use of "pitsos" (traditional community gatherings) and HIV counseling and testing (HCT), the establishment of prevention of mother-to-child transmission (PMTCT), and the planned provision of antiretroviral therapy (ART). The GoL has clearly assisted in building momentum for a

coherent response to the epidemic. Additionally, GoL has attracted substantial funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)[1]. A perceived need for improved coordination is being taken seriously, and efforts are underway to improve the national coordination mechanism, namely the formation of a National AIDS Commission (NAC) and the transformation of the Lesotho AIDS Program Coordinating Authority (LAPCA) to function as the secretariat to the NAC. The GoL has the potential to develop an effective mechanism to provide a multisectoral response to HIV/AIDS.

Leaders at all levels are looking for opportunities to support prevention, care and support and treatment. Sixth, the United Nations agencies, through the UN theme group and activities such as WHO's 3 by 5 initiative, and WFP's support for food for patients receiving DOTs and ART, are contributing to the response. Finally, and perhaps most importantly, there are several important indigenous networks, with the potential to mobilize communities, educate the population and deliver a comprehensive package of services for infected people and affected communities.

However, significant challenges also remain. Prevention messages are frequently not conveyed in Sesotho and primarily focus on condom use through social marketing and targeting of high risk groups. Prevention interventions have not been developed to address the common multiple/concurrent partnerships that take place outside of the context of sex work.. Condom promotion appears to be the main focus of prevention efforts but condoms are not always readily available, and promotion efforts do not appear to have addressed the substantial barriers to correct and consistent condom use that exist in long-term or regular partnerships. Some efforts have been made to intervene within the context of internal and external work migration, but these programs are in need of support to expand their reach. It also appears that there is great promise in working with the initiation schools and other traditional structures to increase prevention among men. Behavioral disinhibition following large scale ART introduction may pose a real risk in the future unless accompanied by strong communication messages.

The delivery mechanisms for HIV/AIDS services appear to be vertical in nature, primarily clinic-based, and planning is sub-optimal. There is room for improving HIV/AIDS health care services and infrastructure (particularly laboratory services) and much is needed to prepare the community for expanded HIV/AIDS services, particularly ARV treatment. Strengthening the primary health care service and community structures will be critical if both are to mutually reinforce each other thus providing the best support possible for PLWHA and their families.

The scaling up of treatment will spark an enormous need for HIV counseling and testing. It is estimated that in order to reach the WHO 3x5 target of 28,000 adults on treatment by December 2005, more than a million people will need to be tested. However, access to testing is still limited in rural areas and is primarily centralized within district hospitals located in

[1] The agreement arrived at with the GFATM has dictated that the Ministry of Finance and Development Planning be the principal recipient for the funds.

urban capitals. While several local groups and support groups exist they appear to have limited access to resources (donor funds and technical assistance). Home and community based care is clearly a priority. However, the coverage, quality, and linkages to primary health care are questionable. Palliative care is non-existent but considered to be critical. Additionally, children with HIV/AIDS have not yet been addressed in treatment rollout plans or strategies.

Until recently, OVC programming appears to be heavily focused on prevention of abandonment, access to food, gardening supplies, and material support followed by access to education rather than on supporting access of orphans and vulnerable children to a full range of basic social services including health. There is also a need to integrate child protection into such activities. Substantial efforts have been made in legislative frameworks, most notably with the Children's Protection and Welfare Bill. However, the Department of Social Welfare is in need of access to programmatic and technical assistance if it is to fulfill its mandate.

Many people are excited about the availability of ART, and are eager to learn more. However it appears that there is tremendous pressure on the GOL to achieve the 3x5 target (set by the WHO) at the risk of compromising the quality of services being provided. This applies in particular to community preparedness and support including treatment literacy and adherence support. The Senkatana Clinic (Lesotho's ART pilot site) and other international ART programs are willing and able to share "lessons learned" with the up-coming public sites. People are hopeful that the new sites will offer a full range of prevention, treatment, care and support services. Much is still needed in order to ensure a move towards a family centered model and for the provision of care, support and treatment of Children. During the rapid appraisal period it was difficult to determine the status of post exposure prophylaxis for health care workers and sexual assault survivors. It also appears that knowledge of, and access to, these services is very limited. Monitoring and evaluation needs to be strengthened and it appears that service utilization and coverage data is not systematically collected.

Despite the ubiquitous nature of the epidemic in Lesotho, few PLWHA, particularly prominent people, such as parliamentarians, religious or traditional leaders or media/sports personalities, have come out publicly and revealed their status. This hinders the flow of information to communities, hampers prevention efforts and reduces utilization of services. PLWHA to date do not have formal representation on key stakeholder or decision-making bodies. Finally, the human resources capacity of the MOHSW, both to manage the response and to deliver services, is stretched to critical levels by a combination of increasing demands on the health system due to the epidemic, illness and death of staff, inadequate enrolment of new cohorts of health workers, and the simultaneous emigration of qualified staff.

Recommendations: The following represent a summary of recommendations for USG assistance to HIV/AIDS activities in Lesotho. Such assistance needs to be placed in the context of current or planned assistance by other major donors, be consistent with the activities of the MOHSW, and be coordinated through the national coordinating body.

In making its recommendations, the USG team sought to identify a balance between support for filling critical gaps in technical capacity and for expanding service delivery in a well-coordinated manner. Furthermore, a substantial proportion of fiscal year 2004 funds are already committed in broad terms to specific partners. Wherever possible these activities will need to be reoriented. Funds for fiscal year 2005 and beyond will follow the strategy outlined in this document.

SUMMARY

The USG, in the short and long term, will support:

- Coordination of HIV/AIDS activities undertaken at the national and district levels.
- HIV/AIDS advocacy and support through key opinion leaders.
- Technical assistance in key technical areas across the continuum from prevention to treatment and palliative care (adults and children).
- A national behavior change communication strategy emphasizing the ABC.
- Expanding HTC throughout the primary health care system and building the capacity of NGOs, community health workers, and caregivers to provide HCT in a variety of settings.
- Strengthen National PMTCT program and community support and provide technical assistance to prepare for and develop PMTCT+
- Community preparedness for ART.
- Strengthening the links between the DOTS infrastructure and the ART referral system at the hospital, clinic and community levels following the network model of the Emergency Plan.
- Strengthening of the laboratory system.
- PLWHA networks to be involved in all aspects of the program at national and local levels.
- FBO, PLWHA, Business Coalition, NGO and journalist networks by facilitating linkages with regional networks in southern Africa and with each other.
- National monitoring and evaluation where possible.

The Following SHORT TERM Recommendations Are Suggested.

The team considers the following guiding principles to be essential:

A) Project support will contribute to national-level policy development;
B) MOHSW capacity can be strengthened particularly at the national and district levels;
C) The UNAIDS "Three Ones" principle (one national plan for HIV/AIDS, one coordination mechanism, and one M&E plan) will be followed closely;
D) USG assistance will be consistent with President Bush's Emergency Plan policies and contribute to its goals; and
E) USG support will be designed to utilize most effectively the comparative advantage of CDC, USAID and other USG agencies including DOD and the Peace Corps.

Prevention

A) Expand support for joint workplace and community-based activities to help facilitate a coordinated approach to addressing the multiple-partnership risks introduced by migration.
B) Provide HIV/AIDS and advocacy training to leaders at all levels of Sesotho society including the involvement of traditional leadership in HIV/AIDS activities through Principal, Area and Local Chiefs.
C) Provide financial and technical support to local NGOs and FBOs. This support can include some training and organizational capacity building as well as technical assistance in developing comprehensive prevention programs using the balanced "ABC" model.
D) Encourage a primary focus on male involvement in all programming.
E) Integrate prevention within the development of a more formal HIV/AIDS training curriculum for CHWs and volunteers.

Care and Support

Laboratory

A) Conduct a comprehensive National Laboratory Assessment and pending the findings, proceed with support to GOL for a laboratory specialist through the regional office of CDC;

HIV Counseling and Testing (HTC)

A) Assist the GoL to expand HTC to the lowest possible level of service delivery - the health center and into communities. This would include the training of a large cadre of professional and non-professional counselors (including CHWs and members of support groups) to provide the service.
B) Expand outreach services to communities and large textile factories to ensure services are available on a regular basis to those who cannot regularly attend hospitals for HTC.
C) Train community leaders, including chiefs, agriculture extension officers, traditional healers, teachers and others.
D) Provide continued support for stand-alone HTC sites run by PSI and support other NGOs that offer a valuable avenue for the expansion of access to HTC.
E) Encourage partners receiving USG support to address important issues identified as technical gaps such as: the testing of children under 18 and skills-building for counselors to address family counseling.

Palliative Care and Home and Community Based Care (HCBC)

A) In collaboration with the US Office of the Global AIDS Coordinator (OGAC) and the African Palliative Care Association (APCA), conduct a palliative care assessment as a first step in mobilizing the national response for palliative care.
B) Provide technical assistance to form a National Palliative Care Association.
C) Assist with a national participatory mapping and rapid assessment exercise to identify current HCBC coverage and efforts, levels of HCBC being provided, gaps (geographic and provision of services), and to review of the effectiveness of HCBC.
D) Support training at the district and community levels in key technical areas: palliative care, children with HIV, psychological and emotion support, dealing with mental health issues, OVC, communication skills, etc.

Prevention of Mother to Child Transmission (PMTCT)

A) Support EGPAF to provide focused technical assistance based on LINKAGES assessment and baseline, such as strengthening quality assurance and data quality.
B) Determine need for comprehensive facility assessment.
C) Work with OHA to coordinate PMTCT partner collaboration (i.e. Columbia Univ., EGPAF, LINKAGES and PSI) to help MOHSW strengthen the national PMTCT program and prepare for PMTCT+. Build on Ministry's strengths in MCH, FP and child health service delivery by providing additional technical assistance for integration.

Orphans and Vulnerable Children (OVC)

A) Support the dissemination of the Children's Protection and Welfare Act (including the translation and printing).
B) Support training for key parliamentarians, chiefs and traditional and religious leaders on OVC issues.
C) Provide technical and programmatic support for community-based programs and structures for OVC.
D) Build capacity of PLWHA groups to contribute to community-level and national OVC activities.
E) Provide technical support to the DSW to review and revise the GFATM HIV/AIDS proposal including OVC services for resubmission.

Treatment

A) Print and disseminate the national treatment guidelines and protocols. These can be printed in both English and Sesotho.
B) Assess the feasibility of developing and implementing a PMTCT+ program including the piloting of the IMCI/HIV protocol as planned at the PMTCT sites (by adapting the current PMTCT program).
C) Assist the Ministry of Health in developing a national training curriculum for community support systems, including CHWs and support groups.
D) Provide both technical and financial assistance to NGOs that provide key treatment support services, including HTC, treatment readiness education and OVC support.
E) Assist the GoL to host a tri-country workshop of Lesotho, Swaziland and South Africa to look at ART implementation, including harmonization of clinical guidelines and access to treatment.

Nutrition

A) Intensify efforts to implement essential nutrition actions (ENA) within existing USG- funded PMTCT and MCH programs.
B) Identify areas of opportunity with key networks and organizations. such as the PLWHA network, Lesotho Infant Nutrition Network, Alliance of Mayors.

People Living with HIV/AIDS (PLWHA) Network

A) Conduct a participatory rapid appraisal of PLWHA groups (formal and informal) in collaboration with PLOHA. Provide support to form the national PLWHA network.

NOTE: Broadly, and over time, the USG would like to provide support both at the national as well as at the district and community levels. In FY 2005 the USG might focus support in a specific underserved district in order to build a comprehensive continuum of care from the community into the formal health system and back into the community. This would include working with a broad range of stakeholders, including the District AIDS Taskforces (DATFs), support groups, district hospitals and feeder clinics, traditional leaders, and others. Alternatively, USG support might focus in particular technical areas across all ten districts.

Recommendations for the medium and long-term are described in the full report. The amount of funding in FY 2005 and beyond will dictate which recommendations can be supported. In addition, a number of detailed assessments not-yet-completed might also shift priorities.

BACKGROUND

1.1 Country Context

Lesotho is a small (30,350 km^2) mountainous country of almost 2.2 million people, encircled entirely by the Republic of South Africa. Despite the country's rich human and water resources, economic and social development in Lesotho is severely constrained by HIV/AIDS, poverty and food insecurity. Along with Swaziland and Botswana, Lesotho is considered to be one of the three countries in the world most affected by HIV/AIDS. Adult HIV prevalence has risen to 28.9 percent since Lesotho's first AIDS case was diagnosed in 1986. Life expectancy at birth is estimated at just 35.7 years down from 60 years just 10 -15 years ago. Prevalence accelerated first in the urban centres of Maseru and Leribe, but now uniformly affects urban and rural areas with an adult HIV prevalence range of 26.1 to 32.3 percent (urban and rural).

An estimated 320,000 people are living with HIV/AIDS (PLWHA) including around 22,000 children between the ages of 0-14 years. An estimated 320,000 people are living with HIV/AIDS in Lesotho, 56,000 of whom are in need of antiretroviral treatment. In 2003, there were an estimated 29,000 people who died of AIDS. The number of orphans in Lesotho is estimated to be 180,000 or 19 percent of all children less than 18 years of age in the country; around 100,000 or 56 percent of these are orphaned by HIV/AIDS. Some 56,000 children are double orphans of which 87.5 percent of these are orphaned due to AIDS. HIV prevalence of 14.4 percent among young women between the ages of 15 to 19 suggests very high rates of new HIV infection. The vast majority of new HIV infections can be attributed to the high prevalence of multiple, concurrent sexual partnerships. Intergenerational sex, high mobility, and early ages of sexual debut for both young women and men may also contribute substantially to HIV transmission.

The HIV/AIDS epidemic has dramatically reduced the size of the productive adult population in Lesotho, such that an estimated 39.2 percent of all residents are under the age of 15 The gross national per capita income in Lesotho is $2,710, and the top 10 percent of households are receiving about 40 percent of the national income, while the bottom 40 percent are receiving about 8 percent. The unemployment rate has risen from 5.7 percent in 1976 to 42+ percent in 2001. Approximately 180,000 children in Lesotho under 18—1 in 5 children—have lost one or both their parents. AIDS has killed more than half (56 percent) of these children's parents. The estimated number of children who have lost both of their parents increased from 70,000 in 2001 to 90,000 in 2003 (UNICEF, 2003).

These numbers only tell part of the story. Besides orphans, there are thousands of vulnerable children. While not orphaned, these children may be living with HIV, caring for siblings and chronically ill family members and/or living in financially stretched households that take in children who are orphans. Some are engaging in high-risk behaviors in order to support their families. These children are more likely to suffer from poor nutrition, lack access to basic health care, miss school and face psychological and emotional difficulties.

Because about 60 percent of the total population lives in rural areas with less access to health and other services, Lesotho faces some unique challenges in scaling up its prevention, care and treatment programs.

Unfortunately, some of Lesotho's recent efforts to address the challenges of poverty and development may have introduced additional barriers to the adoption of HIV/AIDS prevention behaviors. The recent dramatic expansion of garment manufacturing operations in Lesotho has resulted in new jobs for more than 56,000 Basotho (approximately 85 percent women), but it has drawn them away from their spouses, families and communities in much the same way that the South African mines drew more than 40 percent of Basotho men away from their home villages to work in the mid-1980s. In 2001, an estimated 15 percent of the male labor force was employed in South Africa. The development of the Lesotho Highlands Water Project, which seeks to harness Lesotho's water resources to supply the Gauteng Province of South Africa, has also contributed to massive internal migration. Rates of multiple partnerships and risky sex are elevated among both miners and textile workers, and this suggests that HIV prevalence is also high in these populations. An analysis of 1999 hospital data projected an HIV infection rate of 51 percent among miners. Although the findings from a recent prevalence study among garment workers are yet to be released, an STI prevalence rate of about 70 percent also suggests high rates of HIV infection in this population.

In 1999, almost 70 percent of reported AIDS cases were among married individuals, about 27 percent of those infected reported working as housewives, and about 20 percent reported working as miners. Prevalence is also higher among women who have completed high school (31.9 percent) than those with no education (28.4 percent), only a primary-school education (26.9 percent) or with a tertiary education (25.8 percent). Adult literacy is higher among women (93.4 percent) than in men (72.6 percent), and women are more frequent consumers of health and other social services. However, Basotho society is traditionally patriarchal, and neither customary nor common laws afford women the same rights and liberties as men. More than 48 percent of all males older than 15 are married, and almost 47 percent of females in the same age group are married.

1.2 Organization of Health Services

The MOHSW has overall responsibility for the provision of health services in Lesotho. The Christian Health Association of Lesotho (CHAL) owns and manages 49 percent of the health facilities in the country and receives annual subventions to provide subsidized health services. Currently, there is work ongoing on a Partnership Agreement that is intended to formalize the relationship between the GOL and CHAL such that the GOL could in effect purchase a package of services from CHAL based on a set of criteria that would be explicitly defined within the agreement

The Three Levels of Health Services:

Service Level	Service Providers
Primary	6000 community health workers
	17 village health posts
	167 health centers
Secondary	4 urban filter clinics
	17 Health Service Area (HSA) Hospitals (9 GoL and 8 CHAL)
	Lesotho Flying Doctor service
Tertiary	1 national referral hospital
	1 mental health hospital
	1 leprosy hospital

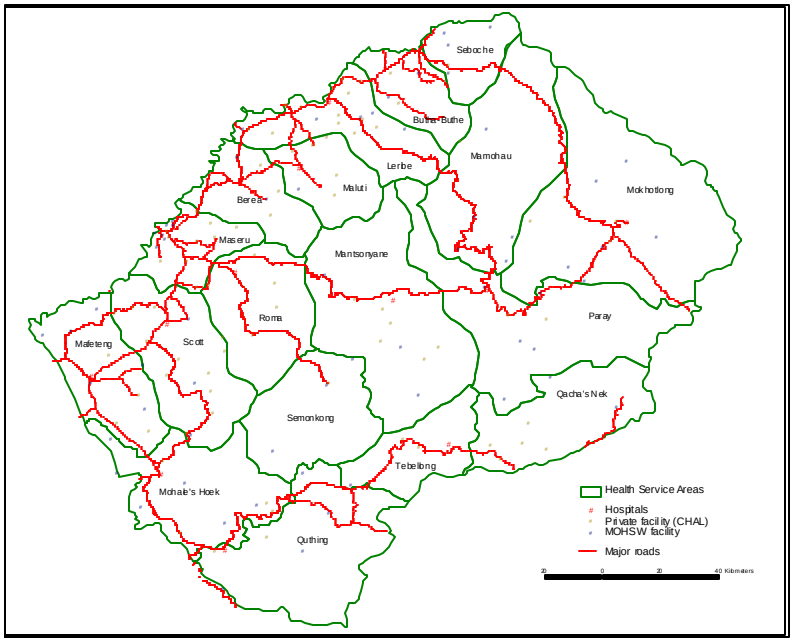
The condition of the various health facilities varies widely. Most GoL facilities have been upgraded, renovated and rehabilitated. CHAL facilities are due for the same with funding from the African Development Bank (ADB), following a study commissioned to inventory equipment and assess infrastructure.[2]

Nineteen Health Service Areas (HSAs)[3] were established in 1979 in order to enhance the delivery of PHC. Although there has been partial delegation of administrative powers to HSAs and government hospitals, functions such as financial management, supply procurement, human resources management, maintenance and much operational decision-making remain centralized.

[2] See: "Lesotho Health Study, Phases I, II, and III"

[3] Though the organisation of the Health Service Areas is around Health Service Area hospitals, there are actually only 18 hospitals in the HAS concept, the nineteenth Health Service Area is the Lesotho Flying doctor's Service that provides services to four health centres that are inaccessible by any mode of transport except a plane. In addition, one CHAL hospital, the Semonkong Hospital has been closed, so in effect only seventeen of the eighteen hospitals are functional

HSA Boundaries:



The Role of Churches in Health Services Provision

The vast majority of Basotho are Christian, and churches play a major role in the structure and function of the PHC system. Christian Mission Hospitals and clinics have been operating in Lesotho since 1863. The establishment of a formal structure for the coordination of health services provision by church-owned institutions took place in 1974 with the formation of the Christian Health Association of Lesotho (CHAL). The CHAL has six church-members (the Anglican Church Of Lesotho, Assemblies Of God, Bible Covenant, Lesotho Evangelical Church, Roman Catholic Church and Seventh Day Adventist Church). They own eight of the 18 hospitals and 73 of the 167 health centers in the country.

Implications of Traditional Structures for HIV/AIDS-related Interventions

Traditional institutions remain influential in Lesotho. Local chiefs and traditional healers are most often the first stops for citizens seeking to remedy social or health concerns. Many young men and women participate in traditional initiation ceremonies, particularly in rural areas. MC – which may reduce the risk of HIV infection by up to 70 percent for men – was routinely an integral component of male initiation, but it may now be less common in urban settings and among those exposed to Western culture. Traditional leadership plays an important advocacy role at the national level through the Senate, and area and local chiefs help establish and entrench norms and standards at the community level. The role of the Royal Family of Lesotho and the respect and pride of the Basotho for the Royal Family cannot be understated. The Royal Family has been particularly active in advocating and educating the public about HIV/AIDS, working with the government, particularly the Senate, and U.N. agencies and others consider it to be a key stakeholder.

Community-Based Interventions

Community-based prevention and care activities have served as the center piece of the national response to HIV/AIDS. Traditional values include the caring for one another in the absence of other treatment and care-related resources. Peer education programs are expanding though both community-based and workplace-based initiatives. Training has been provided to 6,000 CHW throughout the country. Lesotho's support groups are beginning to play an instrumental role in providing Home-Based Care to PLWHA and for other illnesses. They are also trying hard to support orphans and other vulnerable children. These community based interventions can be built upon and utilized for service, education, and commodity provision.

Reorganization of the Health Sector

The first case of AIDS in Lesotho was reported in 1986. This case triggered the establishment of the National HIV/AIDS Prevention and Control Program (NAPCP) to spearhead interventions that were aimed primarily at prevention and transmission control. At the time when it was established, the NAPCP was placed within the Disease Control Division of the MOHSW. Initial financial and technical support was through the World Health Organization (WHO) through its Global Program on AIDS (GPA).

At its inception the program was initiated through a Short-Term Plan that defined the requirements for structures, functions and the staff complement. Four units were set up: Administration, Epidemiology, Counseling and Information, Education and Communication (IEC). The staff for the four units (Administrator, IEC Specialist and epidemiologist) consisted of personnel seconded from the GPA. Complementary staff was in the form of local staff including a Program Manager, Counselor and IEC and Epidemiology counterparts.

The NAPCP was allocated a separate budget from the Disease Control Division. Additionally, the AIDS Program Manager had full signing powers over the budget and was accountable for expenditure and implementation of prevention (education/awareness campaigns, condom promotion and blood safety), surveillance and counseling. This would seem to indicate that there was already recognition, even at the inception of the program, that there was (or that there would be) need for a high level of management for the program, particularly given the threat posed by the nature and scope of the pandemic.

Over the years, the evolution of the NAPCP has taken place through the development and implementation of a number of plans that covered the spectrum from short to medium to long term. A key characteristic of the evolution was the transition of the NAPCP from a program that focused primarily on health interventions to one that facilitated and encouraged both multisectoral involvement and coordination. However, with the establishment of the Lesotho AIDS Program Coordinating Authority (LAPCA) in the Prime Minister's office in 2001, the NAPCP has had to redefine its mission and objectives in order to be in line with the LAPCA. This entailed and demanded that there be significant improvements in the planning,

coordination, leadership, implementation, supervision and monitoring of a much-strengthened health sector response to HIV/AIDS.

Recent Developments

The recent expansion of HCT services and establishment of the country's first pilot site for public-sector ARV delivery promise to provide new opportunities and challenges. In response to mounting local and national pressure to meet treatment targets set by the WHO 3x5 initiative, the GoL hopes to expand to five public ARV sites and treat 5,000 people by the end of 2004. This will likely also require an expansion of VCT availability beyond the current 23 sites (include the 6 stand-alone VCT sites established through PSI and CARE and the 17 HSA hospitals) that are clustered around Lesotho's urban centers.

Coordination of HIV/AIDS Services

Currently, the main national coordinating body for HIV/AIDS activities is LAPCA. LAPCA was established in March 2001 when a Chief Executive was appointed. The mandate for LAPCA is to:

- Facilitate the development of sectoral plans for the mitigation of the effects of the pandemic
- Ensure that policies and strategies agreed upon are implemented and convene regular meetings with the various organizations and individuals within the country that have programs designed for intervention in the HIV/AIDS arena
- Manage research activities relating to HIV/AIDS and STIs in the country to ensure that they are relevant and further that they lead to the production and popular dissemination of educational information to prevent and control the spread of HIV/AIDS
- Mobilize and allocate available resources based on identified needs and on institutional capacity
- Monitor and evaluate the national HIV/AIDS Program
- Facilitate the effective input of all stakeholders

Lesotho is currently revisiting its approach to the coordination of the national response to HIV/AIDS. LAPCA is likely to be subsumed under a new National AIDS Commission (NAC) and will most likely function as the NAC Secretariat. The Expanded U.N. Theme Group on HIV/AIDS proposed the NAC in 2003 to address concerns that LAPCA was being drawn into an implementation capacity that was detracting from its ability to fulfill core coordination responsibilities and it was understaffed to fulfill both its *de facto* implementation and its *de jure* coordination roles. However, to date, the NAC still has not been formally convened, and LAPCA continues to try to coordinate the national response with limited support and in the shadow of an uncertain future.

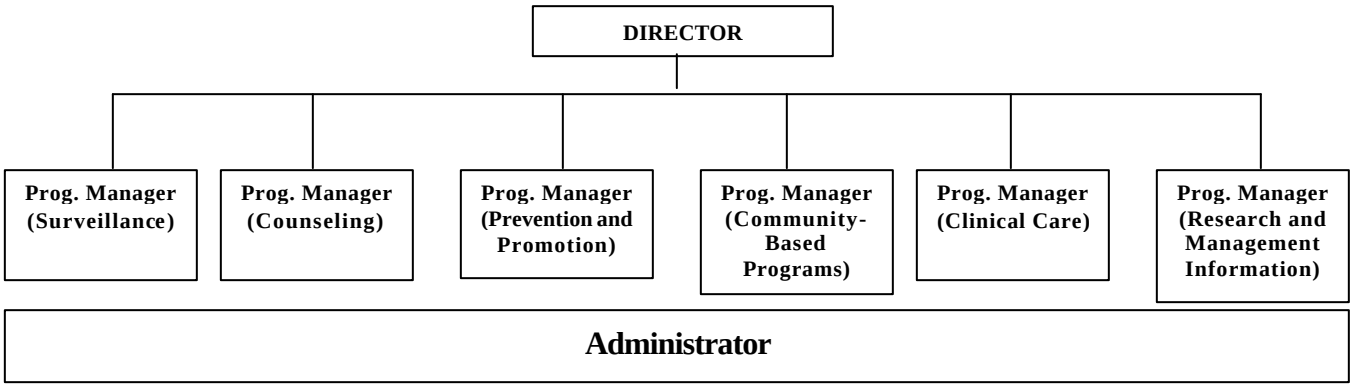
The HIV/AIDS Directorate

The response to the HIV/AIDS epidemic has evolved from a program focusing mainly on prevention to a multisectoral response with complementary prevention, care and treatment and mitigation strategies. For the MOHSW, a strong HIV/AIDS Directorate is critical for the success of the multisectoral response. In this context, the MOHSW is expected or mandated to undertake the following:

- Promote effective (preventive and curative) interventions
- Provide health services including ARV treatment and comprehensive care and support
- Catalyze action at other levels of society
- Mobilize, coordinate, monitor and evaluate strategic players and resources for the implementation of interventions defined for the Health Sector4
- Facilitate mainstreaming and scaling-up of HIV/AIDS related activities in the MOHSW's various departments including a Work Place Program for Health Care Workers
- Facilitate the improvement of health standards, health systems, policies and strategies that are critical for a strengthened health sector response to HIV/AIDS

It is expected that the newly established HIV/AIDS Directorate shall be the institution responsible for the coordination of the development of a health sector-specific response to the pandemic and the provision of stewardship in matters of coordination, monitoring and evaluation. Institutions to be worked with shall include not only the MOHSW but also all public and private organizations implementing health-related HIV/AIDS interventions.

HIV/AIDS Directorate Structure



HIV/AIDS Activities in Other Ministries

Recommending and legislating that all ministries allocate 2 percent of their budget towards HIV/AIDS work not only demonstrated the GoL's commitment to a multisectoral response. The National AIDS Strategic Plan (NASP), a three-year rolling plan outlining the national response to the HIV/AIDS epidemic, guides the overall budget framework. LAPCA, at the central level, works in close collaboration with the ministries and in particular the MOHSW. In the MOHSW, the departments of Health Education, Disease Control and Social Welfare and the HIV/AIDS Directorate are important links. Other important ministries include Education, Agriculture and Finance and Planning and Development.

The participation of each ministry and its associated departments varies from district to district. The current situation is that HIV/AIDS programs seem to constitute an additional responsibility, which is incorporated only when there are human resources. With HIV/AIDS issues being seen traditionally as a health-sector issue, the MOHSW, through its Department of Social Welfare and HSAs, plays a proportionally bigger role than any other ministry. Most ministries are still formulating their specific sectoral plans.

Donor Involvement in HIV/AIDS

The involvement of development partners in the Lesotho national response varies from limited to extensive support. Bilateral support comes from the United States, Ireland, the United Kingdom, France, Germany, Japan and Sweden.

Development Cooperation Ireland (DCI) devotes $1.7 million per year or up to 7 percent of its total bilateral assistance to governmental agencies and nongovernmental organizations in Lesotho for the development and implementation of HIV/AIDS prevention, care and support and treatment programs.

The U.K. Department for International Development (DFID) is supporting the GoL and CBOs to mitigate the impact of HIV/AIDS on the agriculture sector, mobilize and strengthen PLWHA groups, support the Strategic Partnership Against Aids (SIPAA)), and develop IEC programs such as the Soul City television program. DFID is also working with the U.N. Development Program (UNDP) to support the GoL in establishing the proposed NAC.

The Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) Round Two HIV/AIDS grant is for $29 million over five years. However, implementation of Global Fund activities has been stalled, and the World Bank recently approved $5 million over four years to support and strengthen the capacity of the GoL and CBOs to implement Global Fund activities.

Bristol-Myers Squibb (BMS) is currently providing $4 million to support two initiatives in Lesotho under Secure the Future. The first ART Clinic in the country, the Senkatana Clinic,

has been established through funding provided by BMS. The funding is for an initial three-year pilot phase after which it is expected that GoL will take over the responsibility for the funding. The second initiative involves support for a HBC program being run by the CHAL.

U.N. agencies in Lesotho include the Food and Agriculture Organization (FAO), UNAIDS, UNDP, the U.N. High Commissioner for Refugees (UNHCR), the U.N. Population Fund (UNFPA) and UNICEF. UNDP is supporting leadership development and support to PLWHA groups and strengthening the district-level response to HIV/AIDS. UNICEF is supporting care and support for children and young people affected by HIV/AIDS and implementing the HIV/nutrition programs, including breastfeeding support for HIV-infected mothers. WFP is providing school feeding in primary schools and food assistance to PLWHAs and making efforts to address food insecurity. WHO supports the MOHSW with HIV/AIDS prevention, care and treatment activities. In response to mounting local and national pressure to meet targets set by the 3 By 5 Initiative, the GoL hopes to expand to five public ARV sites and treat 5,000 individuals by the end of 2004. This will likely also require an expansion of VCT availability beyond the six current sites that are clustered around Lesotho's urban centers.

The Expanded U.N. Theme Group on HIV/AIDS represents an attempt by the donor and development community to improve coordination for HIV/AIDS activities in Lesotho. The intention is that all development partners, through their membership in the Theme Group, would be on the same level with regard to their understanding of the HIV/AIDS situation in Lesotho. There will also be an understanding as to "who is doing what," and thus donors can avoid the duplication of efforts that has characterized past attempts at support for national initiatives.

1.2 Previous USG Support

Lesotho currently does not have either a USAID or CDC office and is a non-focus country for the President's Emergency Plan for AIDS Relief (PEPFAR). In recent years, through the Corridors of Hope Initiative (COH), the Ambassador's initiative on HIV/AIDS and other support to non-government organizations (NGOs) and to the Government of Lesotho (GOL), the United States Government (USG), primarily through the regional offices of CDC and USAID, has emphasized prevention of HIV/AIDS among high risk groups such as truck drivers, taxi drivers, and commercial sex workers. In addition, USG assistance has been provided in VCT, regional policy activities, capacity building, and networking and information sharing.

USG support facilitates access to comprehensive HIV/AIDS services at high transmission cross-border areas. This cross-border initiative, known as Corridors of Hope (COH), focuses largely on condom social marketing, behavior change, and Sexually Transmitted Infection (STI) management. The cornerstone of the program is the use of peer educators to deliver information on HIV and education. The COH program in Lesotho is implemented by Care/SHARP and PSI. Sites exist in Maseru and Maputsoe, with particular emphasis on the

border posts and factories. Condoms are made available at free distribution points in high-risk areas - pedestrian areas in the border posts, STI clinics and bars and hotels where commercial sex takes place. In addition, since July 2004, VCT has been supported through the partnership with the PSI. Implementation priorities for three free-standing "new start" VCT centers have included program start-up and staff training.

Since the inception of RHAP in 2000, the Policy Project, in close collaboration with the U.S. embassy, has provided technical assistance (TA) in the planning and implementation of the U.S. Ambassador's Initiative Program in Lesotho. Through a series of capacity and skill-building workshops and the disbursement of small grants, institutions are able to advocate and/or increase their involvement in HIV/AIDS activities, develop local partnerships, and facilitate the development of HIV/AIDS activities. In addition, POLICY is assisting the Chinese Government Manufacturers (CGM), an umbrella organization overseeing and regulating individual textile firms, in the development, design, and implementation of HIV/AIDS workplace policies and programs. POLICY works directly with the Thetsane Textile Industry, the largest textile firm under the CGM umbrella, and the Association of Lesotho Employers (ALE) in developing workplace policies that will benefit the entire sector.

Anticipating increased funding for Lesotho for FY 2005, a rapid appraisal of the USG strategy was conducted from September 5-13 with a team comprising USAID, CDC and FHI technical staff from both Washington and a senior health consultant from Lesotho. The major objectives of the rapid appraisal were to plan a joint USG strategy for Lesotho and make recommendations to reorient USG programs within a generalized epidemic. In addition, although Lesotho is not a focus country for PEPFAR, it was felt that the program can clearly contribute to and benefit from aligning itself with the Emergency Plan goals of treating 2 million PLWHAs, preventing 7 million HIV infections and caring for 10 million PLWHA and orphans and vulnerable children (OVC) by 2008. The rapid appraisal was not designed to be a formal evaluation of interventions previously or currently supported by the USG or other donors.

Prevention

2.1 Background and Current Status

A strategic approach to prevention involves targeting the underlying causes of new infections. The majority of new infections in Lesotho can be attributed to multiple or concurrent heterosexual partnerships. Although polygamy is uncommon and almost 50 percent of males and females over 15 are monogamously married, about 55 percent of adult men, and about 39 percent of adult women report more than one regular partner. A 2002 population-based reproductive health survey found that among the sexually active population, 19.3 percent of males between 12 and 54 and 6.1 percent of females between 12 and 49 reported two or more partners in the past four weeks. Recent studies have identified concurrent partnerships as particularly efficient transmission mechanisms, in part due to the extremely elevated viral loads that accompany recent HIV infection.

A recent Behavioral Surveillance Survey (BSS) found that while 32 percent of miners surveyed from Maseru and Leribe reported having multiple sexual partners in the past year, less than 4 percent reported having commercial partners during the same period. About 59 percent of sexually active taxi drivers surveyed in these cities reported having multiple partners in the past year, and 1.5 percent of these drivers reported having commercial partners during this period. More than eighty percent of married miners and taxi drivers reported having sex with non-marital partners in the past year. This same study found that 51 percent of female garment workers surveyed had engaged in risky sex in the past year, and it concluded that despite high infection rates and levels of awareness of HIV/AIDS, multiple sexual partnerships remain prevalent among both men and women. Along these lines, several key informants for this appraisal mentioned that it is quite common for men and women to have one or more "nyatsi" – the Sesotho term for a regular partner beyond one's main or marital partner. Many local informants identified this practice as being a possible key mechanism though which HIV continues to spread.

While condom promotion has played an instrumental role in reducing prevalence in concentrated HIV epidemics fueled by commercial sex work, it does not seem to have translated into population-level declines in prevalence in the highly generalized epidemics of sub-Saharan Africa. For example, reported condom use at last higher-risk sex rose to 75 percent of young women and 88 percent of young men by 2001 in Botswana, but HIV prevalence has remained steady at almost 38 percent of the adult population for the past few years. Where HIV/AIDS is primarily spread outside of the context of commercial sex and perceived higher-risk partnerships, the promotion of correct and consistent condom use has proven to be an elusive goal. Issues of comfort, suspicion and trust in ongoing relationships seem to introduce barriers to both the initiation of condom use and continued consistent use over time.

Levels of reported condom use in Lesotho vary widely in different reports. The 2002 population-based reproductive health survey found that only 38.3 percent of adult males and 24.4 percent of adult females reported ever having used a condom. However, the 2002 BSS found that 57.2-72.9 percent of in-school male and female youth in Maseru and Leribe reported using a condom during their last instance of higher-risk sex. Reported condom use was slightly higher in women than in men in this sample. About 59 percent of commercial sex workers reported using condoms during their last instance of commercial sex, and reported condom use at last higher-risk sex among male military personnel, miners, and taxi drivers ranged from 50 percent to 74 percent. About 36 percent of female garment workers reported condom use during their last higher-risk sexual encounter. Some 12 percent of contraceptive users utilize condoms for the purposes of birth control.

Key informants for this appraisal voiced concerns that the high levels of reported condom use in the BSS could be misleading pointing out that condom availability appears to be quite constrained in Lesotho. WHO reported that only 94,500 male condoms and 6,000 female condoms were distributed nationwide between April 2003 and February 2004. However, CARE Lesotho/South Africa distributed 540,934 condoms during the past three years of its SHARP! Program in the border towns of Maseru, Maputsoe and Mafeteng. A key informant from the HIV/AIDS Directorate in the MOHSW stipulated that approximately 7 million condoms funded by the GFATM for the MOHSW's Family Health Division have been in storage due to distribution issues for almost one year.[5] Government condoms are not widely available outside of hospitals and health clinics, although many key informants referenced opportunities to improve condom access and education by using community and village health workers to distribute them and demonstrate proper use.

Early initiation of sexual activity may also contribute to high rates of new HIV infection in Lesotho. The 2002 population-based reproductive health survey found that the median age at first sexual intercourse was 18.1 years for males and 17.4 years for females. However, the 2002 BSS found that the median age at first sex for in-school youth in Maseru and Leribe was 15 years for males and 16 years for females. Among 15 to 19 year old out-of-school youth surveyed in Maseru, Leribe and Mafeteng, the median age at first sex was 15 for males and 19 for females. On average, females have first sexual partners who are five years older, and males have first sexual partners who are one year younger. Nationally, 13+ percent of female between 15 and 19 are either mothers or pregnant with their first child.

Poverty, migration, food insecurity, intergenerational sex and alcohol abuse are all likely to contribute indirectly but importantly to high rates of new HIV infections in Lesotho. More than nineteen percent of males between 20 and 59 are currently working in South Africa, and the female migration within the country is expected to spike again in the coming months with

[5] This reflects a long-standing issue of commodities such as condoms being bought on a program/project-specific basis. It was thought that the seven million condoms were for the exclusive use of the Family Health Division through the Family Planning Program and that they were not meant for use by other programs. This misunderstanding has since been cleared up and preparations are well-underway for the widespread distribution of these condoms.

the opening of a new textile factory in Mohale's Hoek. Key informants interviewed for this appraisal noted that transactional relationships are commonly formed outside of marriage to fill the emotional and material needs of men and women who must live and work across borders or in urban centers to support families in their rural villages.

Girls and young women may be particularly vulnerable to new infection by virtue of having older male partners. According to recent surveys, 14.3 percent of females between 15 and 19 and 18.8 percent of females between 20 and 24 have had sex in the past year with a partner who is at least ten years older. Key informants noted that older men are sometimes seen as more attractive than younger men, as they are perceived to have more disposable income. However, older men are also more likely to be HIV-infected than younger men. Key informants also noted alcohol consumption as a likely contributor to high rates of HIV infection, and an association between alcohol and HIV risk has been documented in nearby Botswana. Lesotho's recent BSS found that about half of miners and taxi drivers and 69 percent of soldiers reported regular consumption of alcohol. Eight percent of in-school males between 15 and 19 from Maseru reported consuming alcohol at least once a week.

By all accounts, circumcision has been a traditional component of the initiation of young men (most often between ages of 14-18 years) into adulthood in Lesotho. However, if male circumcision remains in common practice, Lesotho would serve as the only country in the world featuring both a high prevalence of male circumcision, and a population-level HIV prevalence rate above 10 percent. Little quantitative evidence is currently available about the actual prevalence of male circumcision in Lesotho. A number of key informants suggested that participation in initiation schools and male circumcision has become less common with increased exposure to western culture. Indeed, the assessment team learned that until recently, boys who left formal schools to attend initiation schools were not allowed to return to complete their formal education. . Efforts from Christian leaders to put a halt to traditional initiations have reportedly also played a role in the previous decline of attendance. Paradoxically, the emergence of HIV/AIDS itself may have put a halt to circumcision practice in a number of communities, because of concerns about infected blood being exchanged though the use of the same blade on each of the initiates from a given class. However, there is strong evidence to suggest that the risk of HIV infection among circumcised men is as much as 70 percent lower than that for uncircumcised men.

Efforts to better understand the actual prevalence of male MC in Lesotho may reveal important opportunities to leverage traditional practice to prevent HIV infections. Key informants for this appraisal did indicate that while neonatal circumcision is very uncommon, MC serves as a popular elective surgery for adult men in their 20s and 30s. If clinic-based MC is indeed acceptable in Lesotho, encouraging men who do not attend initiation schools to seek the service before they become sexually active might help to avert new HIV infections. However, MC should not explicitly be promoted as a method of HIV prevention because doing so would likely result in reduced perceptions of susceptibility and increased engagement in risk behaviors.

Stigma and discrimination are likely key barriers to behavior change and service uptake in Lesotho, but there are indicators that justify a degree of optimism with regard to Lesotho's ability to address them. Eighty percent of adults participating in the 2002 Reproductive Health Survey said that they would disclose their HIV status to their families if they knew that they were HIV-positive, and almost 90 percent of urban and about 70 percent of rural adults said that they were willing to care for HIV-positive relatives in their homes. About 94 percent of adults felt that it was acceptable to discuss HIV/AIDS on the radio. Almost 80 percent of respondents felt that HIV status be made public, but only one in three respondents said that they would buy groceries from a shopkeeper they knew to be HIV-infected. In rural areas 30-40 percent of individuals felt that healthy, HIV-infected teachers be allowed to continue teaching, and the same percentage felt that HIV-infected students be allowed to continue attending school. However, about 60 percent of urban residents felt this way, suggesting that those with greater exposure to HIV/AIDS information and program activities may be more accepting of people living with HIV/AIDS.

Despite their emphasis on the importance of prevention in Lesotho's response to HIV/AIDS, many of the local stakeholders interviewed for this appraisal expressed doubts about the feasibility of promoting each one of the "ABCs" of prevention: Abstinence, Being faithful, and the correct and consistent use of Condoms. The 2002 Reproductive Health Survey found that among females between 20 and 34, about 28 percent who said that they were abstaining to protect themselves had actually had sex in the past four weeks. Fifty percent of those who reported using condoms to protect themselves said that they did not use a condom the last time they had sex in the past four weeks. Those who said that they were sticking to one partner to protect themselves were more likely to have done so: less than 3 percent of females between 20 and 34 who reported sticking to one partner to protect themselves had sex with more than one person in the last four weeks. Several interviewees described abstinence, fidelity, partner reduction, and correct and consistent condom use as impractical or unrealistic, based either on their assessments of prevalent cultural norms or on concerns pertaining to empowerment and gender. In particular, young women were cited as being poorly positioned to abstain from sex or to negotiate condom use. Fidelity and partner reduction were identified as important ways to prevent new infections, but they were seen as limited due to the perception that it is normal to have more than one partner and that those who adopt these strategies may still face exposure via the risk behaviors of their main partners. The achievement of correct and consistent condom use was seen as unlikely in the context of the regular, transactional and "trusted" partnerships that probably contribute the most to new infections in Lesotho.

Nevertheless, a recent review of HIV/AIDS-related programs in Lesotho identified a least 46 current initiatives and activities focusing on prevention and an additional six prevention programs currently in development. Of the current initiatives, 22 are implemented by state agencies, 19 by development agencies, four by U.N. agencies, and only one through by an NGO. In addition, the review noted that the most common exposures to prevention activities come not through large national programs, but thorough informal arrangements such as

church, community and other gatherings. "Pitsos," or traditional community meetings, continue to serve as popular local channels for prevention education. At these meetings, local political, traditional and religious leaders typically join hands with service providers and PLWHAs to raise awareness of issues pertaining to the epidemic. Peer education and counseling approaches are also pervasive at the community level, and they are increasingly being applied to promote HIV/AIDS prevention behaviors in workplace settings.

Beyond the commendable efforts of Lesotho government to utilize leaders and community volunteers to support the adoption of prevention behaviors, a highlight of Lesotho's current programmatic approach to prevention is the link between CARE Lesotho/South Africa's Sexual Health and Rights Promotion (SHARP!) program and the Private Sector Coalition Against AIDS in Lesotho (PSCAAL). During its three years of operation, SHARP focused on peer educator training, support group capacity building, community service provider capacity building, voluntary counselling and testing, and the development of home-based care strategies in the border communities of Maseru, Maputsoe, and Mafeteng. In all, SHARP has trained 455 peer educators, and reached a total of 836,751 people. As of January 2004, a total of 158 people had received care through the program, and four support groups of people living with HIV/AIDS – with a total of 56 members – had been formed. The program has received a one-year funding extension for the Maseru and Maputsoe sites, but has not been active in Mafeteng since late 2003. An appraisal team visit to the Mafeteng site revealed that several peer educators and home-based care providers were still trying to remain independently active in the area, but expressed concerns about their ability to do so in the absence of some of the training and support formerly provided through SHARP!.

Some of the linkages between SHARP! and PSCAAL around the growing textile and manufacturing operations in Lesotho may represent a particularly promising approach to prevention. SHARP! works outside of factories in Maseru and Maputsoe, targeting women seeking employment with health education and commodities through peer education and edutainment such as participatory dramas on HIV/AIDS.

Meanwhile, PSCAAL seeks to establish VCT, peer educators and counselors, and HBC linkages within the workplace, while also convening and supporting the management of different private-sector organizations around the issue of workplace HIV/AIDS policy development and implementation. Since July 2002, PSCAAL has trained 229 peer educators in 27 private-sector organizations, and it has trained individuals in peer-counseling and care and support in 23 of these organizations. PSCAAL also works with TEBA and its worker registry to ensure that community-based care and support are provided to retrenched miners who return to their homes in Lesotho. Since the Prime Minister launched Lesotho's Know Your Status universal testing campaign at the beginning of 2004, there has been a major effort to provide VCT in workplace settings and particularly among the ministry workforces. A number of NGOs and initiatives, including PSCAAL/CARE, Population Services International (PSI) and the Lesotho Planned Parenthood Association (LPPA), have been asked to help provide VCT services to ministries as part of this campaign.

PSI, with support from USAID, is working on four major HIV/AIDS initiatives in Lesotho: the rollout of three new VCT centers in Maseru and Leribe, the Corridors of Hope Initiative, Condom Social Marketing, and the Trusted Partner Campaign. None of the PSI Corridors of Hope prevention messages that the Lesotho appraisal team encountered focused on either abstinence or partner reduction, nor were any of the materials printed in Sesotho. Through social marketing of the Trust brand condom, PSI says that it has tripled the number of condom sales outlets in Lesotho and tripled the number of condoms sold. However, since correct and consistent condom use is likely a better indicator of prevention benefit than condom sales, it remains difficult to assess the impact of these efforts. It seems clear that additional formative and outcome evaluation of both PSI's condom social marketing and Trusted Partner Campaign efforts would be useful. While the Trusted Partner Campaign does seem to identify multiple partnerships outside of the context of sex work as a key transmission route for HIV, its priority focus on condom use and to a lesser extent abstinence, may prove problematic. Although the promotion of condom use in the context of regular partnerships is a worthy goal, it seems unlikely to occur independently of the promotion of frank and open discussion at all levels about the risks associated with having multiple or concurrent partners. On a more general note, as the team traveled around Maseru, Roma, Mafeteng and Mohale's Hoek to conduct its appraisal, virtually all of the few HIV/AIDS messages it encountered – whether in English or Sesotho – focused on condom use. There were few, if any, communications around abstinence, partner reduction, or VCT.

The Soul City program in South Africa is actively tailoring its regional radio drama and other activities to Basotho audiences, but some key informants remarked that they felt the activity did not have a sufficiently "local" feel, and that some important opportunities exist to use radio more effectively to bring prevention messages to rural areas. Two radio stations were identified as broadcasting nationally, including the state-run Radio Lesotho. Given that the country features just one national language and radio can serve as a relatively inexpensive mechanism to reach remote audiences, it seems worthwhile to explore an expanded use of the medium for advocacy and for edutainment purposes.

One of the major limitations of this appraisal relates to team's inability to secure a meeting with the HIV/AIDS focal point from the Ministry of Education. Based on our discussions with other contacts, it appears that the ministry has not yet mainstreamed either Life Skills education or HIV/AIDS into the public school curriculum. Members of the U.N. family have provided some financial support for this effort, and a draft curriculum was reportedly developed through the National Curriculum Development Center, but it has not been finalized or adopted. In the meantime, the Lesotho Association of Teachers has been working to secure resources from Education International to supply teachers with Life Skills training and to build the literacy and capacity of teachers with respect to HIV/AIDS.

The LPPA is also trying to reach youth with an expanding network of centers offering peer education, youth-friendly services and activities, VCT, peer education, and IEC materials development. The LPPA has started a small youth-friendly HIV/AIDS resource library as part of its center in Maseru.

There appear to be few organizations attempting to address the joint challenges pertaining to alcohol and HIV/AIDS. In addition to providing residential treatment services, the Blue Cross Thaba Bosiu Centre does has small group of three peer educators who do outreach among both in- and out-of-school youth – as well as among community elders – around the HIV and STI risks that relate to alcohol consumption. However, in the appraisal team's discussions with community informants in Mohale's Hoek and in Mafeteng, alcoholism and alcohol abuse were raised as concerns, but were seen as independent of the challenges posed by HIV/AIDS.

Supporting PLWHA involvement in the development and implementation of prevention, care and support and treatment activities can have important benefits. In terms of care, support and treatment, the PLWHA involvement can insure that services are appropriately focused and well tailored to address actual preferences and needs. From a prevention perspective, PLWHA involvement can help to cultivate programs that appropriately foster a personalization of risk and risk avoidance while also reducing stigma. While a number of community and support groups engage in prevention activities, it currently appears that there is neither an organization nor a mechanism to help coordinate PLWHA activities in Lesotho. Support for the development of such an organization or network could help to ensure that programs benefit from the valuable input that PLWHAs have to offer and could help to provide PLWHA with important opportunities to advocate for specific issues, policies and activities.

Strengthening the capacity of leaders across a wide range of domains appears to be a key opportunity in the expansion of Lesotho's response to HIV/AIDS. In meetings with formal and informal leaders at all levels – from the Senate and chiefs, to the Parliament and politicians, to religious leaders, heads of organizations, teachers and others – the appraisal team was singularly impressed by the desire of leadership in Lesotho to rise to the challenges posed by HIV/AIDS. By joining hands through "pitsos" and other advocacy and community mobilization efforts, leaders have helped to raise awareness such that 94 percent of males, and 93 percent of females have heard of HIV/AIDS. The Senate has also provided HIV/AIDS training to Lesotho's principal and area chiefs, but it has not yet been able to extend this training to all of the local chiefs. In light of the continued high prevalence of key risk behaviors, and as new opportunities arise for care, support and treatment, it is worthwhile to identify additional opportunities to support leaders in their advocacy efforts. These efforts can not only focus on helping leaders to communicate more effectively, but can help them to better appreciate and act with respect to key issues pertaining to the national response.

For example, key informants noted that Lesotho plans to expand ARV delivery from its one pilot site (Senkatana Clinic) to three additional sites by the end of 2004, but it has not yet developed a communication strategy to help communities prepare for the:

- Benefits of ARVs;
- Needs that patients will have for community support;
- Fact that ARVs are not a cure;

- Fact that starting ARVs is a lifetime commitment;
- Dangers associated with developing resistance and
- Primacy of prevention in the context of treatment.

To ensure that ARVs are indeed of benefit and guard against treatment optimism and other mechanisms through which they could in fact cause harm, local leaders will need to be highly literate and conversant in treatment issues.

Similarly, there does not appear to be a uniform understanding among opinion leaders of some of the likely key issues in prevention: norms around partner reduction, the importance of correct and consistent condom use, the role that alcohol may play with regard to behavioral risk, male norms and gender relations, MC and the unfortunate impact that development efforts may have on HIV incidence if issues pertaining to mobility and workplace policies are not addressed.

Nevertheless, leadership in Lesotho has proposed, and can be supported in, the pursuit of some highly innovative approaches to prevention. In *Turning a Crisis into an Opportunity*, a strategic document developed jointly by the GoL and the U.N. Expanded Theme Group on HIV/AIDS, male initiation schools are prominently identified as important settings through which young men can be reached with prevention education and skills *before* they become sexually active. Given that women are traditionally greater consumers of health and other services, the contexts in which men can best be reached can at times be difficult to identify. However, by partnering with traditional leaders and healers to: 1) integrate prevention education into the initiation school curriculum, 2) foster the development of a "service component" of this rite of passage into adulthood such that young men cultivate social responsibility and develop skills to provide HBC and 3) ensure that young men may safely benefit from the potential HIV/AIDS risk reduction accompanying MC, Lesotho may be positioned to transform a unique local response into a regional best practice.

Even beyond establishing links with the initiation schools, efforts to reach men, and particularly to involve them in care-giving activities, can have important prevention benefits. In a project conducted by Horizons in Zambia, involving young men in care provision appeared to result in stigma reduction, increased personalization of risk and increased uptake of prevention behaviors. In Lesotho, working with the Taxi Drivers' Association may also represent an opportunity to reach men by recruiting the drivers and their assistants as peer educators and change agents and partnering with them to share information, materials and condoms. Bartenders and shopkeepers could similarly be trained and empowered. Because peer education approaches often have the greatest impact on the peer educators themselves, such a model could strategically reach both the men in these work settings and their clients.

Coordination of HIV/AIDS activities remains a major challenge in Lesotho. In light of the planned transfer of coordination responsibilities from LAPCA to the NAC, a number of donors cited reservations to the appraisal team about making substantial investments in

LAPCA. However, it seems clear that there remain opportunities to foster specific types of coordination and communication to benefit prevention within and across other well-established organizations and institutions. For example, the team was apprised of efforts to consolidate the HIV/AIDS committees of the Senate, Parliament, Cabinet and Assembly, and it feels that this synergy could result in an important prevention benefit. Part of Uganda's success in reducing national prevalence from 15 percent in 1989 to less than 5 percent today is attributed to the communication of clear and consistent messaging about the importance of partner reduction by leaders at all levels. In connection with other activities, these efforts likely changed prevailing norms around multiple partnerships and created a population-level shift in risk behavior.

Similarly, the Lesotho Council of NGOs (LCN) is expected to soon receive support for an HIV/AIDS Coordinator through the Global Fund. The creation of this position represents an opportunity for NGOs to benefit from a common focal point through which they can coordinate their prevention and other programming, align their resources and messaging and share new ideas and new opportunities. Depending on the background and expertise of the person filling this position, the provision of additional training, technical and support resources to the LCN may contribute substantially to more strategic NGO programming. The appraisal team also felt that substantial benefit could come from efforts to build the capacity of local NGOs to access Global Fund and other donor resources.

Because the Directorate of HIV/AIDS under the MOHSW is newly formed, it justifiably appears focused more on the development of a prevention/BCC strategy than on the expansion of its current prevention activities. Although it is unclear whether this will serve as the national HIV/AIDS BCC strategy, or the MOH HIV/AIDS BCC strategy, the BCC Unit under the Directorate of HIV/AIDS anticipates getting a consultant from Skillshare International to provide assistance with the development of the strategy within the next month. Key informants noted that the focus of this strategy will likely be on strengthening the capacity of community and village health workers to provide HIV/AIDS education and developing more strategic partnerships with NGOs to program for prevention and build linkages to the PHC system. The secondment of a USG technical advisor to either the ministry or to the NAC secretariat in a longer-term relationship could represent an important opportunity to support the design and implementation and coordination of specific activities under this strategy. The provision of additional prevention, care and support and treatment training to village and community health workers could also help to better engage community members in behavior change and in service uptake.

Note: Although reliable data on the proportion of new HIV infections associated with injection drug use (IDU) or men who have sex with men (MSM) are not available, key informants suggested that neither of these contexts contributes substantially to HIV transmission in Lesotho. The Lesotho Blood Transfusion Service reports that 100 percent of the 2,700 units of blood transfused in the past year were adequately screened for HIV according to national or WHO guidelines. Based on the data gathered for this appraisal, it also seems unlikely that blood safety issues are a major source of new infections in Lesotho.

2.2 New Directions and Recommendations for Prevention

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

A) Expand support for joint workplace and community-based activities in the areas of peer education, VCT, care and support and workplace policy development to help facilitate a coordinated approach to addressing the multiple-partnership risks introduced by migration for work (in the workplace home communities).

B) Provide HIV/AIDS and advocacy training to leaders at all levels of Sesotho society: By raising the HIV/AIDS literacy of leaders across a variety of topics – transmission dynamics, risk factors, prevention opportunities, care and support issues, OVC care issues, approaches to VCT, treatment literacy and policy issues – leaders may be in a better position to pool resources and make informed policy and programmatic decisions.

C) Provide financial and technical support to local NGOs and FBOs. Each of the NGOs, CBOs and FBOs with whom the appraisal team met cited hardships in terms of being able to access donor support. In some cases, the difficultly resulted from donor mechanisms requiring lengthy bureaucratic procedures involving government agencies, and in others the challenges related to having sufficient capacity to meet donor proposal requirements. This support might include some training/capacity building for local organizations in proposal development, project planning and project monitoring.

D) Encourage a primary focus on male involvement. Through the grants scheme and other mechanisms, programs will be supported that reach men on the issues of partner reduction, male responsibility, intergenerational sex, gender roles and male involvement in PMTCT, care and support and treatment. Targeting taxi drivers and conductors, sports clubs, the uniformed services and bars and other settings where men congregate can help to build a groundswell of support for changes in male norms and risk behaviors, and can help to secure additional support for women seeking to negotiate prevention behaviors, pursue PMTCT, adhere to therapy or secure care and support.

E) Integrate prevention within the development of a more formal HIV/AIDS training curriculum for CHWs and volunteers. Village and community health workers are well positioned to carry HIV/AIDS education to the most remote areas of Lesotho and take the time necessary to work personally with groups and individuals to foster behavior change and build understanding.

MEDIUM AND LONG TERM

A) Support a comprehensive approach to prevention in the context of male initiation. The lasting tradition of male initiation in Lesotho presents a rare and powerful opportunity to prevent HIV by influencing male behavior.
   - Provide HIV/AIDS training for traditional healers and traditional leaders.
   - Assist in the development of an HIV/AIDS curriculum for youth attending initiation schools – this can cover the ABCs of prevention within the local context, addressing issues of gender roles, intergenerational sex, mobility, male responsibility, care-giving skills and MC education.
   - Assist in the development and implementation of a "community service" program for new initiates that establishes care giving as a primary responsibiliy of adulthood.
   - Support training and resources needed to ensure safe, voluntary male circumcision for youth who elect to pursue this procedure.

B) Provide technical support to the development and implementation of a Life Skills curriculum for the Ministry of Education that features a strong HIV/AIDS component. While it is the understanding of the appraisal team that U.N. partners have provided financial support for the development of a Life Skills curriculum, it appears there may be additional need for technical support. If this is the case, it can be treated as an important priority for prevention. The curriculum should take care to specifically educate girls and boys about the risks associated with intergenerational sex. USG support could focus on curriculum development, teacher training, materials development and/or other areas.

C) Support the development and implementation of a national HIV/AIDS BCC strategy: Although it appears that the Directorate of HIV/AIDS will soon be securing a short-term consultant to help develop its BCC strategy, it is unclear whether the product of this consultancy will serve as a strategy for the MOHSW or a strategy for the overarching national response to HIV/AIDS. The USG might seek out opportunities for supporting this effort and might consider making a BCC technical advisor available on long-term secondment to the GoL if such assistance is desired.
   - Assist with the harmonization of prevention efforts across implementing partners in some key areas: partner reduction and the role of migration, intergenerational sex and male norms, youth prevention and delay of sexual initiation and the likely links between alcohol and HIV/AIDS.
   - Assist with an increased focus on important communication needs surrounding HCT promotion, community preparedness for ARVs, and the prevention of behavioral disinhibition through treatment optimism.

D) Support research, as appropriate, on the prevalence and acceptability of adult and neo-natal circumcision. As stated in this report, little information is available about the actual prevalence or acceptability of either neo-natal or adult circumcision in Lesotho. By simply including the question: "Are you circumcised?" on the upcoming DHS, one may procure a

E) vital sense of the prevalence of circumcision and of any local associations between circumcision and HIV status. Based on evidence from other countries, it appears that circumcision prior to sexual initiation may have an important HIV prevention benefit.

F) Provide support for a locally written and produced Sesotho radio drama, broadcast on Radio Lesotho or another station with national coverage: The CDC has developed a model for establishing local-language radio soap operas using local writers, actors and producers, and it seems worthwhile for the USG to consider supporting a similar initiative in Lesotho.

Care and Support

3.1 Laboratory Services
3.2 HIV Counseling and Testing (HCT)
3.3 Palliative Care
3.4 Home and Community Based Care (HCBC)
3.5 Prevention of Mother to Child Transmission (PMTCT)
3.7 Orphans and Other Vulnerable Children (OVC)

Note: The USG is committed to comprehensive and collaborative support that addresses the full continuum of care for people with HIV, including STI, TB and OI management. In the time available for the appraisal team, it was not possible to fully explore broader issues of clinical HIV care, including TB, STI and OI management and quality of services. However, several of the stakeholders consulted expressed concern about the support for TB programs. In addition, several stakeholders in clinical settings indicated that the main problem in OI management relates to drug supply management.

3.1 Laboratory Services

3.1.1 Background and Current Status

A reliable system of laboratory services will support the foundation of a responsive HIV/AIDS prevention and care program. Quality-assured laboratory testing cuts across effective VCT, HIV/AIDS diagnosis, patient management, blood transfusion safety and operational research, and it also supports expanded testing and monitoring capacity for PMTCT and ART. Moreover, a well-organized, comprehensive laboratory system that is fully integrated, at each health care level, will have broad impact on prevention and quality management.

Although some basic laboratory services were available in Lesotho prior to 1979, there are no documents describing the status of services of this era. In 1979, Ireland Aid (now DCI)

established a two-year certificate-granting Laboratory Technology Training Program. This training, conducted at Lerotholi Technical Institute in Maseru, prepared a core cadre of laboratory personnel for Lesotho. Approximately 140 staff students were trained in laboratory technology during the period between 1979 and 1989.

In 1989, DCI support for the laboratory certificate training program ended. The GoL established the National Health Training College (NHTC) to prepare nurse clinicians and specialists, pharmacists, health assistants and laboratory technicians. The laboratory technician certificate training continues today at NHTC. The curriculum evolved into a two-year course of laboratory theory and a one-year practicum service held at NHTC and at the central and district hospital laboratories. Approximately 12-14 students enroll in laboratory training each year and 60 percent complete the three-year certificate program. There are eight third-year students in the class of 2004. The recently completed Human Resources Consultancy, undertaken for the MOHSW under the auspices of the Health Sector Reform Program, has revealed that opportunities for continuing education are few-and-far between for Laboratory staff and for all health professionals. Thus, it has been very difficult for Laboratory Science tutors at NHTC to keep abreast with new developments in their area of operation.

Approximately 80-85 laboratory technologists work in Lesotho presently: 60 within the central Ministry and district hospitals and 20-25 within laboratories of CHAL hosptials. This corresponds to a coverage level of approximately 0.3 laboratory professionals per 1,000.

Organization Structure and Financing

Since 1989 all laboratory services within Lesotho are under the authority of the Director of Laboratory Services of MOHSW. There is no National Health Laboratory Services Board. The National Laboratory Services office includes the Director, Laboratory Manager, Principal Pharmacists and laboratory personnel who staff its sections. These units function to manage the delivery of laboratory services by the Central Laboratory as well as by all institutions operating at the HSA level.

Responsibility for decisions about quality and diagnostics, research and training coordination, budget and financing and management and maintenance lies ultimately with the national Laboratory Manager. Some functions of laboratory management become decentralized at the district level.

The laboratory system in Lesotho is organized into 18 laboratories throughout the HSAs, includes the Central Laboratory at Queen Elizabeth II Hospital in Maseru and one laboratory in each of the 17 HSAs. The Central Laboratory functions also as the National Referral Laboratory and the National HIV Reference Laboratory. The Central Laboratory provides the highest complement of laboratory services in the country including hematology, biochemistry, microbiology, mycobacteriology [TB], cytology, histology and blood typing.

The Central Laboratory conducted approximately 65,000 laboratory tests across all laboratory services in 2003. Each laboratory within the remaining HSAs provides routine hematology and biochemistry services.

The laboratory system is financed by GoL allocations and budgets vary by service level and district. Annual budgets are prepared by laboratory staff, and allocated funds are always significantly less than requested. Laboratory services are considered free in Lesotho; however, there is a 10 Maloti fee charged per hospital visit. Detailed laboratory system finance management including recordkeeping occurs at the central level. Laboratory managers participate annually in budgetary planning training coordinated by the MOFDP.

National Laboratory Guidelines and Quality Assurance

There are no national laboratory guidelines or national laboratory policy. The national testing policy mandates retesting by Enzyme-Linked Immunosorbent Assay (ELISA) of 10 percent of all specimens tested by rapid tests. Written Standard Operating Procedures (SOPs) exist that are used in laboratories throughout Lesotho. While there are components of quality assurance associated with some steps of the laboratory testing system, there is neither a comprehensive laboratory QA plan nor a strategy that ensures quality throughout the laboratory testing process. There appears to be no QA training within the Laboratory system.

Operations

Procurement: Inventory is maintained and supplies are requested through the government by laboratory staff at all levels. The national Laboratory Manager is responsible for the placement of tenders and service contract management.

Specimen collection, transport and receiving: Clinicians and clinical officers complete requisition forms, collect specimens from patients and give forms and samples to outpatients. Patients arrive at the laboratory with requisitions and specimens for the laboratory technologist. For inpatients, non-emergency specimens are taken by the clinicians and sent to the laboratory. Within the hospital, there is no designated position for specimen transport. At the central laboratory, a trained laboratory clerk records all specimens received by hand into a register.

Specimen processing and testing: Specimens are processed according to SOPs by laboratory technologists in the central and district laboratories. Laboratory results and all other information management are recorded by hand into registers and on laboratory slips that are returned to practitioners for filing into patients' charts.

*Status of HIV/AIDS Testing***:** Basic biochemistry and hematology are done routinely throughout the laboratory system. The volume of basic tests will increase shortly as the GoL expands ARV access and therefore increasing the need for monitoring of liver function and

anemia. Simple rapid HIV testing occurs at VCT sites and at sentinel ANC surveillance sites in Lesotho, with 10 percent of the samples validated by ELISA at the Central Laboratory in Maseru.

An HIV rapid test kit (RTK) evaluation was conducted in 2002 to test the performance of Determine 1-2 using an ELISA gold standard. The current national testing algorithm, using Determine 1-2, was established based on results of the 2002 RTK evaluation. A Korean-based RTK was proposed for use in 2003, and the evaluation was repeated using this new RTK. RTK evaluations are not conducted on any schedule, and they are only conducted as new RTKs become available for use in Lesotho.

Serum ELISA is done at the Central Laboratory. Simple rapid testing is easing some of the diagnostic burden but it is expected that with ARV expansion, the volume of ELISA tests will increase. CD4 testing is done at Maluti Hospital. Polymerase Chain Reaction (PCR) testing is planned but presently not available. Viral load is referred to private laboratories in South Africa. OI testing **(**particularly cryptococcal antigen, diarrheal agents and PCP testing), Acid-Fast Bacillus (AFB) testing, and Syphilis and Gonorrhea testing are done at all levels.

Challenges of Current Laboratory Situation

Policy and Administration: There are currently no written national guidelines with specified goals and direction and no organizational structure with an advisory board. In addition, it is unclear what the national testing algorithm is. There is a need for an improved information system, as the paper-based reporting system is not meeting the current demands of the system.

Infrastructure: Many laboratories within the system have inadequate space for the volume and breadth of testing. In addition, crowded laboratory facilities function within dilapidated buildings. For example, at the Central Laboratory - the highest capacity facility - tests are conducted and services administered for six laboratory service areas in an area with no benches and inadequate space. Some equipment is dates and does not have the capacity to meet the current volume. Workplace safety is suboptimal with a high prevalence of TB and high risk for laboratory-acquired infections. Hazardous waste management is suboptimal as there are no guidelines and waste is often managed as nonhazardous waste and piled in areas of public access

Human Resources: There currently are no dedicated administrative staff for large volume activity. There are few lab technologists proportionate to the burden presented by increased ARV access. Training is not commensurate with the expanded need.

3.1.2 New Directions and Recommendations for Laboratory Services

SHORT TERM

As the GoL will soon initiate its national ART program, it is recommended that the CDC Laboratory Team, in collaboration with the MOHSW, conduct a thorough laboratory system assessment and develop an action plan. The GoL has already extended an invitation to CDC\Atlanta in 2004 for laboratory collaboration, and it is awaiting a response. Follow up on this invitation by the USG Regional Office may expedite the satisfaction of this pressing need.

Areas needing action in both the short and long-term include:

- Review the national testing algorithm;
- Collaboratively develop National Laboratory Guidelines;
- Expand existing QA activities and develop a comprehensive national QA plan;
- Rehabilitate and outfit laboratories in need of renovation;
- Review and expand testing at all levels to meet increased need;
- Expand theoretical and practicum training to address emerging testing and laboratory priorities and review curriculum for addressing core skills needed to provide technical support services;
- Develop laboratory staff human resource plan; and
- Develop comprehensive plan to facilitate recordkeeping and retrieval and communication by electronic information system.

3.2 HIV Testing and Counseling (HTC)

3.2.1 Background and Current Status of HTC[6]:

HTC is a key strategy for both prevention and care, and it is also an entry point for treatment. The primary HTC providers for HTC in Lesotho are the GoL, NGOs, and CHAL.

There are currently approximately seven free-standing service points for HCT provision. The LPPA, CARE-Lesotho and PSI manage six of these service points. HTC services are available in all 17 HSAs, but they are not as yet decentralized to the health center/clinic level.

HTC has been given prominent attention and there is an urgent need to expand all levels of the health care system, public and private, in order to ensure access to ART.

[6] Please note that in Lesotho VCT is referred to by the acronym HTC, standing for HIV testing and counseling. HTC encapsulates both the "classic" VCT services, as well as routine and diagnostic HIV testing and counseling, which is based on the opt-out model.

With more HTC centers opening up, the demand for HTC services has increased dramatically over the past six months. This has also been a direct result of the "Know Your Status" campaign that was launched in March 2004. The campaign received a tremendous boost when the Prime Minister underwent public HTC in Qacha's Nek, an occurrence that received widespread media coverage in Lesotho.

Since then the "Know Your Status" Campaign has focused on ensuring that all public servants have access to HTC and currently over 3000 public servants have undergone VCT. The average prevalence across ministries was approximately 29 percent, which is in line with the general prevalence rate of 28.9 percent. The initial public service campaign made use of outreach clinics to conduct the HTC program in the ten districts. HTC sites were set up in the ten districts for civil servants to access this service, and the campaign was generally conducted on a ministry-by-ministry basis. A few ministries at the national level have a permanent on-site HTC counselor.

Within the framework of the "know Your Status" campaign, once a public servant has tested HIV positive and chooses to disclose that status (usually to the HR or HIV/AIDS Unit), he/she can access care and support services, including ART and nutritional support in either a CHAL facility or through a private physician. In certain ministries, this support is extended to spouse and children of public servants (referred to as the nuclear family), although in some ministries spouses and not children are provided with treatment and care. This clearly highlights the need for a clear, standardized policy across all ministries. The GOL is in the process of establishing an Inter-Ministerial HIV/AIDS Committee that would need to address this as a priority area. The treatment and care services for public servants are funded from a 2 percent allocation for all government ministries. With more ART centers opening up in the PHC system, many of these public servants will transfer into the public sector program, as fees are much lower than in the CHAL and private sector. This initial program of expanding HTC into a workplace program for the public sector is certainly commendable, and the challenge for the GOL will now be to maintain the momentum of this initiative.

Anecdotal evidence from the various stakeholders consulted by the appraisal team indicates that there is still a fear of testing in many sectors of society. However, outreach does seem to produce results. An example would be the increased uptake of HTC in the Mohale's Hoek district hospital following a concerted effort from the counselors to group counsel in the waiting room since June. Uptake of testing in that facility increased by more than 500 percent between June and August.

The framework for the provision of HTC is found in the *National Guidelines for HIV Testing and Counseling* that were developed and disseminated in May 2004. The vision for HTC in these guidelines can be summarized in the following bullets:

- HTC will become a routine part of health care wherever medically indicated in the context of clinical care as follows: during attendance at antenatal clinics; at diagnostic and treatment facilities for tuberculosis (TB) and sexually transmitted infections (STIs), and for hospitalized patients. This entails moving beyond the traditional model for VCT where concerned individuals present themselves for counseling and HIV testing.
- Currently HTC in the public sector is only available in district hospitals, and it is not established at the clinic level, although the HTC guidelines refer to it being "implemented more widely using existing health care facilities." The service delivery models to achieve this greater access are through integrated services, stand-alone services, outreach services and the private sector.
- The implementation plan includes ensuring that HTC is offered to STI, TB, family-planning and ANC clients. This includes inpatients in hospitals.
- Outreach will be integrated with existing PHC services and provided by mobile vans.

Counseling for HIV/AIDS is provided by a cadre of HIV/AIDS-trained counselors that includes professionally trained counselors (e.g., health workers and teachers), counselors trained to a basic level and community-based counselors. However, due to the limited time available to the appraisal team, it was not possible to fully explore the quality of counseling within the various settings in which HTC is available in Lesotho.

Initially, government-supported HTC used ELISA tests and all samples were sent to the main referral hospital and its central laboratory at Queen Elizabeth II hospital; however, with UNDP support, the GoL is rolling out rapid testing. Most rapid testing kits (RTKs) are procured from Abbott in South Africa. The country will follow the WHO recommendations on serial testing. Ten percent of all tests will be sent to the central laboratory at Queen Elizabeth II hospital for quality assurance. A key issue raised by many stakeholders was the supply chain for RTKs. This might be an area of potential USG support.

It is important to note that the testing of children is not currently provided in Lesotho beyond the PMTCT context. Lesotho will introduce PCR testing for children who were enrolled in the PMTCT program within the next few months. This testing will be done once these children reach 18 months after birth. This will replace the current system of testing children between 12 and 18 months with ELISA or a rapid test. However, given the newness of the program, there are currently no children in the Lesotho PMTCT program that have reached that age and have been tested.

Testing of children and adolescents under the age of 18 is provided for within the GoL HTC guidelines, providing there is parental consent. Children under 18 who are married are considered "mature minors", and they can obtain HTC without parental consent. However, in practice there are virtually no HTC services for children under 18 within the public sector. This is predominantly related to the inability of counselors to counsel children or adopt a family-counseling model.

There are several NGO providers of HCT in Lesotho. PSI with USAID funding works in partnership with the MOHSW to manage three free-standing "new statrt" voluntary counseling and testing (VCT) sites in Maseru, Maputsoe and Mafeteng. These sites were opened in July 2004. PSI, with CDC funding, and in collaboration with the MOHSW aims to open 2 more sites. LPPA is another important service provider, and importantly, it provides for youth VCT as part of its youth-friendly service sites. CARE offers both center-based and workplace-based VCT through PSCAAL. Care has also assisted the Ministry of Works in the testing of their workers.

Finally, it is quite evident that Lesotho needs to expand HTC. HTC is one of the first steps in the service delivery model for ART. In fact, in order to reach the target of putting 5,000 people on treatment by the end of 2004, approximately 86,000 people will need to be tested. In addition, the GoL needs to reach more than a million people with HTC in the next 15 months in order to achieve the 3x5 target of placing 28,000 people on treatment by the end of 2005. These estimates are based on the assumption that prevalence at the testing sites is the same as the national rate (28.9 percent) and 20 percent are eligible for treatment. The availability of treatment might also act as an incentive for people to know their status and further drive the demand for HTC. The yield of HIV-positive and treatment-eligible individuals would be even higher in hospitals, TB wards and in STI clinics. Data from the hospital at Mohale's Hoek between January and August 2004 confirms this, with 207 of 335 or 62 percent patients tested being HIV-positive. This is primarily a function of people presenting late for care and treatment.

3.2.2 New Directions and Recommendations for HTC

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

<u>SHORT TERM</u>

A) Assist the GoL to expand HTC to the lowest possible level of service delivery - the health center and into communities. This would include the training of a large cadre of professional and non-professional counselors (including CHWs and members of support groups) to provide the service.

B) Expand outreach services to communities and large textile factories to ensure services are available on a regular basis to those who cannot regularly attend hospitals for HTC. An example would be the PSI outreach program. The model for PSI is to go to remote communities and set up the service in a private room provided within the community. This is preceded by community mobilization a few days earlier to encourage uptake.

C) Train community leaders, including chiefs, agriculture extension officers, traditional healers, teachers and others. If these community leaders actively promote HTC and show a "united front", community members are more likely to want to know their status.

D) Provide continued support for stand-alone HTC sites run by PSI and support other NGOs that offer a valuable avenue for the expansion of access to HTC. This support would be even more useful if organizations such as CARE, PSI and LPPA were to look at mechanisms of establishing HTC in workplace environments, notably the large textile companies that collectively employ more than 56,000 people in Lesotho.

E) Encourage partners receiving USG support to address important issues identified as technical gaps such as: the testing of children under 18 and skills-building for counselors to address family counseling.

MEDIUM AND LONG-TERM

A) Assist the GoL to strengthen the national M&E system to ensure that HTC data is captured efficiently at the facility level and feeds into a national Health Management Information System (HMIS). This forms part of a wider proposal to support M&E and HMIS.

B) Provide TA to the GoL to develop strong messages and mobilization efforts to strengthen the existing "Know Your Status" campaign. The Know Your Status campaign has been very effective in mobilizing public servants to know their status, but less so for the wider populace in Lesotho. Such a campaign might highlight the preventive aspects of knowing one's status, including positive living, avoiding re-infection and maintaining HIV-negative status. Some of these messages might form part of the mobilization efforts recommended in the Prevention section of this report that target men specifically.

C) Provide TA to the GoL to strengthen the QA of ELISA and rapid testing in the central laboratory. This forms part of the recommendations on strengthening laboratory services.

D) Determine what support currently is provided to the GoL on supply chain management, and in the context of HTC, for the continuous and uninterrupted supply of RTKs. Depending on the findings, this may be an area of long-term strategic investment.

3.3 Palliative Care

Palliative Care is defined as an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[7] The terms palliative care and care of the dying (end of life care) are often confused. End of life care is only one component of palliative care because palliative care addresses need across the spectrum of care.

3.3.1 Background and Current Status of Palliative Care

While the MOHSW, LAPCA and several CBOs and support groups have identified palliative care as an important component of comprehensive care and support, very little has been done to implement it. There is no mention of palliative care in the NASP2002/2003-2004/2005. There are no palliative care policies or guidelines (including pain and symptom control), and advocacy for palliative care is very limited. Palliative care is included in nursing pre-service training on a very limited basis. During this appraisal period, it was difficult to ascertain if there was any formal in-service training, although one hospital reportedly received palliative care training from an organization in Durban. Community-level training is minimally provided through the National HCBC training guide.

Drug access for symptom control and pain management is also limited. Pain management primarily consists of Paracetamol (Panado), Ibuprofen and Indocid (Indomethacin). The current provision of pain management in health facilities and households relies heavily on the use of aspirin and Paracetamol. The current use of Paracetamol may mask underlying issues including allowing for appropriate investigation of emotional pain, mental illness or physical ailments such as neuropathic pain.[8] At the other end of the spectrum, the limited availability of morphine, especially morphine syrup, may hinder effective management of severe pain especially near or at the end of life. While pain management, specifically access to opioids including morphine, is a priority for quality palliative care, comprehensive programs should address a wide range of needs including non-pharmaceutical pain management skills, management of chronic diarrhea, cough and skin disorders, oral health, increasing ability to carry out activities of daily living, spiritual and emotional support and palliative care for infants and children. Clinical and medical comprehensive palliative care and palliative care for children are nearly non-existent. Given the lack of progress in palliative care, service delivery in this regard primarily consists of fragmented social, spiritual and psychological support (with limited bereavement support).

The team found it difficult to identify funding sources for palliative care in Lesotho. For example, palliative care is not mentioned in the GFATM proposal.

[7] World Health Organization definition of palliative care.
[8] The heavy reliance on aspirin increases the risk of gastric irritation (especially for people who are unable to eat). Misuse of paracetamol (panado) can lead to liver failure.

An important milestone for Lesotho was its representation at the inaugural meeting of the African Palliative Care Association (APCA) in June 2004 in Arusha, Tanzania. At this seminal meeting, agreement was reached on definitions, goals, and palliative care priorities. It was a general expectation across all countries that National Palliative Care Committees would be established and would be the main coordination and advocacy mechanism for palliative care activities in-country. However, the Lesotho committee has yet to be formed.

Despite the above, Basotho have a long tradition of caring for one another with the aim of relieving suffering and dying with dignity. Basotho will not directly say that someone is dying, they know when death is coming, and will express it through words such as "*bophelo bo hae bo felile*" (his or her life is finished). When these words are spoken, it is expected that the person will soon die. Basotho will try, by all means, to be with a person who is ill, to provide physical, spiritual and emotional comfort and to be there at the time of death. If someone is left alone during the time of suffering and death, it is considered to be a very sad affair. What may seem to be simple words, actions or desires are actually critical to the provision of palliative care and are indications that although formal palliative care is not provided, there is a strong traditional foundation that must be built upon to provide comprehensive care at the facility, community and household levels. Although the provision of formal comprehensive palliative care is nearly non-existent in Lesotho, it is clear that the tradition of care-giving among Basotho to will provide a strong foundation for the implementation and scaling-up of palliative care.

3.3.2 New Directions and Recommendations for Palliative Care

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

<u>SHORT TERM</u>

A) In collaboration with the US Office of the Global AIDS Coordinator (OGAC) and the African Palliative Care Association (APCA), conduct a palliative care assessment as a first step in mobilizing the national response for palliative care. It is recommended that the team be comprised of local stakeholders including PLWHA and traditional healers.

B) Provide technical assistance to form a National Palliative Care Association.

<u>MEDIUM AND LONG TERM</u>

A) Provide TA in the following key areas:
   - Inclusion of palliative care in the soon-to-be-revised National AIDS Strategic Plan;
   - Development of national palliative care policy, guidelines, standards and protocols including palliative care for children;
   - Development of a national M&E system for palliative care; and

- Inclusion of pain and symptom management and other critical elements of palliative care in HCBC assessments.

B) Provide technical and programmatic assistance for:
   - Pre- and in-service training of health professionals and training of community-based health workers; and
   - NGOs, CBOs and FBOs including those working in HCBC to increase their palliative care skills and program coverage.

C) Provide support to strengthen and advocate for community-level palliative care for the spectrum of the population from infants to the elderly (using a family-centered approach). Some of this support can include the adaptation of the up-coming southern Africa Palliative Care Training Guide for Children Living with HIV and other Life-Threatening Illnesses.

3.4 Home and Community Based Care (HCBC)

Home and community based care is a "the provision of care and support that endeavors to meet the nursing and psychosocial needs of persons with chronic illnesses and their family members in their home environment"[9]. The fundamental distinction between HCBC and palliative care is that HCBC is a delivery system adapted to the home environment and palliative care is a specific type of care that is offered wherever it is applicable – in the home, community and in facilities (hospitals, hospices, etc.)

3.4.1 Background and Current Status of HCBC

HCBC is considered an essential element of care in Lesotho. Various sectors and organizations including the parliamentary HIV committee, Ministry HIV focal persons, community support groups, NGOs, FBOs, Local and Area Chiefs and PLWHA reported either working in HCBC or listed it as a priority area. Traditional culture and customs in Lesotho are very supportive and sensitive to the need for HCBC. This tradition is what most HCBC programs in Lesotho try to build upon. Despite the HCBC workers' limited resources, they collectively provide HCBC to large numbers of people and use their own very limited resources to care for, feed and support ill people in their communities.

The structures charged with delivering HCBC in Lesotho are spread across several sectors and levels of government and NGOs operating in the country. Although Lesotho has several government and multi-stakeholder units coordinating HCBC activities, including the MOHSW and LAPCA, and even though HCBC is addressed in the NASP, the country does not have a unified coordinating body, strategy or policy on HCBC provision. There is therefore fragmentation and a lack of coordination at the national level. National training

[9] Family Health International, Comprehensive Care and Support Framework

manuals have been developed and appear to be widely used. However, there is little attention given to ART literacy or to the notion of treatment adherence. The HCBC training manuals are considered by many to be temporary national guidelines. There is no readily available information on the national coverage, status, and/or quality of HCBC activities. In addition, there is also no accreditation process for HCBC.

HCBC is also a primary element of the work of District AIDS Task Forces (DATFs). DATFs are reportedly provided with limited and inconsistent supplies of HCBC kits and are only minimally assisted with HCBC trainings. They have, as a result, indicated a strong need for assistance in order to improve the coverage, quality and monitoring of their work. DATFs supply HCBC initiatives with HCBC Kits provided by the GoL through LAPCA. The materials contained in the kits are very basic (e.g., soap, bleach and gloves, etc). Kits are requested annually and very rarely re-supplied during the year. This is due to the lack of existing resources. They are dependent on donations from various international organizations including occasional donations from pharmaceutical companies. There is no regular supplier of HCBC kits, and the content and numbers of kits vary depending on the donor providing them.

The MOHSW has revamped its CHW program and therefore has developed a strong foundation comprising a village network of over 6,000 volunteer CHWs. However, there is concern regarding the extent to which CHWs have been trained in HCBC. There has also reportedly been an increase in the number of formal and informal groups providing HCBC. Hence, HCBC is provided by both CHCW and volunteer HCBC workers (hereafter referred to as HCBC workers). Of particular concern is the severe shortage of nurses and the small number of social workers in the county.

The delineation of responsibility for each level of HCBC has not been mainstreamed and the referral system from the household to clinical services for symptom management and early treatment remains weak. A number of factors contribute to the challenges in the referral system including a lack of community-level mobilization and coordination, transport, the frequent rotation of nurses and the ratio of HCBC and CHCWs to home-care providers and clients and nurses to CHCWs.

Access to clinical services at the community level is considered critical to effectively scale-up care and support services including VCT, PMTCT, clinical management and ART. However, the technical capacity of HCBC workers is limited and there is a great deal of concern regarding the availability of required human resources and technical skills at the community level. The upcoming introduction of ART will require access to cadres of HCBC workers who can provide much-needed support for care and treatment literacy campaigns and adherence monitoring.

In addition to the government, there are several traditional groups and activities such as stokvels (traditional savings groups), burial societies, women's church groups and support groups who often visit households with ill family members as well as groups of village

members who organize themselves to assist ill people. These structures are the frontline response to social and community problems. Furthermore, the church plays a vital role in assisting people through spiritual support, minimal material support and organized activities.

HCBC workers do not receive any remuneration, payment, incentive or subsidies in cash or kind; instead, they use their own resources to help the families they are working with. This is viewed as a major challenge for the workers as they find it very difficult to "go to someone's home that is hungry, sick and has nothing and not give something to help them". Many instances are cited of giving food from their own gardens or supplies, blankets, transport money for the clinic, soap, etc. In extreme cases, this has caused problems for the workers with their spouses who become upset that "the little they have is being given away." The workers expressed a strong desire that even if they are not paid for what they do that they are given assistance to find ways of providing for the families they work with. HCBC workers interviewed reportedly conduct the following activities:

Respite care e.g., house keeping and washing of clothes, blankets and linen.	This is often done on a daily basis for bedridden clients who are living on their own. For clients with other household members it is done approximately on an as needed basis.
Cooking	Daily basis for bedridden clients if food is available, as needed for those with other household members
Bathing client	Daily basis for bedridden clients who are living alone and as needed for those with other members in household
General Assessment	Per visit but there is no checklist, monitoring tool for clients or guide for consistency.
Monitoring of medication	Inconsistent observation for clients on medication –HCBC workers not trained in any aspect of medication use.
Provision of panado, paracetamol, Nystatin	As needed per opinion of client and HCBC worker. Panado and Paracetamol are given for just about any symptom. Use of Nystatin not clearly articulated.
Counseling and prayer	Much of the support is in the area of counseling and prayer. Clients as well as HCBC workers often belong to different churches. An interdenominational approach is most commonly used.
Referrals primarily to clinic and other care and support services	As needed, yet no clear guidelines or resource guide. Clinic relationships vary according to staff. HCBC workers reportedly try to accompany client to clinic and at times will use own money to pay for the visit and/or medications
Provision of traditional remedies	Basotho commonly uses traditional remedies. The most often cited is Soso a drink made from boiling a mixture of peach tree branch, pine tree bark, grape leaf, African potato (moli), algae (bolele), aloe (moriri oa matlpa) and mofifi[10] which is sipped throughout the day. Soso is believed to clean ones blood, provide strength, and to help with ulcers but is *not* believed to cure AIDS or other illnesses. Other types of traditional remedies were also cited.
Pain Management	No access to pain medication or systematic way of assessing/managing pain. Heavy reliance on Panado and Paracetamol without clear understanding of the difference.
Material Support	HCBC workers provide as much as they can from their own homes. Some HCBC groups have started their own gardens to provide fresh vegetables to clients and a few are starting IGA activities with the hope of raising money to support clients.
Nutritional Support	Donations from HCBC workers. Inconsistent and loosely targeted food assistance from WFP and UNICEF. Monitoring of food intake – including asking client what they will eat that day and checking in the home to see if the food is there.

HCBC workers and stakeholders are reportedly faced with many issues related to orphans and other vulnerable children within the context of HCBC including children who are suspected to be HIV-positive. However, a review of literature, training materials and key informant interviews indicates that specific training or skills-building in this area is very weak. Although the primary focus of the HCBC workers is their client, it appears that their ability to provide care and support is sometimes

[10] No translation is available for mofeefee.

compromised by the complicated family and household issues of their clients such as communication around illness and the early identification of other family members who may be ill, especially children.

Funding for the national HCBC program is provided mainly by the Global Fund. Under the Global Fund grant, funds have been allocated for the training of 100 HCBC workers per district per year for five years through a training the trainers (TOT) strategy and the provision of a limited supply of HCBC kits. Services are also provided by individual NGOs, FBOs and mission hospitals receiving limited support from charities and other small donors.

3.4.2 New Directions and Recommendations for HCBC

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

A) Assistance with a national participatory mapping and rapid assessment exercise to identify current HCBC coverage and efforts, levels of HCBC being provided, gaps (geographic and provision of services), review of the effectiveness of CHCW and HCBC.

B) Provide technical and programmatic assistance at the district and community level in the following areas:
   - Assistance to DATFs to develop HCBC strategies and implementation plans including M&E processes.
   - Training and on-going education in key technical areas: palliative care, children with HIV, psychological and emotion support, dealing with mental health issues, OVCs, communication skills, etc.
   - Review of the contents of HCBC kits and of options for improving the content and supply of kits. Review funding possibilities for provision and replenishment.

MEDIUM AND LONG TERM

A) Provide technical and programmatic assistance at the National level in the following areas:
   - HCBC consultative workshop to scale up the national HCBC response and to facilitate the development of a HCBC coordinating structure.
   - Development of a National HCBC Policy and Strategic Action Plan to include essential elements of care at the home and community level, the content of HCBC kits

- and a mechanism for restocking and re-supplying, and determining the roles and responsibilities of key stakeholders.
- National HCBC Database and Resource Guide.
- Identification of the possible need for and development of national accreditation processes for HCBC workers and HCBC organizations.
- Development of a national accreditation process for HCBC workers and HCBC organizations.

B) Provide assistance in strengthening the role of HCBC within ART treatment for adults and children and support mechanisms for strengthening home-care support for those on treatment including care and treatment literacy, side effects and adherence monitoring and support.

C) Encourage USG supported partners to strengthen HCBC as an entry point for prevention. Incorporate HIV/AIDS prevention education activities/services into the routine of HCBC workers.

D) Encourage PLWHA support groups to identify one or more representatives to be actively involved in HCBC. The level of involvement can be decided between the PLWHA and CBOs, FBOs, NGOs and support groups, but at a minimum, it is suggested that the PLWHA representative be actively involved in planning and monitoring activities.

E) Provide assistance in improving care and support for HCBC workers. Address issues related to working and living in an environment with high HIV prevalence, including the emotional and physical stress related to their professional and personal lives.

F) Explore mechanisms to financially support HCBC workers in order to decrease the amount of money and resources they are personally putting into their work. Remuneration for HCBC workers might also be considered. For example, in South Africa, HCBC workers are provided with R500.00 per month (with discussions currently taking place to increase this amount).

3.5 PMTCT

(Note: The Lesotho team was unable to include someone with specialized expertise in PMTCT and consequently the team was less able to address this program area than others. RHAP's Senior Advisor for FP, MCH and PMTCT Integration made three visits to Lesotho between September and December 2004. This section was expanded in January 2005 based on these site visits and review comments provided by Dr. Letsie, Director, Family Health Division.

3.5.1 Background and Current Status of PMTCT

With an estimated HIV prevalence of 26.4 percent, 73,000 births per year, and a vertical transmission rate of 25-48 percent, it was projected in 1999 that 7,000 infants in Lesotho would become HIV-infected through MTCT. PMTCT by ARV prophylaxis , nevirapine, at the onset of labor and an infant dose within 72 hours of birth, has been proven to reduce transmission by as much as 80 percent. In 2003 the Family Health Division of the MOHSW piloted the introduction of a formal PMTCT program as a means of reducing MTCT and increasing child survival.

The effort to develop a comprehensive PMTCT pilot program in Lesotho began with a sensitization of government in 2002. Central level managers and District/HAS PMTCT focal persons from the MOHSW participated in the PMTCT Training of Trainers course in Uganda. The training manual used in Uganda was subsequently adapted for Lesotho. A one-week training in PMTCT and a two-day training in infant-feeding for nurses was held at each participating PMTCT facility in Lesotho, the initial eight 'pilot' sites. National PMTCT and infant feeding guidelines have also been drafted and redrafted, but are not yet operational.

Lesotho's National PMTCT program was launched in eight pilot sites in January 2003. By late 2004, fifteen ANC sites (including the four original GoL and four CHAL sites) were implementing the PMTCT program.

The national PMTCT program model was designed to be fully integrated into ANC care and child health services in Lesotho. Integrated service delivery for FP, MCH, nutrition, PMTCT and EPI appears to be the standard model of care adopted by the MOHSW's Family Health Division. When a client arrives for her first antenatal visit, she is offered HCT. The HCT model, with signed consent, is specified within the draft National PMTCT guidelines. According to these guidelines, the PMTCT testing algorithm includes an initial rapid test. If the results are negative, they are confirmed by a second rapid test. Results are given to the client in a post-test counseling session, along with recommendations for follow-up rapid testing in three months. If the initial test is positive, test results are not given to the ANC client until follow-up confirmatory ELISA tests take place. Although this results in patients not obtaining their results on the same day, it has been the experience at the pilot sites that clients usually return for their results. Clients are encouraged to bring their spouse or partner to this first visit. Spouses and partners are also offered HCT. Post-test counseling for discordant couples and HIV-positive mothers includes more information about HIV infection and the development of strategies for safer sex and infant-feeding. PSI, funded by RHAP, launched voluntary counseling and testing services in July 2004 at four New Start Clinics located on four hospital sites where PMTCT is offered. Where ANC clients access VCT at New Start Clinics, test results are provided on the same day. In mid-2004, the Prime Minister announced the decision to adopt a universal approach to counseling and testing. By late MOHSW and Family Health Division made the commitment to ensure the opt-out approach is adopted in all PMTCT sites. ANC services include OI treatment as needed.

The Lesotho PMTCT ARV regimen includes a single 200 mg dose of nevirapine given to the mother at 32 weeks to carry home , with instructions to take orally at the onset of labor in the case of home delivery or labor onset at home or en route to the ANC. According to the Family Health Division, the proportion of HIV+ ANC women who deliver in the health facilities has increased since the PMTCT program was initiated. All clients are advised to bring their newborns to the ANC within 48-72 hours after delivery for a dose of nevirapine syrup. CHWs follow PMTCT clients in the community. Some CHWs are traditional birth attendants (TBAs) who counsel on the benefits of facility-based deliveries to HIV-positive pregnant women who are planning to deliver at home.

A brief review of client records reveals that PMTCT uptake varies by facility. Uptake at government sites is reportedly greater than at CHAL facilities. The uptake range is estimated to be from 50-90 percent throughout the PMTCT facilities.

PMTCT clients are advised to breastfeed exclusively for six months or less, consistent with national infant feeding guidelines. Most clients comply with this recommendation. Less than 3 percent of

women request replacement feeding, and usually those that do are working mothers. There is a moderate amount of discrimination in Lesotho against mothers who do not breastfeed their infants.

Constraints to PMTCT identified during the pilot include small counseling spaces at some facilities, the inability to provide same-day testing, and inadequate human resources to most efficiently provide PMTCT services.

In March 2004, the Honorable Minister of Health requested assistance from USAID and AED/LINKAGES to conduct an assessment of the PMTCT program. The assessment was begun in October with the facility-based review in three sites designated by the Family Health Division. The draft PMTCT and Infant Feeding policies were also reviewed. The behavioral survey and baseline will be completed by the end of January 2005.

Two representatives from Columbia University, a USAID and CDC implementing partner for PMTCT+, recently spent two days in Lesotho visiting several sites with the Director for the Family Health Division. Findings from this visit indicate the Ministry's interest in and readiness to embark upon PMTCT+ planning. The potential for involving Columbia University in the country program through their core co-operative agreement was then actively pursued by the RHAP Integration Advisor with the Office of HIV/AIDS in Washington. As of mid-December 2004, Columbia University had agreed to work in partnership with EGPAF and LINKAGES to help strengthen the national PMTCT program and plan for PMTCT+. Currently, the MOHSW anticipates that when ARVs become available nationally, PMTCT clients will undergo CD4 testing at ANC clinics and, if eligible, will be referred to the nearest ARV-providing center. This approach will be carefully reviewed by the USG PMTCT partners for efficacy and impact, to ensure eligible HIV+ women have equal access to care and treatment. In addition, preliminary findings of the LINKAGES assessment will be shared with USAID and other PMTCT partners in preparation for a joint country visit planned for early March.

3.5.2 Recommendations for PMTCT

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

A) Work with OHA to secure commitment from the CTO and Columbia University to work with EGPAF and LINKAGES to support the national PMTCT program and plan for PMTCT+. RHAP will carry out all coordination and planning activities to ensure a joint PMTCT partnership that is comprehensive and coordinated in a collaborative fashion.

B) Review findings from the LINKAGES assessment; the three-site assessment, the review of policy documents, the behavioral survey and the community baseline.

C) Based on the review of previous assessments/appraisals, the LINKAGES assessment, on consultations with MOHSW, and on the proposed joint EGPAF, Columbia University and LINKAGES country visit in March, 2005, determine the need for additional assessments,

such as a more comprehensive facility-based assessment to determine the strength of existing PMTCT, ANC, and post natal care services, including client flow; provision of services; costs, commodities, M&E/data; human resources; management; counseling, testing, laboratory services, obstetrical services; referral systems for mothers, their infants and families for other care and support needs; and community outreach and support for MTCT.

D. Work with the Population & RH Office and the MCH Office as well as with PMTCT partners ensure the program strengthening efforts integrate family planning and neonatal care and maternal and child health. Seek additional technical assistance to evaluate the implementation of the enhanced model as part of the regional FP, MCH and PMTCT integration initiative.

3.6 Orphans and Vulnerable Children (OVC)

3.6.1 Background and Current Status of Support for OVCs

Lesotho has ratified the U.N. Convention on the Rights of the Child. It has committed itself to the outcomes of the U.N. General Assembly Special Session (UNGASS) on HIV/AIDS (May 2001) and UNGASS on Children (2002). These milestones have provided the impetus for the GoL to pursue national policies and strategies and a legal framework to ensure that resources are allocated to address the needs of children. Although the GoL has made progress, primarily in the last year, there are several opportunities for strengthening existing efforts.

In the Children's Protection and Welfare Act, a child is defined as "a person between 0 to 18 years of age," orphans are defined as "children who have lost one or both parents." Beyond this definition, there appears to be a lack of consensus on a national definition of orphans and other vulnerable children. Despite the lack of a national definition, there seemed to be consensus among those interviewed that a vulnerable children include children who live alone or in a sibling-headed household, with parents or guardians that are incapable of caring for them, with poor elderly grandparents, and that are physically challenged and/or abused. Other identified areas of vulnerability include lack of access to food, clothing, healthcare, education and psychological care.

While Basotho are faced with complex challenges due to the combined impact of HIV/AIDS and poverty, families and communities remain at the forefront of responding to the needs of OVCs. Lesotho's community-based care and support system is based on traditional practices and principles of communalism especially in relation to the well-being of children. Consequently, all GoL ministries with HIV/AIDS initiatives expressed the desire to assist in this area. There are many examples of local communities, with little or no support from outside, that are taking responsibility for helping OVCs, but they remain in great need of assistance. Additionally, the Department of Social Work (DSW), the department responsible for the well-being of children and families, is making concerted efforts to address their needs despite their current lack of resources (both human and technical) and decision-making authority.

External support has primarily consisted of material support with a heavy focus on the provision of food, clothing and educational support. The response remains fragmented, and few programs have been able to comprehensively address the major needs of children infected and affected by HIV/AIDS. These needs include psychological support and ensuring access to basic health services as well as specific HIV prevention, care and treatment services. Children have not been adequately addressed within the context of the continuum of HIV/AIDS prevention, care and treatment. During this rapid appraisal process, the team was unable to identify a comprehensive program providing for all of the needs of children.

There is only one private pediatrician in the country providing comprehensive clinical services for the treatment of HIV-positive children, and the only public ART site (the Senkatana Clinic) does not provide treatment for children. There are no clear plans to include the treatment of HIV-positive children in the government ART rollout plan despite the fact that a pediatric drug regimen is included in the Lesotho National ARV Guidelines. However, it is important to note that the original plan for the provision of PMTCT services included piloting the recently development IMCI/HIV protocol. While PMTCT has started in the country, no funds or support have been identified for piloting the IMCI/HIV protocol.

Primary support for OVC is provided by U.N. agencies, UNICEF in particular. They provide the most comprehensive support including nearly all aspects of current services for OVC. UNICEF support includes resources for a consensus-building process leading to a formal OVC task force, the development of an OVC policy and the design of an OVC strategic plan. In addition, Lesotho is one of the focal countries for the UNICEF Rapid Assessment, Analysis and Action Planning of the Response to Children Orphaned and made Vulnerable by HIV/AIDS (RAAAP). WFP is the primary provider of food assistance and is working closely with the GoL to assist with school feeding.

The remaining support for OVC has come from Save the Children UK, an organization that has provided substantial technical and financial support for children's legislative and legal reform. They have also supported, albeit in a more limited fashion, direct OVC service implementation by national NGOs and CBOs. Although Save the Children UK recently pulled out of Lesotho, Save the Children Lesotho is still active. In addition, the Office of the First Lady supports OVC programs.

The GFATM supports limited OVC activities through a HIV/AIDS grant initiated in 2003. Support is focused on information dissemination through the production of IEC materials and through support for public gatherings, school fee assistance and food parcels. The primary NGO receiving funds through the GFATM grant is World Vision, which supports OVC activities in nine of the ten districts within the context of broader integrated development, utilizing an "Area Development Project" approach that does not focus on OVC alone. Due to the limited time of this appraisal, it was difficult to determine the quality of the World Vision program.

The GFATM did not approve a recent Lesotho HIV/AIDS proposal including $33,236,000 for OVC programs. Funds of this magnitude would have dramatically accelerated the OVC response. Those working with OVC are very concerned about future funding for enhancing and scaling up the service-delivery and referral systems for an expanded response to OVC in Lesotho. The DSW is planning to review and revise the HIV/AIDS proposal for resubmission.

Despite funding and technical support limitations, Lesotho has participated in key OVC consultations and developed a draft National Action Plan.[11] Since the most recent Regional Workshop on OVCs in 2002 in Maseru a Lesotho OVC delegation has met once to share the draft action plan with other stakeholders. An official and multisectoral OVC coordinating body, although slated to commence work in April 2004, has not yet been formed. An interim national coordination body is meeting, but leadership for this effort reportedly rests predominantly with donor organizations.

A recent national situation analysis identified the following factors inhibiting the scale up of OVC responses in the country. There is a need for:

- A policy for the care and protection of OVC;
- Guidelines for action based on best practices;
- A strategic national action plan for OVC;
- A systematic procedure of providing grants to families willing to take in OVC;
- An administrative and legal framework that provides for a comprehensive and well-monitored and supervised foster care and adoption system;
- Universal standards in DSW for granting assistance to OVC;
- An organized system and procedures for registering and monitoring the situation of OVC;
- The mapping of services and the identification of specific geographic and service needs;
- A national monitoring and evaluation mechanism for comparing OVC and non-OVC access to basic social services;
- A national body that coordinates and facilitates cooperation among key stakeholders; and
- Financial, technical and human resources.

There has been increasing action towards the development of children-related laws and policies. The DSW with UNICEF support have hired a consultant to develop an OVC policy. The Social and Welfare Policy was recently enacted; it allows for the exemption of health and nutrition services fees incurred by orphans in order to increase their access to fundamental services. However, delivery of these exemptions is constrained by bureaucratic obstacles that prevent caregivers from receiving information about the rights of orphans for eligibility and hence, stall fee waivers. The provision of basic health and nutritional services for all children is impacted by infrastructural constraints and the lack of funds earmarked for the health and social sectors. Despite setting goals that would ensure access by all children to adequate nutrition, social and health services by 2005, progress toward these goals is undermined by limited finances and absence of a clear implementation plan.

[11] Key consultations include the first and second Southern and East Africa Regional OVC Consultations (2000 and 2002) and the Strengthening National Responses: Southern Africa Workshop on Orphans and other Vulnerable Children (November 2003).

Children's Protection and Welfare Act

Lesotho is to be commended for the Children's Protection and Welfare Act which represents a milestone in the path to building an enabling environment for children affected by AIDS. The Act reflects international child rights standards, and was developed through a highly consultative process, including the direct participation of children. The Lesotho Law Reform Commission was tasked with the process and the act is a model for the region. Highlights of the Act include:

- Provisions for establishment of an Independent Children's Commission to monitor and report on violations of children's rights;
- Provisions for birth registration;
- Provisions for fostering and adoption;
- Safeguards protecting property and inheritance rights of orphans;
- Legislation against unlawful transfer of children and trafficking;
- Mandate that the DSW carries out social investigations;
- Provisions for places of safety and their accreditation by the DSW;
- Measures against child labor; and
- Measures discouraging institutionalization of children.

With the passage of the Children's Protection and Welfare Act, the DSW is mandated to supervise and monitor services for children. However, this will be difficult as the DSW is seriously understaffed and overextended and financial support for the dissemination and implementation of the act has not yet been identified.

Department of Social Welfare

The DSW has been instrumental in the progress made to increase support to OVCs, but it is faced with many challenges. The DSW and DOH both fall within the MOHSW and report to one minister. Anecdotally the team found that the relationship between the departments could be strengthened and it might be beneficial for the DSW to be autonomous. One critical concern is the reported over-focus on ART and corresponding lack of focus on issues faced by OVC, their families and communities.

In the current financial year the budget for the DSW is 6 million Maluti, which appears to be inadequate. Budget constraints also limit the number of social workers employed in the country. There are 21 total social workers in Lesotho including two in management positions in the DSW and two in regional positions. This leaves most of the districts with just one social worker. The total number of social workers may increase to 24 if three currently advertised positions are filled. There is no midlevel social worker cadre. The lack of human, financial and technical resources is having a severe impact on service delivery including the scaling-up (coverage and quality) of current services.

The training of auxiliary social workers is one solution to this challenge that the DSW would like to explore. The ADB reportedly proposed funding for this initiative, but with the condition that a Director for Mental be appointed before funding is provided.

The first cadre of social workers trained in Lesotho will graduate with degrees in Social Work from the National University of Lesotho in 2005. It is not clear that the DSW will have funding to create additional posts for these graduates, and the fear is that they will leave the country to seek employment.

Despite these severe constraints, the DSW has made commendable efforts to achieve its primary focus, i.e., "the alleviation of human suffering, focusing on services for children, the elderly and the disabled." The primary programmatic elements are:

The DSW provides social assistance recipients with 100 Maluti per family per month. Currently, there are approximately 4,000 families receiving this support. There is unfortunately a long waiting list. The DSW has stopped enrolling people on the waiting list. With additional funding, the DSW could reportedly double the current number of families receiving support to 8,000, which would still be inadequate in a country with 50 percent unemployment (1.1 million people). Recipients of the 100 Maluti also receive medical fee exemptions, bus warrants and a coffin in the case of death. School fee support was previously provided, but it has been replaced by a bursary scheme by the Ministry of Education. It is expected that a new social assistance scheme will be implemented in 2005 whereby people over 70 will qualify for a pension of 150 Maluti per month.

The GoL, through the Ministry of Education, has implemented universal primary education (UPE) through a Free Primary Education Scheme. This was introduced on a one-year rollout basis in 2000 with the goal of having it complete by 2007. Despite the establishment of UPE, school attendance is reportedly constrained by associated costs including transport, clothing and books. Education, however, has always been a priority to the Basotho, and Lesotho still boasts one of the highest literacy rates on the continent.

The DSW is also responsible for providing services for abandoned and abused children through approximately five NGO and FBO partners. These few NGOs and FBOs are constrained by lack of funds and technical assistance and are primarily concentrated in the Maseru District. The GoL used to support temporary children's homes with a salvation grant of 20 Maluti per child per month, but this ended at the end of 2003 due to a lack of funding. The primary focus of these NGOs and FBOs in collaboration with the DSW is the identification of children for reintegration with relatives and into communities. For instance, the Maseru Children's Village (the primary activity supported by Save the Children Lesotho) currently has 24 children in their care, and it reunited ten children with their families. They are only able to provide monthly follow-up with these families and very limited community outreach and mobilization despite a strong desire to do more. The second-line response is adoption and foster care. Although the GoL does not desire long-term institutional care of

children, there is concern about the reportedly increasing number of long-term shelter institutions and lack of capacity (human and financial) to adequately address the issue.

The DSW is currently in the process of compiling an OVC stakeholders directory, both as an electronic database and as hard copy for general distribution. A consultant (a member of the Law Reform Committee) has been appointed to complete this task.

A recent UNICEF initiative to compile a register of OVCs through the Department of Local Government has provided training to people as registrars. The DSW is concerned that this initiative may not be the best use of funds, be too difficult to maintain and undermine community mobilization and support initiatives.

The DSW is seeking ways to improve coordination among CHWs, NGOs, FBOs, CBOs, PLWHA and support groups at the community level. Following family structures and traditional community support, support groups play a primary role of supporting children and families at the community level, but their geographic coverage is limited primarily to Maseru and some of the northern part of the country. Support groups are composed of community members who have organized themselves to provide a variety of functions including very basic HCBC (primarily respite care), care for children, and peer education initiatives. Support group members often include traditional leaders and healers and a variety of community members including men, women and youth. Much of their work is based on Basotho traditional principles. For instance, among those visited it was made clear that community members want to keep "their" children (even those in child-headed households) within the community and in their original homes. They reportedly prefer that children remain in their original homes, where ancestors, neighbors, support group members (of whom many are neighbors) and traditional structures can care for and protect them. There is currently no registration process for support groups, and the DSW advises them to register as associations to enable access to funding.

Although there are some small NGOs, FBOs and promising support groups, there is a critical need for TA, resources and coordination support to increase their capacity to mobilize communities, provide essential care and support services for OVCs and provide family-centered care. There is also a clear need for synergy between the community response and that of government and international partners.

Given the recognition of the plight of OVC, the strong community support structures and potentially increased funding for OVC, Lesotho has the potential to dramatically expand its OVC response. Traditional community structures and responses are in critical need of support. There is the potential to not only support and reach a vast number of children and families in Lesotho but to also use USG support to build a comprehensive OVC response.

3.6.2 New Directions and Recommendations for supporting OVC

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

A) Support the dissemination of the Children's Protection and Welfare Act (including the translation and printing).

B) Train key parliamentarians, chiefs and traditional and religious leaders on OVC issues.

C) Provide technical and programmatic support for community-based programs and structures for OVC to further expand initiatives and increase their capacity to mobilize communities, strengthen community-level coordination, provide essential care and support services for OVC including children with HIV and strengthen prevention activities within care.

D) Build PLWHA group capacity to contribute to community and national level OVC activities.

E) Provide technical support to the DSW to review and revise the GFATM HIV/AIDS proposal for resubmission including OVC services.

MEDIUM AND LONG TERM

A) Support for the integration of IMCI/HIV throughout the country.

B) Provide technical support for implementation of the provisions of the Children's Protection and Welfare Act.

C) Provide support for standardizing refresher training for all social workers, as well as specialized training in child welfare for senior regional officers.

D) Provide support for documenting community-based OVC lessons and models.

TREATMENT (Antiretroviral Therapy – ART)

4.1 Background and Current Status of Antiretroviral Therapy (ART)

Antiretroviral Therapy (ART) involves the provision of a comprehensive evidence-based package of services through a network of linked providers in the public and/or private sectors as well as in the community. Such services should include the provision of HTC as an entry point, ART clinical investigations, treatment counseling and support, ARV drugs, laboratory support, PMTCT, TB control, STI management and overall clinical care of these infected with HIV/AIDS, HMIS and M&E.

The provision of ART requires a strong health provider and community interface as well as strong public-private partnerships (PPPs). This may be especially true in countries in sub-Saharan Africa where a larger proportion of doctors (general and specialized) are in private practice. In Lesotho, this is especially true, where the majority of doctors are in the private sector, and nurses make up 85 percent of the public-sector health force.

The 3x5 target for Lesotho is to have 28,000 people on treatment by 2005. This is half of the approximately 56,000 people in Lesotho that require ART, and places tremendous pressure on a country where key required services are still in their infancy, notably HTC.

Lesotho currently has two centers where adult ART is offered, the Senkatana Clinic and the Maluti Hospital. The combined total of patients in treatment in these two facilities is approximately 2,000. The Maluti Hospital is a CHAL facility, and it charges a higher fee for treatment than the Senkatana Clinic, which charges the GoL fee of M10 per month. Although the Senkatana Clinic is a GoL clinic, the funding for its ART program is through a GoL-Secure the Future partnership[12].

The 2,000 people on treatment do not include patients receiving treatment from private physicians in Lesotho, including one pediatrician in Maseru.

The Senkatana Clinic serves as the model site for the ART rollout plan for Lesotho. The appraisal team had the opportunity to visit the Senkatana Clinic. The Senkatana Clinic essentially is very different from other centers where ART will be provided in that it is a stand-alone outpatient ART facility that does not offer a comprehensive range of health services. Patients who are on treatment at the clinic will however receive some basic OI management.

The clinic opened in May 2004 and currently has more than 300 patients on treatment. Nearly 1,200 patients underwent HCT. BMS also uses the clinic for operational research, and thus the clinic has specific entry criteria. The research component accepts only new

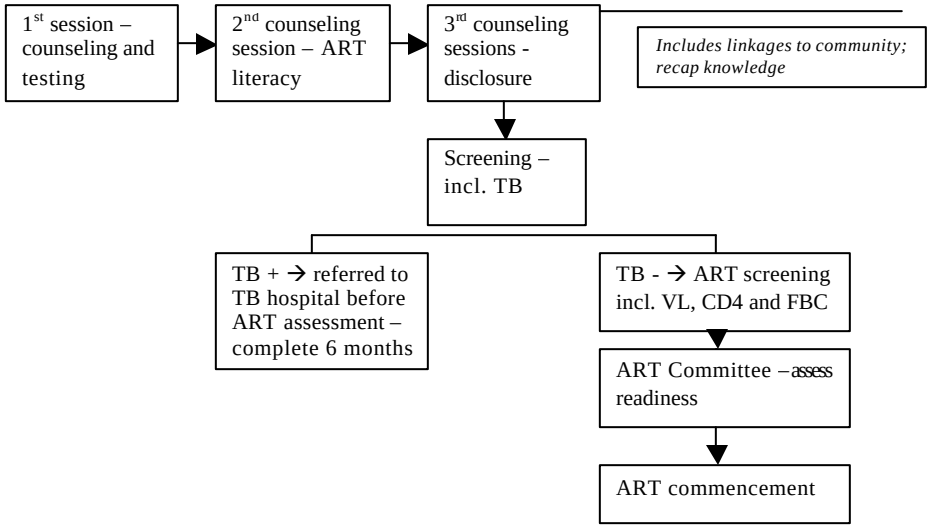
[12] It is to be remembered here that the intention with Senkatana Clinic is to have it function as a pilot site for three (3) years after which the expectation is that it will be absorbed into the MOHSW recurrent budget

(treatment-naïve) patients living in the Maseru district. Patients that fall outside the scope of these criteria are not included in the research component.

The BMS funding provides for ARVs, lab tests, the initial staff complement, start-up OI drugs and operational research. The clinic also received a $50,000 donation of ARVs from the Government of India, which ensured that patients outside the scope of the research criteria could be enrolled in ART.

As will be the case for the other new public-sector treatment centers to be opened in Lesotho, the main referral center is the Queen Elizabeth II Hospital, which is also the location for the Central Laboratory Service where all blood tests for screening and monitoring are performed. Viral load tests are conducted in South Africa.

The algorithm for services in the Clinic is as follows[13]:



The criteria for adult ART commencement are similar to those of WHO, namely CD4 count below 200 and/or stage 3 or 4 AIDS-defining illnesses. Patients with a CD4 count between 200 and 350 are considered to be on the borderline, and they are only followed up periodically. Patients who test positive for TB during the screening are referred for TB treatment and must complete the full treatment course of six months before being enrolled in ART. This is a BMS requirement that is much more stringent than the WHO recommendation of two months of TB treatment before ART commencement. The *National Antiretroviral Guidelines* developed by the MOHSW confirm the preferred method is to have the TB patient complete his/her TB treatment before commencing ART (two weeks after completing TB treatment). Technical advice could be given on adjusting this element of the guidelines in line with WHO recommendations and based on international experience.

[13] This is a simplified version of the Senkatana Clinic algorithm

The clinic does not provide for pediatric ART and refers all children requiring treatment to the Queen Elizabeth II Hospital. There are only 2 pediatricians in the country, one each in the private and public sectors. The capacity for pediatric ART is thus extremely limited, and there are two options for ensuring access to treatment for children: 1) for the private-sector pediatrician to work sessions in one of the public sector facilities, probably Queen Elizabeth II Hospital or 2) for public-sector physicians to receive specific training in early identification of children suspected to have HIV and case management for children with HIV including treatment within a family-centered approach[14].

With the assistance from the WHO, the GoL has developed a plan for the national ART rollout for September 2004 to December 2005.In that time the GoL plans to open eight new ART centers, thus ensuring that there is equity in access to ART across the country. These new centers will be opened in a phased approach:

- September-December 2004: Queen Elizabeth II Hospital in Maseru, Leribe Hospital, and Mohale's Hoek Hospital
- January-March 2005: Lesotho College of Education Center and Mafeteng ospital
- April-September 2005: Centers to be opened in Mokhotlong, Qacha's Nek and one more site to be identified

The ART rollout plan developed for Lesotho will follow the lessons learned from the Senkatana Clinic. The HTC model, however, will be slightly different, as ART will be provided in a comprehensive care setting (district hospitals) and not a stand-alone ART facility. HIV testing and counseling (HTC) adopted for the national ART rollout will comprise the following concurrently implemented methodologies:

- Classical VCT, which will be provided in the stand-alone VCT centers (such as PSI)
- Universal testing with an opt-out in workplaces, including government ministries and factories
- Routine testing for STI, TB, ANC and in-patients with "silent consent" but opt-out
- Diagnostic testing for patients with suggestive clinical signs or symptoms of HIV infection without pre-test counseling but with opt-out

However, despite the fact that the Senkatana Clinic is a model site to guide the national rollout strategy, Senkatana Clinic staff have had very little input into the development of the strategy. The lessons learned from the experiences at the clinic have not been properly documented for use in the planning process.

In addition, both the Senkatana Clinic and the ART rollout plan appear to pay insufficient attention to the importance of community preparedness to support uptake and adherence and guard against treatment optimism. This is an area that is pivotal to ensuring the required uptake of services, including encouraging people to know their HIV status and dispeling

[14] Please note that no one option excludes the other.

myths about ART as a cure. Very few relevant stakeholders consulted by the appraisal team had played an active role in the development of the ART rollout plan. It was not possible to find information on the community preparedness plan or communication strategy of the GoL.

The MOHSW issued ARV treatment guidelines in March 2004. These guidelines cover the areas of integrating ART into existing services, drugs regimens for both adult and pediatric patients, side-effects/toxicity of ART, PMTCT, occupational exposure and special considerations. However, there is no strong section on HMIS or pharmacovigilance, and these are potential areas for support from the USG.

The drug regimen utilized in the Senkatana Clinic is d4T, 3TC and nevirapine. If there is a reaction to nevirapine, it is replaced with efavirenz. This is essentially a BMS regimen, similar to the WHO guidelines; the plan for the national ART rollout was originally to use the same regimen as in the March 2004 *National Antiretroviral Guidelines.* However, the GOL subsequently decided to use the cheaper fixed-dose combination of Triomune. One reason cited for this is the high cost of efavirenz. The Clinical Advisory Group within the Ministry of Health will adjust the treatment guidelines.

Patients on treatment will return to the relevant ART center for monthly follow-ups to receive their drugs and have periodic clinical monitoring tests conducted. The plan does not currently make provision for dispensing and monitoring to be decentralized to the clinic/health center level.

An important opportunity for assistance identified by the Senkatana Clinic, and confirmed in the discussions with other providers, is the need for improved community mobilization and preparedness, general heath education and treatment literacy at the community level, including the development of a standardized training module.

The ART rollout plan for Lesotho does not have a specific focus on nutrition, but patients in Lesotho can access food supplements from the WFP. This is offered to people with HIV and/or TB and malnourished children. The Senkatana Clinic did include nutrition counseling as part of the counseling sessions, and will also start a food garden at the clinic. This is an area that could be strengthened in the current plan.

The other main focus areas of the ART rollout plan are:

- Policy and technical guidance – the relevant national treatment guidelines and procedures manual have been developed. This includes the standardized treatment protocols, referral systems and uniform reporting and documentation forms.

- Laboratory capacity – this section specifies the human resources, infrastructure and equipment requirements. The vision for the GoL is to have laboratories established in each of the ten districts in the ten district hospitals.

- Procurement of drugs and supplies – this is being done through the newly-established HIV/AIDS Health Products Coordination Unit (HAHPCO).

- Human resource needs – focusing primarily on the need for additional doctors, nurses, pharmacists, phlebotomists and counselors.

- Community mobilization and support – the focus is on using the "buddy system," which is similar to the DOTS methodology, mass communication on ART and recruiting and utilizing community counselors.

- Monitoring and evaluation – eight indicators to measure the ART rollout have been developed, and a database is being established in HAHPCO.

- Operational research – this is to be guided by a Clinical Advisory Group within the Ministry of Health

The cost of implementing the national ART rollout plan is estimated at $16-20 million (September 2004-December 2005). Funding for this would come from the following sources:

- GoL allocation $357,000
- GFATM $3,500,000
- BMS $4,000,000
- DCI €250,000

In addition, the GoL receives technical support in some key areas of the plan, including HMIS (drug distribution, pharmacy stock levels and patient information) developed by Boston University. Given that Boston University only provides technical and not financial support, there will still be a definite need for provision of financial support for the implementation of the system developed through the TA.

The funding thus currently available is less than half of the estimated budget. However, there are some potential savings to the estimated budget, especially if, as planned, drugs are procured through a partnership with the Clinton Foundation. This would reduce the drugs component of the budget by more than half.

The GoL already provides some of the support for treatment through a program that provides access to ART for all government employees who have tested HIV-positive in the Know Your Status campaign and choose to disclose their status. This is funded out of the current 2 percent HIV/AIDS allocation from all government ministries. Some of the treatment for public servants is currently provided by private providers, but it is at a higher cost than would be the case in the public sector. There are thus a number of patients that would transfer into the public-sector ART program, as was the case when the Senkatana Clinic opened.

One area that was not sufficiently addressed in the current ART rollout plan is the provision of HTC and treatment services in prisons, which provide only limited health services. Prisons provide a good opportunity to expand prevention, care and support services, and the [type of?] assistance given by the USG to the South African Department of Correctional Services may be of value to Lesotho as well. The provision of TA to the GoL to ensure prevention, care and support programs in the uniformed services would also be of value. The Parliamentary HIV/AIDS Committee as well as some of the HIV/AIDS focal points in government ministries also expressed this opinion.

Based on consultations in the private and public sector, the most critical challenges in implementing the ART rollout plan are:

- Human resource capacity in facilities and communities;
- Lack of trained CHW and community support structures, specifically for treatment literacy and adherence support;
- Laboratory infrastructure;
- Health information, education and communication (IEC) of HIV/AIDS generally, and treatment specifically on a universal basis. Knowledge and information resources seem to be concentrated around urban environments;
- Space for implementation within facilities to provide ART;
- Referral links between hospitals, health centers and communities to ensure a continuum of care; and
- Pediatric experience to ensure access to treatment of children in a family treatment approach.

Despite these challenges, the GoL has greatly accelerated its response over the last year, especially through expanding HTC, and setting up the initial ART learning site at the Senkatana Clinic in Maseru. The challenge to scaling up this response and implementing it in a fashion that ensures equity, access and quality of care throughout the country provides an ideal opportunity for targeted USG support in Lesotho.

However, as the model for implementing ART in the PHC sector in Lesotho is more comprehensive than that at the Senkatana Clinic, it is important that TA be geared towards integrating ART into existing health services. Current PMTCT, STI and TB programs provide an ideal entry point for identifying patients for HTC and clinical screening. In Lesotho, the rate of TB and HIV co-infection is approximately 50 percent, and one study showed that 62 percent of people presenting with STIs were HIV-positive.

There is now a growing body of expertise in the region that the GoL could utilize to develop and implement a strong ART program. This includes looking at regional models to increase community and PLWHA involvement in this process (e.g., Khayelitsha in the Western Cape).

4.2 New Directions and Recommendations for ART

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

A) Assess feasibility of developing and implementing a PMTCT+ program including the piloting of the IMCI/HIV protocol as planned at the PMTCT sites (by adapting the current PMTCT program). Provide specific technical advice on early identification of children suspected to have HIV (through IMCI/HIV) and providing ART to children, including the development of a family treatment approach and training curricula.

B) Assist the Ministry of Health in developing a national training curriculum for community support systems, including CHWs and support groups.

C) Print and disseminate the national treatment guidelines and protocols to all HCWs. These might be printed in both English and Sesotho.

D) Provide both technical and financial assistance to NGOs that provide key treatment support services, including HTC, treatment readiness education and OVC support.

E) Assist the GoL to host a tri-country workshop of Lesotho, Swaziland and South Africa to look at ART implementation, including harmonization of clinical guidelines and access to treatment. This is especially important due to the high cross-border mobility and to ensure that patients on ART from Lesotho who work for extended periods in South Africa have access to continued treatment.

MEDIUM AND LONG TERM

A) Assistance (technical and/or financial) for periodic reviews of all national treatment guidelines and protocols, including standardization on key issues, such as when to initiate treatment if a patient is tested TB-positive and reviewing existing protocols in other areas (e.g., STI management, OI management and PMTCT).

B) Assist the HIV/AIDS Directorate in the MOHSW to develop a national training curriculum for health workers, including professional and non-professional counselors. This can be a comprehensive curriculum embracing ART (adults and children) literacy and adherence support, palliative care, family counseling and general HIV/AIDS prevention, care and support. A good model would be to provide support for a mobile training team that could provide training at the district level. In addition, this training can target professional health care workers (public- and private-sector), CHWs and volunteers the general public (through mechanisms such as peer education and using key community leaders).

C) Provide assistance for a process to document and share the lessons from the Senkatana Clinic to better inform the national ART rollout plan, especially moving beyond the immediate scope of the plan for decentralizing treatment at the health center level.

D) Assist the GoL in developing a longer-term plan that decentralizes ART services and support to the health center/clinic level, including clinical screening, HTC, ongoing monitoring, OI management and drug distribution (including pharmacy services).

E) Assist the GoL in developing a pharmacovigilance strategy to ensure systems are in place for the reporting of adverse events and for ensuring access to specialized HIV/AIDS and ART support when required.

F) Assist the GoL in developing and implementing a comprehensive communication strategy that incorporates prevention, care and treatment. This would include the development of mass as well as community-driven tools and messages.

G) Assist the GoL in conducting donor mapping to identify all current and potential sources of funding for ART.

H) Provide TA to the GoL to develop a comprehensive plan for strengthening and decentralizing laboratory services (this forms part of broader recommendations in the section on laboratory services).

I) Assist the GoL to develop a nutrition strategy and SOPs for patients with HIV and TB that address both short-term nutritional support (food supplements) and sustainable food security that includes nutrition, counseling, therapeutic feeds (children and adults)and food distribution and security.

J) Assist the GoL to implement a comprehensive human resource plan that addresses recruitment, retention and the use of private practitioners within the public sector based on work that has already been done by the GoL.

K) Explore with the GoL the option of providing comprehensive HIV/AIDS prevention, care and treatment in prisons and the uniformed services.

L) Assist the GoL with expanding access to HTC at the lowest possible level (also refer to the recommendations in the section of HTC).

M) Provide TA to the GoL on the development of a strong M&E program that captures the required data on the ART program as well as other health indicators

Nutrition

5.1 Background and Current Status

HIV/AIDS compromises the nutritional status of infected individuals, increases energy requirements and causes symptoms that constrain dietary intake and reduce nutrient absorption. In addition, HIV exposure and infection exacerbates problems of child malnutrition. Lesotho is preparing to roll out ARVs. ARV therapy improves nutritional status, but it may also have side effects and metabolic complications. Communities, policy-makers and PLWHAs, need to have accurate information regarding nutrition and HIV/AIDS. Additionally, concern was expressed regarding the marketing and use of "immune-boosters," which are often very expensive. The most well known distributer of these items is "Positive Health" based in the capital. Desire for information and directions on their use and effectiveness was expressed.

5.2 New Directions and Recommendations in Nutrition

In light of the background, current activities and opportunities detailed above, the appraisal team strongly encourages the USG to consider support for the following activities:

SHORT TERM

A) Intensify efforts to implement essential nutrition actions (ENA) within existing USG- funded PMTCT and MCH programs, recognizing the special needs of HIV-positive mothers and children.

B) Identify areas of opportunity with key networks and organizations such as the PLWHA network, Lesotho Infant Nutrition Network, Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAAL), Elisabeth Glazer Pediatric AIDS Foundation (EGPAF), Academy for Education Development (AED) and others.

MEDIUM AND LONG TERM

A) Provide financial and/or technical support to existing advocacy groups to increase awareness, knowledge and understanding among policymakers and stakeholders about the relationships among nutrition, food insecurity and HIV/AIDS.

B) Provide financial and/or technical support to scale up nutritional education and counseling as part of a preventive care package to maintain body weight, prevent food and waterborne infections, manage dietary complications of HIV-related symptoms and secondary infections, manage side effects from ART and OI medications and assure safe infant-feeding practices in health facility, community, and home-base care programs.

C) Provide financial and/or technical support to plan targeted evaluation activities on nutrition interventions in HIV/AIDS programs.

D) Since there is no Title 11 program in country, work with the WFP to analyze the determinants of HIV/AIDS and food insecurity using data from the mapping of malnutrition, food insecurity, HIV/AIDS prevalence/impact and community capacity. Determine the geographic coverage of HIV/AIDS, nutrition and food security programs in order to identify the highest-risk areas, gaps in services and appropriate strategies for linking existing programs.

E) Assist with the development, adaptation or revision (as appropriate) guidelines for nutrition care and support for HIV-positive adults and children.

F) Provide technical support for the revision and finalization (as appropriate) of the national nutrition policy to include considerations for HIV-positive adults and children and HIV-affected families.

G) Support the development, adaptation or revision (as appropriate) of SOPs to integrate nutrition interventions into HIV/AIDS prevention, care and treatment (particularly PMTCT, ART, HBC and OVC) programs.

H) Provide programmatic and technical assistance for the development of job aids and education/counseling tools (based on formative research) for use within HIV/AIDS prevention, care and treatment programs.

I) Assist with the training of clinic, community and home-based providers in the nutrition SOPs and on how to use the job aids/tools.

J) Provide technical review of local regulations related to product safety and marketing of foods, medicinal herbs and nutrition supplements and strengthen enforcement capacity (as needed) to protect PLWHAs from dangerous and/or ineffective products.

People Living with HIV/AIDS (PLWHA)

7.1 Background and Current Status

Over the past year, there has been a reported increase in the number of PLWHAs that have publicly disclosed their HIV status both within and outside emerging support groups. During this appraisal period, only two organizations were found that specifically refer to themselves as PLWHA groups. These are Positive Action and People Living Openly with HIV/AIDS (PLOHA). Positive Action is a small NGO composed of both HIV-positive and -negative members that provides a variety of services including emotional support and IGAS. PLOHA is considered the national PLWHA organization and is composed of 56 PLWHAs. PLAHO was started by one woman who publicly disclosed her HIV status in 2000. No situation analysis has been done to identify PLWHA groups in Lesotho. LAPCA indicated that they intend to start a network for all PLWHA groups . Due to limited resources, little has been done to form this network.

The PLAHO founder has spoken before international organizations such as UNAIDS and government bodies such as the Senate HIV/AIDS Committee. Working closely with the Senate HIV/AIDS Committee, the PLWHA groups assist with HIV sensitization and training of traditional leaders, much of which is focused on speaking with communities about their experience as PLWHAs, dispelling common myths and spreading prevention messages. DCI has provided a small grant enabling PLOHA to recently open a one-room office within LPPA in Maseru.

PLOHA has an agreement with the Senkatana Clinic to provide community outreach services. Through this experience, PLOHA has become concerned that the clinic provides limited services and needs strengthening in areas such as OI management and community support. PLOHA enjoys a strong relationship with a physician at the Queen Elizabeth II hospital who offers clinical services to its members. PLOHA does not have representation on key stakeholder committees or task forces.

Through their work with BMS, team leaders are paid R1000 per month, lay counselors R600, community outreach personnel R300, and buddies R200. These salaries are provided through the BMS funding (25,000 Maluti per annum) and intended only for their work with BMS. Other funds are obtained through fundraising activities (e.g., bake sales and dinner-dance events) to pay for overhead costs. The organization cannot access GFATM funds due to its stringent requirements. PLOHA has found it difficult to raise funds from donors. Positive Action, founded and run by an expatriate, has more visibility in and access to the donor community.

PLOHA enumerated a number of challenges and opportunities including: the difficulties in engaging men in HIV/AIDS prevention and care; the deep concern about a perceived increase

in depression and suicide; and an urgent plea for increased support to the country to achieve universal access to care and treatment.

In addition, a number of needs exist including the need for: (1) training for PLWHAs in a variety of areas such as public speaking, resource mobilization, etc. (2) increased quality of HTC counselors, (3) establishing a PLWHA network, (4) increased support for community support groups, (5) basic commodities (e.g., condoms and gloves), (5) education and training for communities on issues such as drug literacy and adherence counseling, (6) more technical resources, such as care for caregivers guidelines, and (7) additional skills and capacity to deal with the many issues relating to care and support of children.

7.2 New Directions and Recommendations for PLWHA support

The critical role of PLWHAs in HIV/AIDS prevention, care and support cannot be understated. The USG is well positioned to provide support in the following strategic areas:

SHORT TERM

A) Conduct a participatory rapid appraisal of PLWHA groups (formal and informal) in collaboration with PLOHA. This could be modeled after the recent PLWHA situation analysis in Swaziland.

B) Provide support to form the national PLWHA network. This could be done in a national consultation whereby the rapid appraisal would be validated and a strategy and implementation plan would be developed.

MEDIUM AND LONG TERM

A) Provide support for PLWHA training to bolster leadership and management skills. There are several emerging PLWHA training groups throughout southern Africa (South Africa in particular) that can be called upon for assistance. This may also be an opportunity for PLWHA twinning activities.

B) Provide resource materials to PLOHA including the South African PLWHA toolkit, Living in Hope (a support group manual), and other prevention, care and treatment materials

C) Support forums that build linkages among community-based support systems and national and regional PLWHA networks.

D) Assess key PLWHA policies and programs to be implemented and available resources for implementation. Identify role of the national PLWHA network in implementation.

Next Steps

1) By September 27, draft report to be shared for comment with U.S. Ambassador, CDC and USAID Regional and Headquarters (HQ) Offices, HHS and OGAC and in-country partners. Comments are to be returned by October 8th and the Report Finalized by October 15th.

2) By September 29, meet with the UN Expanded Theme Group on HIV/AIDS to brief them on appraisal findings and recommendations.

3) By October 15, US Ambassador, appraisal team members and CDC/USAID regional directors to provide a formal briefing to the US Office of the Global AIDS Coordinator.

4) By October 22nd, representatives of CDC and USAID regional offices to review budget for Lesotho and determine which activities can be initiated immediately and which will need to wait for confirmation of additional FY 2005 funding.

4) By the end of November, US Ambassador and CDC/USAID Regional Staff to meet with GoL in order to confirm USG FY 2004 support and discuss potential FY 2005 activities.

5) By the end of November, the CDC/USAID Regional offices to develop a joint USG plan of action in response to the recommendations including planning of short-term TA and identification of country technical back-stops at regional and HQ levels.

*__Note on implementation:__ The U.S. Ambassador and U.S. Embassy HIV/AIDS support staff will play a pivotal role in moving the USG team effort forward. This will be achieved through on-going dialogue and close communication with the MOHSW, NAC, LAPCA, other USG agencies (such as the Peace Corps and the Department of Defense (DOD) and community partners such as the FBOs, NGOs, PLWHA networks, and Public-Private Partnerships (PPPs).

An umbrella grant mechanism through Pact will allow activities to be expanded immediately. The CDC and USAID Regional Offices need to develop additional funding mechanisms for working with the U.S. Embassy, MOHSW and other key stakeholders that are implementing HIV/AIDS programs. Certain HR and procurement policies for non-presence countries may need clarification as programs are scaled up. Furthermore, TA could be provided predominantly through the CDC and USAID regional offices; ideally, there might be designated focal persons to provide continuity in their specific technical areas of expertise.

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ANNEX 1: SCOPE OF WORK

LESOTHO AND SWAZILAND HIV/AIDS PREVENTION, CARE, SUPPORT AND TREATMENT, RAPID APPRAISAL

United States Agency for International Development (USAID)
U.S. Center for Disease Control and Prevention (CDC)

August 10, 2004

Purpose: To inform the design of USAID and CDC - supported HIV/AIDS prevention, care, support and treatment programs in Lesotho and Swaziland and to improve performance and greater program/resource integration in addressing the HIV/AIDS pandemic.

Objectives:

- Rapid appraisal to identify the current status of HIV/AIDS prevention, care, support and treatment including strategies, available resources, and the coverage and effectiveness of ongoing and current activities undertaken by Lesotho and Swaziland government, UN supporting agencies, local and international NGOs and other private sector organizations and donors.

- Identify linkages (between national and community programs; between supporting government institutions and other sectors, non-government and private organizations) that are required for HIV/AIDS prevention, care and support, and treatment approaches for the spectrum of the population including infants to elderly to succeed.

- Identify strengths and weaknesses (policy, resources, technology) of current efforts (what is working and what is not working including geographical targeting of resources, coordinating mechanisms, and activities).

- Identify potential constraints to and opportunities for scaling up successful interventions and strategies to address constraints. Opportunities can build on and complement on-going activities in HIV/AIDS prevention, care, support, and treatment.

- Make recommendations for greater program and resource integration to support improved performance in addressing the HIV/AIDS pandemic including assistance needs. This will include the identification of technical assistance needs and resources for scaling up prevention, care, support, and treatment programs in Lesotho and Swaziland (individuals, organizations, training institutions).

- Identify the potential role that RHAP and the CDC regional office can play in support of USAID and USG's larger efforts to confront and support HIV/AIDS comprehensive prevention, care, support, and treatment based on outcomes of the rapid appraisal and existing evidence of key interventions. This will include the identification of key strategic interventions and partnerships for RHAP to consider.

- Identify potential in-country key stakeholders to play a future role in guiding USAID and CDC implementation support.

- Identify potential stakeholders and technical expertise in the region to play a future role in strengthening program.

- Provide feedback to in-country stakeholders

The appraisal will specifically look at the following aspects and linkages related to HIV/AIDS prevention, care, support, and treatment for the spectrum of the population from infants to elderly (see appendix A for details):

- HIV prevention programs and activities
- Prevention of Mother to Child Transmission of HIV/AIDS
- Care including palliative care for people living with HIV/AIDS across the spectrum of the infant and elderly population across the disease continuum[15]
- Clinical HIV Management including OI, ART, STI, etc
- HIV counseling and testing
- Referral systems and linkages for clients and families for care, treatment and prevention needs
- Orphans and other vulnerable children
- Nutrition and food security
- Traditional structures, services, and practices
- Community involvement and participation
- PLWHA involvement in prevention, care, and treatment
- Human resources and capacity
- Coordinating structures and policies
- Organizational capacity

[15] Looking at providing the key services, strengthening systems and building the policies that enable quality, holistic home-based, community-based and clinic based care across the disease continuum.

Appraisal Team Tasks

1. Refine and approve SOW. Develop appraisal tools and process. This will also include agreement on the roles and responsibilities of each team member.

2. Review literature (e.g., research, strategies and program documents) on HIV/AIDS programming (per above focus areas) in Lesotho and Swaziland. Some documents will be available for review before in country fieldwork others will only be available in country hence reviewed in country. See Appendix A for list of key documents.
3. Conduct appraisal/field work per SOW.

4. Draft document including documentation of existing strategies, coordinating mechanisms, and programmatic responses to address comprehensive HIV/AIDS prevention, care, support, and treatment per technical focal areas outlined. The review might cover programs supported by government, USAID, UN organizations and other donors or development agencies as well as national HIV/AIDS strategic plans. Document the extent to which plans include comprehensive HIV/AIDS care, treatment and prevention programs and considerations.

5. Finalize Report.

6. Develop and participate in dissemination and debriefings (in-country and other) as planned by appraisal team.

Methods

The appraisal will be based on the review of available literature and data, key informant interviews, informal focus group discussions, stakeholder meetings and project site visits.

Team Composition

Ideally each team will have a combination of technical skills per the aspects and linkages related to HIV/AIDS prevention, care and support, and treatment outlined in the objective section of this SOW. The following specific technical expertise for the spectrum of the population including infants to elderly will be essential within each team:

Clinical HIV/AIDS management and ART across disease continuum
- Prevention (including Behavior Change Communication)
- Orphans and other vulnerable children
- Palliative care
- Home based care
- Socio-economic support
- Monitoring and Evaluation
- Comprehensive HIV/AIDS strategic design
- Organizational Capacity
- PMTCT and maternal, neonatal and child health

Lesotho Team
Ms. Kendra Phillips, Director, USAID/RHAP
Ms. Celicia M. Serenata, CDC, Global AIDS Program Southern Africa
Dr. Cheryl Scott, CDC, Global AIDS Program Southern Africa
Dr. Michael Cassell, Prevention Technical Advisor, USAID/OHA
Dr. Kelello Lerotholi, Health Consultant
Ms. Sara Bowsky, Sr. Technical Officer, FHI (Team Leader)
Ms. Monica Fako, Logistical Assistance

Swaziland Team
Ms. Kendra Phillips, Director, USAID/RHAP
Dr. Melanie Duckworth, CDC, Global AIDS Program Southern Africa
Dr. Peter Salama, Principal Advisor HIV/AIDS, USAID/Africa Bureau (Team Leader)
Dr. Daniel Halperin, Prevention Technical Advisor, USAID/OHA
Ms. Julie Cory, HIV/AIDS Technical Advisor, US Embassy Swaziland
Ms. Sara Bowsky, Sr. Technical Officer, FHI
Mr. Dlamini, Logistical Assistance

Deliverables

1. Debriefings – one for local USAID/USG staff and other partners in Lesotho and Swaziland and one for USAID/Washington.
2. Final report documenting the findings. Describe how HIV/AIDS prevention, care, support, and treatment efforts are being implemented, the strengths and challenges, and recommendations for strengthening current efforts in each country. Appendices including SOW and tools used for the appraisal. The report will also identify appropriate local resources for strengthening the program and will be shared with local partners, USAID/Washington, CDC/Atlanta, USAID and CDC Southern Africa Programs and other key partners.
3. List of names, contact information and qualifications of potential in-country key stakeholders that might play a future role in guiding USAID and CDC implementation support.
4. Dissemination plan for findings/report.

Time Frame*

3 weeks in total for initial document review, travel, debriefings, drafting and finalization of the report.

August 13th: Key documents and draft tools sent to teams.

August 21-30th **Swaziland**: first day to review SOW and tools, 7 days to conduct rapid appraisal, 1-2 days for writing and in country debrief.

September 5 –14th **Lesotho**: first day to review SOW and tools, 7 days for conducting rapid appraisal, 1-2 days for writing and in country debrief.

September 24th: Final Reports disseminated.

Key Questions and Considerations

Care for positive adults and children across the disease continuum that looks at providing the key services, strengthening the systems and building the policies that enable quality, holistic home-based, community-based and clinic-based care across the disease continuum:

Services

1. Physical care for adults/children: OI prophylaxis and treatment; ART adherence support; STI treatment; pain and symptom assessment and management with non-opioids and opioids; nutrition assessment, counseling and supplementation interventions (as appropriate); linkages or access to appropriate child survival interventions for positive kids; access to clean water/hygiene; access to ITNs; process for identification and referral system for OVC programs within the care program; integration of appropriate prevention activities along the care continuum (e.g. strategies for caregivers working in the home, community, clinic – building prevention on a foundation of care); basic nursing care (including hygiene for client and home).
2. Psychological and emotional support services - including mental health care, spiritual support, substance abuse, bereavement counseling and end of life support for PLWHA, their families and caregivers (especially specific strategies for kids and caregivers)
3. Socio-economic support services: Legal support (will making, succession planning, property issues); stigma reduction; food security; economic strengthening activities e.g. IGA for PLWHA and caregivers, etc.

Systems

1. Human, financial resources and capacity to deliver family-centered, holistic care in the home, clinic and community – including support for caregivers.
2. Education and Training: pre-service, in-service and other training programs and curriculum on HIV/AIDS care for physicians, clinical officers, midwives, nurses and community health workers
3. Quality Standards in care

Policies

1. Drugs: access, regulation and prescribing privileges of nurses, midwives, clinical officers and physicians to provide and prescribe OI medications, ART and narcotic analgesics at tertiary, district and community settings.

2. Status of national policy on palliative care, hospice care or home based care (may be included in the national HIV/AIDS policy)

Palliative Care

1. National policies on palliative care
2. Status of national palliative care committee (coordination, advocacy and other palliative care activities, particularly on access to pain control for adults and children living with HIV/AIDS).
3. Status and future plans for providing and strengthening the care services, systems and policies as described above.
4. What are the activities, challenges and future plans for advancing the area of pain and symptom control in Swaziland and Lesotho?
5. Who are the country-specific leaders or champions in the area of palliative care? (and their contact information). What are their priorities? Who is assisting them?
6. Understand and address the status of Pain/symptom control, including ADL areas and opioid availability,
7. Pre and in-service training in palliative care,
8. Prescribing and dispensing privileges of all types of medications in HIV/AIDS care and treatment by physicians, nurses, nurse midwives, rural health motivators and community carers

Treatment

1. Public hospitals already doing ART if there are any. Otherwise those doing PMTCT only. Consider Mbabane Govt, Raleigh Fitkin in Manzini, and Good Shepherd in Siteki.
2. The laboratory, pharmacy, OPD, ANC, and maternity in each of those facilities
3. The central laboratory for HIV testing (which used to be in Manzini)
4. The central medical stores (which used to be in Matsapha)
5. The training institution, if any, which has done or would do ART training (? if the Institute of Health Sciences in Mbabane is involved)
6. The TB clinic or hospital (which used to be in Manzini)
7. The head of the local HIV clinicians society if there is one affiliated with the society in South Africa, or, a private practitioner (Dr. Zama Gama in Manzini is an old friend of mine and would be a good source of what is happening in the private sector if an appointment could be made)
8. Whomever in the national AIDS program is tasked to oversee PMTCT, ART
9. Potential partners for ART which those on the ground with the USG have identified to provide ART
10. It would be helpful to see any existing MOH plans, guidelines, curricula with respect to ART, PMTCT, and VCT; current support for ART, PMTCT, and ART from other donors; GFATM application if available; current Medium Term Plan, etc

ANNEX 2: ORGANIZATIONS AND INDIVIDUALS INTERVIEWED

Organization	Individuals Interviewed	Title/Position
LAPCA	M. Momaheng A. Mongoako T. Matete; T. Mohlabi; T. Mokobori	Director Chief Rehabilitation Officer Communications Officers
Parliamentary Committee on HIV/AIDS	K. Rasitapole K. Mathaba; M. Molapo; R. Nthako; S. Damanae M. Tsiilliba; N. Mphafi; S. Maphalla	Chairperson Members
Ministry of Health	M. Phooko T. Ramatlapeng N. Letsie M. Rasethuntsa	Minister of Health Director General Health Services Head Family Health Division Deputy Principal Secretary
US Embassy	K. Albrecht	Deputy Chief of Mission
UNAIDS	T. Rwabuhemba	Country Representative
Sankatana Clinic	Dr. Ntsekhe	Director
PLWHA Group	N. Matela	Director
Ministry of Health, Epidemiology	Dr. Mashologu	Epidemiologist
CHAL	P. Jankie M. Mohale A. Ntholi	Financial Manager PHC Coordinator Deputy Asst. Secretary
Care/SHARP!	G. Forrest M. Leteka	Program Director Program Manager
Senate AIDS Committee	S. Lejaha L. Makhasla M. Maluke M. Peete M. Sekhonyana; A. Mathibeli	President Vice President Clerk Senator/Principal Chief Senator
Health Lifestyles Clinic	Dr. Monyamane	Director
PSCAAL	M. Mohatla	Director
Boston University	Dr. Odin	Technical Advisor
Maseru District AIDS Task Force	L. Majoro M.. Chabeli T. Qobolo S. Makosholo	City Council PLWHA District Secretary's Office Beautiful Gate (OVC Home)
WHO	Dr. Angela Benson	Country Representative
US Embassy	June Carter Perry	US Ambassador
GoL , ST/HIV/AIDS Directorate	M. Khaebana	BCC Manager
GoL, Laboratory Services	D. Mothabeng M. Mareka Dr. L. Nteene	Lab Manager Principal Lab Technician Histopathologist
First Lady's Office		
PSI		
NGO Meeting		
Positive Action		
Department of Social Welfare		
HIV/AIDS Ministry Focal Points		
St. Joseph's Hospital		
PLWHA Support Group		
Mohale's Hoek DATF		