Government of Lesotho

National AIDS Strategic Plan

2000/2001-2003/2004

A Three-Year Rolling Plan for the National Response to the HIV/AIDS Epidemic in Lesotho

September, 2000

Table of Contents

		Page
PREAMBLE		iii
ACKNOWLEDGEMENTS		iv
LIST OF ACRONYMS		iv
BACKGROUND		
1.1	Country Setting	1
1.2	Population and Demographic Context	1
1.3	Socio-economic Context	2
1.4	Education Systems	3
1.5	Health System	4
HIV/AIDS SITUATION ANALYSIS IN LESOTHO		
2.1	Magnitude and Extent of HIV/AIDS in Lesotho	4
2.2	Driving and Restraining Forces, and Impact	8
2.3	AIDS Work in Lesotho	11
STRATEGIC DIRECTION OF NAP 2000 – 2003		
3.1	Vision	14
3.2	Mission Statement	15
3.3	Cherished Values	15

3.4 Target, Stakeholders and Vulnerable Groups 17

3.5 Strategic Aims 18

STRATEGIC ACTION PLAN

4.1 Introduction 19

4.2 Strategic Objectives 19

4.2 Action Plan 2000 – 2003 21

4.3 Implementation Schedule 33

4.4 Strategic Budget 42

MEASURES OF PLAN IMPLEMENTATION

5.1 Strategic Assumptions 46

5.2 Monitoring and Evaluation of Plan 47

5.3 Multi-Sectoral Structure 48

5.4 Development of Mini AIDS Action Plans 53

5.5 Process and Time table 54

List of References

Annexure: Problem Structure Analysis of HIV Transmission

i

PREAMBLE

The preparation of this HIV/AIDS Policy and Strategic Plan was done in two phases. In the first phase, Government of Lesotho (GOL) with the technical assistance of the Institute of Development Management (IDM), prepared the initial draft Policy and Strategic Plan for the HIV/AIDS control. Consultations were undertaken with different ministries and other relevant stakeholders including NGOs. These ministries and other stakeholders were then requested to submit their plans in line with the Strategic Plan. The documents were received from a select number of these stakeholders, and reviewed. Further input was made at a Consensus Workshop held on 3-4 July, 2000.

It then became necessary to finalise the review of the documentation with a view of consolidating and integrating them into the plan for presentation to Cabinet. This constituted phase two of the process. GOL then commissioned an independent Consultant under the supervision of the chairperson of the HIV/AIDS Core Group. The **Terms of Reference** for this consultancy were to:

- Synthesize the minutes prepared by the rapporteurs into one document;
- Review both the policy and strategic plan and update them in line with bullet one;
- Review the individual ministry and NGO submissions and integrate them into the plan;
- Make topographic and semantic modifications to the documentations to make them more user friendly;
- Obtain approval of the updated documents from the Core Group;
- Submit the final documents to the chairperson of the Core Group, on diskette and hard copies, for final submission to the Government.

ACKNOWLEDGEMENTS

The preparation of this plan was coordinated and supervised by an HIV/AIDS Core Group chaired by the Ministry of Health and Social Welfare (MOHSW).

The initial draft was undertaken with the technical assistance of the Institute of Development Management (IDM). The IDM consultant was Dr. Stanley Buckens.

Consultations were undertaken with a whole range of relevant stakeholders whose contributions have enriched and enhanced the quality of the final product. These included government ministries, NGOs, the business sector, ecumenical and other interest groups, as well as PLWHAS.

All the documentation from the Consensus Workshop was reviewed, synthesized and integrated into the final product submitted to Cabinet for approval by Mr. Caleb Nchafatso Sello, an independent Consultant.

The UN Theme Group made this plan possible through its technical and financial support.

GOL is appreciative and thankful for all the support, collaboration and encouragement given by those we have acknowledged as well as to many others whose names have not been mentioned.

LIST OF ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ANC	Ante Natal Care
BOS	Bureau of Statistics
CHAL	Christian Health Association of Lesotho
CHW	Community Health Worker
CORPs	Community Organized Resource Persons
GOL	Government of Lesotho
HBC	Home Based Care
HSA	Health Service Area
HIV	Human Immunodeficiency Virus
IEC	Information, Education, Communication
KABP	Knowledge Attitude Behaviour and Practice
LAPCA	Lesotho AIDS Programme Coordinating Authority
LCE	Lesotho College of Education
NAP	National AIDS Programme
NGO	Non-Governmental Organisation
LHWP	Lesotho Highlands Water Authority
MIS	Management Information Systems
MOHSW	Ministry of Health and Social Welfare
MTCT	Mother To Child Transmission
NTTC	National Teacher Training College
PHC	Primary Health Care

PLWHA	People Living with HIV/AIDS
RSA	Republic of South Africa
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAC	Technical AIDS Committee
TB	Tuberculosis
TBA	Traditional Birth Attendant
VHW	Village Health Worker
WHO	World Health Organisation

1. BACKGROUND

1.1 Country Setting

The Kingdom of Lesotho is situated in the Southern region of Africa. It is surrounded by the Republic of South Africa and lies between 27 and 30 degrees east and between 28 and 30 degrees south. The area of Lesotho is approximately 30 350 square kilometers.

Lesotho is referred to as the Kingdom in the Sky, because of its high altitude which is in excess of 1 500 meters above the sea level, the highest part in the east reaching about 3 500 meters above sea level. Mountains cover the majority of Lesotho's terrain, approximately 59%.

The Maluti Mountains consist of basalt rock with relatively fertile but thin layers of soil on the steep slopes. The low lands have clay and loam soil, and sandy soil is usually found on the riverbanks. Lesotho has a temperate climate with clearly defined seasons viz. summer, autumn, winter and spring. During the day, temperatures range from below 0 degrees Celsius in winter to about 30 degrees Celsius in summer.

1.2 Population and Demographic Context

Lesotho's population, with a growth rate of 2% per year, has been reliably estimated to be 2.1 million in 1999. Based on a low growth variant scenario, the Lesotho population is projected to reach 3.3 million in the year 2026.

The population distribution in Lesotho is determined by ecological, economic and administrative factors. The resultant pattern of population settlement is greatly favouring the lowlands, as is illustrated in table 1.

Table I. Percentage Distribution by Population, Zone and Surface Area

Zone	Surface Area Population
Lowlands	17% 58.6%
Foothills	15% 12.4%
Mountains	59% 22.8%
Senqu River Valley	9% 6.2%

Source: *Lesotho Population Census 1996, BOS*

The national average density is 61 persons per square kilometer. However, the arable land density stands at 588 persons per square kilometer.

Lesotho has a young population structure. According to the 1996 census, 39.2% of the population is 15 years of age, with a male/female sex ratio of 96/100. This means that in 2001, under low growth assumptions, Lesotho will have 853 887 persons (39.2%) below 15 years of age, 1 078 673 (49.6%) persons within the productive age group of 15-49 years of age, and 240 608 (11%) persons above 50 years of age.
Both internal and external migration is a striking characteristic of the population of Lesotho. Labour migration to South Africa is predominantly undertaken by the uneducated male workers, whilst women are mainly involved in internal migration for reasons of marriage and employment. In this regard, migration in Lesotho is age, education, skill and sex selective. Internal migration is dominated by young females between 15-29 years of age, being better educated than their male age mates, they are more readily absorbed in the local labour market.

The 1996 census established the expectation of life at birth to be 59 and 60 years of age for males and females respectively.

It is expected that there will be a rapid down turn in life expectancy as more people in the productive age group are infected by the HIV/AIDS virus and will eventually die. It will have a negative effect on the dependency ratio and the general life expectancy in the nation.

Other demographic variables besides labour migration, such as a high unemployment rate of 35%, an unacceptably high illiteracy rate of 22%, and the ever growing numbers of rural-to-urban migrants, resulting in a rapid urbanization (17%) are deemed to be major contributory factors underlying the rapid spread of the HIV/AIDS epidemic in Lesotho.

1.3 Socio-Economic Context

Economic growth in Lesotho in recent years, received a boost from the construction sub-sector, spearheaded by the Lesotho Highlands Water Project (LHWP), and the rapidly expanding export-oriented manufacturing sub-sector; the growth potential of the agricultural sub-sector is, however, limited due to scarcity of arable land, adverse weather conditions, serious soil erosion and a poor land tenure system.

It is estimated that half of the population of Lesotho lives below the poverty line, with 54% of the rural households being poor and 29% ultra poor. The poorest families are in the highlands, but urban poverty is also on the increase. The gross national per capita income is M3 133 or USD570. Furthermore, income distribution is extremely skewed with the top 10% of the households receiving 44% of the national income, whilst the poorest 40% have to be satisfied with only 8% of the annual national cake.

For long Lesotho's economy has been characterized by a high degree of labour migration to the Republic of South Africa (RSA). This trend has been gradually decreasing from 40% in 1986, to 25% in 1996, and to an estimated 15% of the male labour force in 2001,

due to retrenchment, internalization of labour and awarding citizenship to Basotho miners in the RSA.

Politically Lesotho has embraced democratic principles of governance, and is determined to come to grips with the tenacious determinants of the 1998 political crisis, as well as with the immediate and long-term impact of the crisis.

Lesotho has made giant strides forward in investing in an educated and healthy human resource base. However, 23% of school-age children are not in school, an estimated 40 000 children are taught in the open air; the average pupil/classroom ratio is 67:1; 23% of teachers are not qualified, and only 26% of boys and 48% of girls complete primary schools, whilst 22% of the Basotho population is illiterate.

Women in Lesotho are more educated than men. At all educational institutions, female enrolment exceeds that of males, although women's legal status is still a major issue for Basotho women, but change is coming slowly. This may change as the Law Reform Commission has completed a document on upgrading the legal status of women.

1.4 Lesotho's Education System

Lesotho's Education was historically missionary initiated and expanded as early as 1830s with countrywide distribution; initially both boys and girls took advantage of education in Lesotho. Issues of access to education are different in Lesotho from many other developing economies. Females in Lesotho have greater advantage of educational opportunities and facilities, as compared to their male counterparts.

The literacy level in Lesotho is estimated at 82%, out of which 50% is male and 70% is female.

Primary Schools

There are 1,289 Primary Schools throughout Lesotho according to 1999 Statistics data sheet. There were 178,481 boys enrolled in Primary Schools as against 196,147 girls. The females represent 52% of the total primary level school population and males accounted for 48%.

Secondary and High Schools

There are 206 Secondary Schools and High Schools and the total enrolment of Secondary and High School levels for males was 27,742 (41%) and for females 39,712 (69%). The enrolment in Secondary and High schools is predominantly female.

Vocational, Tertiary and other Learning Institutions

In Lesotho there are 5 Tertiary and 6 Vocational Institutions, and one University. Enrolment is still predominantly more female than male.

1.5 Lesotho Health System

In Lesotho the health care delivery is at four levels viz. the Central level, Health Service Area (HSA) level, Health Centre level and Community level.

Centrally there are 6 departments which are stipulated as follows: Primary Health Care (PHC), Laboratory Services, Nursing Services, Mental Health Services, Pharmacy Department and Social Welfare Services.

A Health Service Area is a delineated geographical area with a hospital as a focus, supervising several satellite Health Centres and Clinics. There are several health centres located at the periphery, with visiting medical practitioners based at the mother hospital (HSA). At the community level, there are the Village Health Workers and Traditional Birth Attendants, and Community Health Workers.

All in all, there are 18 Health Service Areas and 160 Health Centres of which 52% are government owned and 48% are managed by the Christian Health Association of Lesotho (CHAL) and other NGOs. Lesotho has adopted the PHC strategy. Hence, all structures operate in a form of multisectorality.

HIV/AIDS SITUATION ANALYSIS IN LESOTHO

2.1 Magnitude and Extent of HIV/AIDS in Lesotho

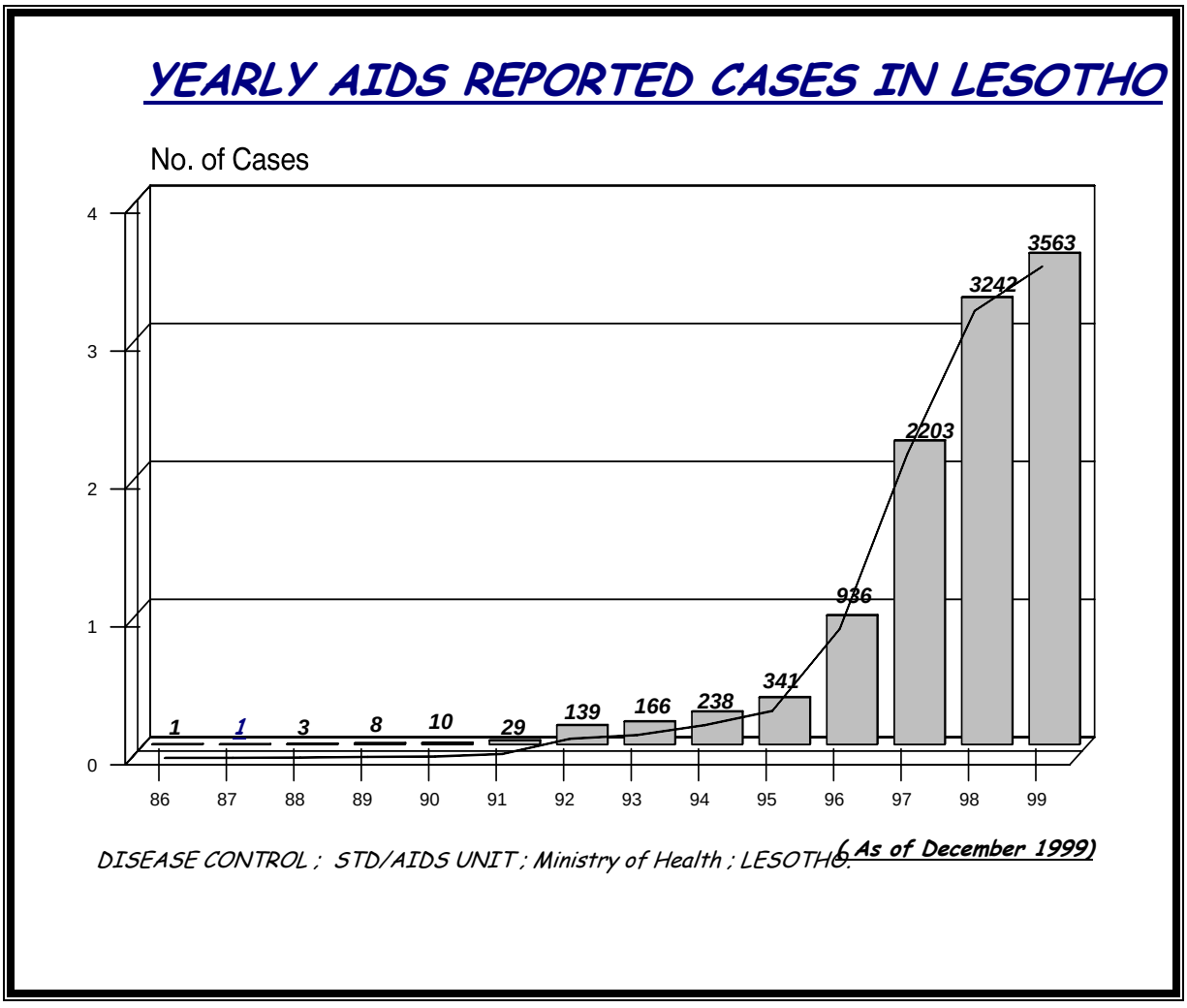
The first case of AIDS in the Kingdom of Lesotho was reported in 1986. Since that time the disease has spread rapidly throughout the Lesotho population. By December 1999, the Ministry of Health had reported 10,880 cases of full-blown AIDS. It is estimated that these reported cases represent less than a quarter of AIDS cases that occurred in the country.

A sentinel surveillance carried out in five sites, Maseru, Mafeteng, Leribe, Quthing and Maluti observed that over the years, there has been a steady upward trend in the proportion of individuals testing HIV positive among pregnant women aged 20-24 years of age. This situation is the same in all five-sentinel sites of the country. The sero prevalence has risen from 3.9% in 1992 to 26% in 1996.

HIV prevalence among the Ante Natal Care (ANC) and Sexually Transmitted Infections (STI) clinic attendants has increased overtime in all sentinel sites below. From a range of 4.8% - 7.1% in 1991 to a range of 34.9% - 63.5% among STI attendants while for ANC it has increased from a range of 0.7% -5.5 % in 1991 to 15.8% to 34.8% in 1996.

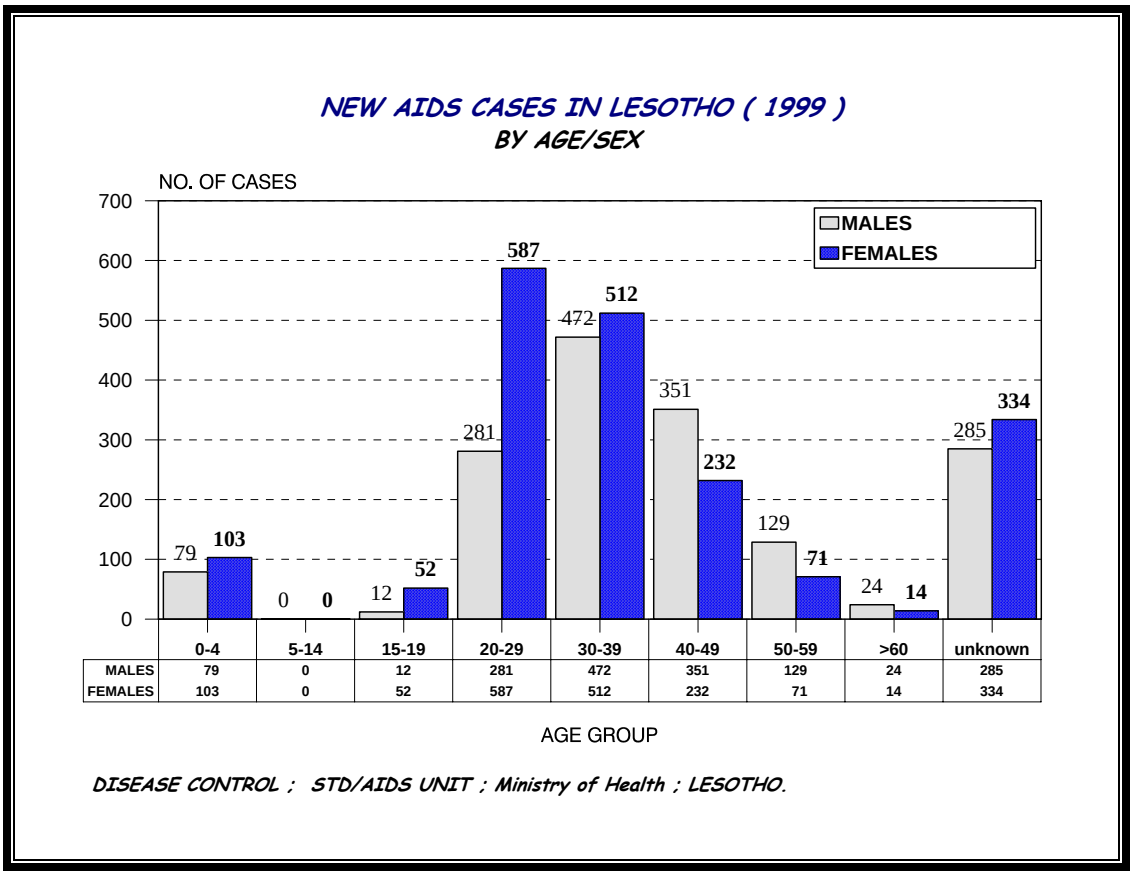
To further illustrate the high prevalence of HIV, the HIV - sero positive rate Tuberculosis (TB) patients in Maseru rose from 11.3% in 1992 to 49.7% in 1996. Similar trends have been observed in other areas of Lesotho.

It was estimated by the World Health Organization (WHO) jointly with the United Nations Programme on HIV/AIDS (UNAIDS) that there were 40 000 adult Basotho aged 15 to 49 living with HIV/AIDS in 1994; this had increased to 79 000 by 1997, 92,000 by 1998 and 101,000 by 1999, representing a sero-prevalence of 11.5% of all adults of this age cohort.



The rate of HIV infection in sexually active adults continues to rise explosively. It is clear that population mobility, patterns of sexual behaviour, and other negative social factors contribute to more than doubling every two years of newly reported AIDS cases.

As HIV rates rise in the general population, new infections are increasingly concentrated in the young age groups. Female AIDS cases is much higher than the male cases in this age group. It is, however, noted that the rate of progression from HIV infection to full-blown AIDS is faster in women than men.

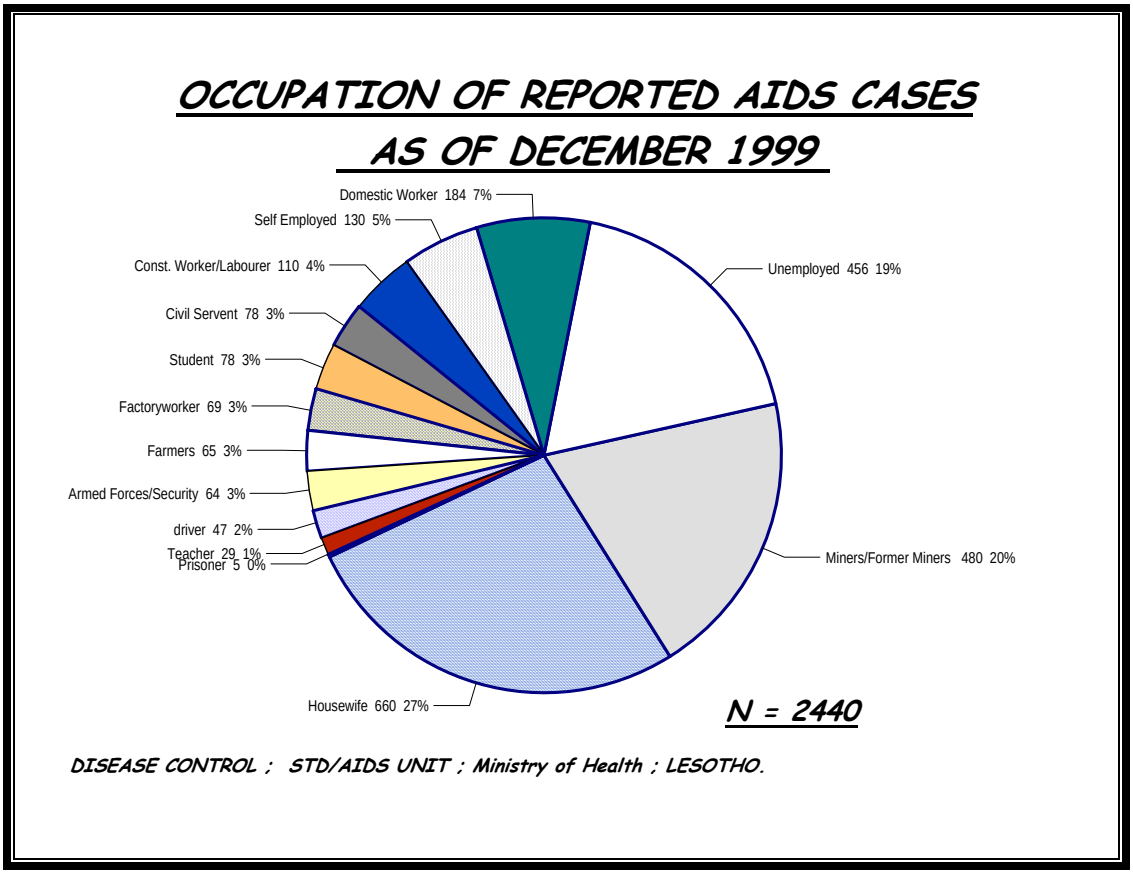


The reluctance of the older and more traditional Basotho to discuss sex and sexuality exacerbates the difficulty of reaching the youth through such formal channels as the public health system, churches or schools. Effective mechanisms are still lacking within these institutions to inform and encourage sexual behaviour changes among Basotho youths.

Most of the HIV infections in 15 to 19 years old are in females. Apart from possible biological factors, there are at least two reasons for the disproportionate risk of young women of acquiring HIV infection early, including an early age of sex debut for girls; and patterns of sexual mixing, where young women tend to have sex with older men in the context of marriage or in exchange for money or advantages, where young men tend to have sex with young women. These high rates of HIV infection in young men and

women call for robust prevention measures among the youth before the onset of sexual activity

Of all AIDS cases in Lesotho so far, 45.1% were male and 54% were female. Of those who reported their marital status, 69.5% were married, 16.6% single, 7.5% separated, 5.4% widowed and 1.1% divorced. This indicates for many women, that promiscuous behaviour of their sexual partners constitutes a major risk factor for contracting HIV infection



The risk for HIV infection in AIDS cases in Lesotho can almost invariably be traced back to patients having had a history of multiple sex partners and a history of sexually transmitted diseases, where only a small fraction had a history of blood transfusion.

The risk transcends urban-rural divides, rich or poor, skilled and unskilled, mountains and lowlands; the data on the advance of the epidemic convincingly indicate that every Mosotho is at risk

2.2 DRIVING AND RESTRAINING FORCES, AND IMPACT

2.2.1 Driving Forces:

Forces in the Lesotho society, which drive the advance of the HIV infection, are generally associated with cultural, traditional, behavioural, economic, technical and biological factors. For details, see the causality analysis in the back of this document.

Cultural practices such as wife inheritance, polygamy and the cultural mistress are more likely to expose partners to contracting the virus. Moreover, the breakdown of cultural and religions codes of conduct, fidelity and no-sex-before-marriage are further enhancing the spread of HIV/AIDS. A culture of silence about sex does also positively contribute to the advance of the disease.

Traditional medicine/practices such as scarifications, ritual shaving at funerals and mass circumsition in traditional schools, if practiced without the necessary precautions, may be occasions for transmission of the infection.

Biological factors such as the physiology/anatomy of women, blood transfusion, mother to child transmission (MTCT) activity, also contribute to the rapid advance of the epidemic.

The most contributory factors to the rapid spread of the disease is undoubtedly unprotected sex, promiscuity, denial and ignorance, as well as the polygamous behaviour of men, sex with multiple partners, the commercial sex industry generally, and early adolescent sex debut, rape, confidentiality, cross border migration and substance abuse.

The contribution of unemployment to poverty has lead to people seeking other means of survival such as commercial sex work, which place them at high risk of contracting HIV/AIDS.

2.2.2 Restraining Forces:

There are also a number of moral, religious, socio-economic and educational, political as well as behavioural forces, which could be strengthened and/or resuscitated to the advantage of prevention and control of the HIV infection.

Reinstitution of moral values such as faithfulness to one's partner, fidelity, virginity and no-sex-before-marriage, as well as religious principles would go a long way in combating the epidemic. It implies a re-instatement of the link between sex, procreation and the

institution of marriage. It calls for a renaissance of traditional values of fidelity and abstinence.

Prevention and control of HIV/AIDS pandemic postulates socio-economic progress in terms of employment for all, recreational opportunities and challenges for the youth, the availability of up-to-date and relevant information on reproductive health and family life education, as well as universal accessibility to and availability of condoms and other methods of safer sex.

Furthermore, there are a number of income generating programmes within ministries and non-governmental organisations (NGOs) that empower people to avoid activities that would lead them to HIV/AIDS.

Also, life skills programmes empower children, youth and adults to realise their human rights and develop skills to avoid risky behaviours of contracting HIV/AIDS.

These and other restraining forces have the potential to make people focus their energy positively and avoid the trap of the epidemic.

2.2.3 Effects and Impact:

The HIV/AIDS crisis has devastating effects on individuals, families, communities, nations, regions and globally. The effects of HIV/AIDS have eroded gains made by social services.

2.2.3.1 Impact of HIV/AIDS on People Living with HIV/AIDS (PLWHAs)

In many localities in Lesotho, people living with AIDS are stigmatized and they experience some form of discrimination. This stigma is even extended to the family members, friends, caretakers and contacts of people living with HIV/AIDS. It is also associated with misconceptions about how HIV/AIDS is acquired. The consequences of such stigma include, but are not limited to an increased burden and suffering among those living with AIDS, a reluctance of individuals to know their HIV status, delay in seeking health care, and delays by communities to respond to HIV/AIDS prevention.

As their health deteriorates, people living with HIV/AIDS lose income because they are unable to work regularly. In the course of treating associated opportunistic infections using folk remedies presumed to cure AIDS, they are reduced to a state of poverty. It is not uncommon for people with HIV/AIDS to be abandoned by their relatives and/or expelled from the family, and left in complete destitution. Some of the psychological consequences experienced include loss of self-esteem, grief, demoralisation and a feeling of rejection.

2.2.3.2 The Impact of HIV/AIDS on Children and Orphans

The adverse impact of HIV/AIDS on child survival is evident in most of the 30 to 40 percent of babies who become infected with HIV will develop AIDS and die within two years. Few survive past the age of five. Many children have been and are being orphaned by HIV/AIDS. These children are often turned away by extended families and have no place to live. Several NGOS care for both HIV infected children and orphans but the need is much greater than the available services.

A recent UNICEF survey estimated that Lesotho currently has 117,000 AIDS orphans. Where are all these children? Who is caring for them? NGOs report that many of these children are living alone or being taken in by elderly women, grand mothers, aunts and neighbours. Many of these children are not going to school, do not receive adequate medical care and are not being fed nutritious food. The long-term impact will be devastating if Lesotho does not plan for and care for these children.

2.2.3.3 Impact of HIV/AIDS on Families

Since AIDS primarily affects adults between the ages 20 - 49, it is likely to affect the most productive members of the family and the impact of HIV/AIDS is more rapidly visible, more worrying on households, specifically when the person affected by the diseases is the family income generator. Drop in family revenue is affecting all.

The impact of the disease on the household varies according to the level of income and the state of the disease.

In addition to the above, there will be problems in meeting the basic needs, the composition of the households will change as some households will be headed by children. Due to loss of income and death of parents, some children will withdraw from school. Therefore, the main impact on households could be summarised as:

- problems in meeting basic needs;
- changes in household structure and composition;
- withdrawal of children from school;
- fear of stigma and exclusion;
- worries about the future for their children.

The cost of a prolonged illness include additional expenditures on health, transport and other needs related to care for the sick that otherwise will have been spent on education fees for children, food or productive investment.

2.2.3.4 The Impact of HIV/AIDS on the Economy in general

It is difficult to establish a direct relationship between the HIV/AIDS epidemic and future economic growth because of the multitude of other intervening factors. Given that AIDS

will disproportionately affect the working age population, the quantity and quality of the labour force will be negatively affected. The cost of overall production is likely to increase. An indirect effect on all sectors is the drop in consumer spending as the economic effects of AIDS spreads throughout society.

2.2.3.5 Impact of HIV/AIDS on Agriculture

AIDS in Lesotho is wiping out gains made in progress and development. HIV and AIDS result in and enhance poverty as breadwinners die, and family resources are rapidly consumed to care for the sick and the dying. It affects food security as tillers of the land are no longer there to grow food crops, or are too feeble to toil on the land.

2.2.3.6 Impact of HIV/AIDS on Health Sector

The impact of HIV/AIDS on the health sector in Lesotho continues to be of much concern given the consequent astronomical costs it will have to bear. One of the intents of decentralization in the context of health sector reform is to increase communities' access to health through the transfer of services and applicable resources from tertiary health facilities to primary health facilities such as rural health centres.

Available information on health seeking behaviour suggests that people continue to bypass the primary level health facilities and go to secondary and tertiary level facilities, in contradiction to the expected outcomes of the reform process. Therefore, the main burden of providing care still falls on hospitals, and on the families themselves. Another aspect of impact on the health sector is the trend of rising mortality rates among health workers.

The cost of training the service providers is not recovered as they are being affected by HIV/AIDS and the service delivery for people including those of HIV/AIDS is compromised.

2.3 AIDS Work in Lesotho

The main accomplishment of AIDS Work in Lesotho has been a joint effort between Government of Lesotho (GOL) and Non Governmental Organization and UN theme group, especially in the area of residential care and support of orphans and HIV infected children. Success has been booked in the following approaches:

Information, Education and Communication (IEC) and Advocacy

High awareness and knowledge on HIV/AIDS through:

- Peer Education
- Women Groups
- Men Groups

    - Cultural Groups
    - Drama and Song Groups
- Material Production
- Condom social marketing
- Ministry of Education pilot schools and Lesotho College of Education (LCE), formally known as NTTC.

Counselling

- Provision of mass counselling
- Training of different cadres in basic counselling services
- Counselling services provided in all health services, areas

Home Based Care (HBC) Services

- Availability of service providers trained in Home Based Care.
- Families and carers trained on care and support
- Availability of support groups
- High awareness on orphan care
- High awareness on income generating projects.

Surveillance and Laboratory Services

- HIV/AIDS sentinel surveillance system with a view to measuring the magnitude of the diseases and monitor trends.
- Sustained screening of blood and blood products for HIV/AIDS
- Procurement of equipment and reagents for HIV/AIDS testing sustained
- During the period several Knowledge, Attitude, Behaviour and Practice (KABP) studies have been conducted.

Multi-sectoral

- Availability of Ministers and Principal Secretaries Task Force on HIV/AIDS
- HIV/AIDS focal points in all government ministries, NGOs and Private Sectors established.
- Presence of HIV/AIDS service organizations
- Existing youth anti AIDS Organizations and Clubs.
- Community Mobilizations.
- Prime Ministers campaigns on HIV/AIDS
- AIDS Commemoration days
- Dramas, songs and walks against AIDS

Constraints and Weaknesses

Despite the modest gains made in the efforts to control HIV/AIDS/STIs in the country, the major weaknesses and constraints of the struggle, needing urgent attention, are:

- Lack of clear policy
- Lack of strategic planning
- Inadequate commitment to a unified visionary strategy
- No clear coordination mechanism
- Problems of attraction, training and retention of highly skilled professionals in AIDS Work in Lesotho
- Lack of multi-skilled central level trainers to conduct Training of Trainers (TOT) and other training.
- Inadequate counsellors and facilities
- Inadequate monitoring and evaluation of HIV/AIDS programmes in Lesotho
- Lack of baseline data on Lesotho KABP towards HIV/AIDS
- Limited change in positive sexual behaviour
- Inconsistent and inadequate supplies including condoms
- Silence about the epidemic due to denial
- Lack of voluntary testing sites

3. STRATEGIC DIRECTION OF AIDS WORK IN LESOTHO

Introduction

The strategic direction describes what Lesotho intends to achieve in the next three years in curbing the epidemic. This is accomplished by formulating an explicit vision viz. of an AIDS free society.

Lesotho's determined effort will be guided by a set of inspiring values cherished by all stakeholders. This paragraph also explicitly states the targets, stakeholders and most vulnerable groups in society, towards whom all efforts are to be directed.

The strategic direction furthermore, outlines the developmental end results envisaged by the programme. Thus, whilst the ultimate impact is contained in the mission statement, the medium-term desired results are stated in the strategic aims.

These strategic aims are the end of the programme results that NAP strives to achieve in the coming two to three years in Lesotho. The action plan, in the next paragraph, contains the concrete strategies and activities to achieve these aims.

3.1 VISION

The vision of the Lesotho National AIDS Programme (LNAP) is an HIV/AIDS free society, with high levels of awareness, behavioural change, safe blood supply, safe sex practices and equitable access to quality care and support for both the infected and the affected.

3.2 MISSION STATEMENT

The National AIDS Programme aims at controlling the spread of HIV/AIDS in Lesotho and mitigating its impact on all vulnerable groups, individuals, families, communities and the nation at large.

To this end NAP is mandated to spearhead and coordinate all HIV/AIDS prevention, support and care activities in Lesotho in collaboration with local and International partners to realise an HIV/AIDS free society.

National Aids Programme targets every Mosotho, especially the youth and the most vulnerable groups and individuals, with accessible, quality information and education with a view to changing attitudes and sexual behaviour, resulting in a decrease of the occurrence of HIV/AIDS.

Furthermore, the programme in collaboration with its partners is wholly committed to promoting counseling, support and compassionate care services for people living with HIV/AIDS, affected families and orphans.

3.3 CHERISHED VALUES
Guiding the NAP:

- Commitment of all national stakeholders
- Accountability to the nation
- Transparency at all levels
- Effective communication among all sectors
- Empowerment and involvement of all stakeholders in decision-making processes
- Culture sensitivity
- Network and exchanging experiences.

Guiding the Service Providers:

- Non-discriminatory
- Professionalism
- High quality services and care
- Accessibility of service to all
- Confidentiality of patients
- Innovativeness

Towards PLWHAs:

- Mutual Trust and Openness
- Quality Compassionate Care
- Interpersonal interaction
- Empowerment and engagement

3.4 Target, Stakeholder and Vulnerable Groups

TARGET GROUPS	STAKE HOLDERS	MOST VULNERABLE GROUPS
a) Children b) Youth c) Women d) Elderly women e) Orphans f) PLWHAs g) People who have not been tested h) Men i) Traditional Healers and Leaders j) Church Leaders k) Homosexuals l) Drug Abusers m) Migrant Labour/Long distant Truck drivers n) Expectant and Breastfeeding mothers o) Elderly p) Street Children q) Care takers r) Security Forces	a) UN Theme Group b) Bilateral agencies c) Traditional healers d) Community Organised Resource Persons (Corps) e) Women, Men and youth groups f) Council of Men g) Churches h) Professional groups/associations i) Business community j) Parent associations k) NGOs	a) Children b) Youth c) Women of reproductive age d) Commercial Sex Workers e) Domestic Workers f) Men g) Herdboys h) Disempowered people i) Orphans

3.5 STRATEGIC AIMS

HIV/AIDS sero-prevalence reduced by 5% by March 2003.

Rate of delayed sexual activities by adolescents (10 - 15 years) increased by 30% by March 2003.

Condom usage increased by 50% per annum.

100% coverage of graded PLWHAs through support, counseling and care by March 2003.

50% of orphans, due to AIDS, cared for by March 2003.

Spread of HIV/AIDS among 15 -49 years of age reduced from present 10% per annum to 5% by March 2003.

Positive attitudinal and behavioural change to multiple sexual partners increased by 5% by March 2003.

Gender sensitive policy in place by December 2000 and enacted by 2003

Baseline study/update survey conducted by December 2001

4. STRATEGIC ACTION PLAN

4.1 Introduction

The findings in the situation analysis have guided the design of the national response to the relentlessly spreading epidemic, as defined in this plan. The strategies favoured reflect the major concerns in the nation as the struggle against AIDS moves into the new Millennium. They focus on a concerted effort of all partners in Lesotho to coordinate the struggle through adherence to common policies, an effective multi- sectoral organization, common vision, mission and strategy, and the mobilization of adequate human, financial and material resources.

The Lesotho national response to HIV/AIDS prevention and care in the next three years will focus on nine strategic objectives:

Strategic Objectives
1. **To establish structures for the effective coordination of the multi-sectoral Programme** 2. **To mobilize adequate resources for the National AIDS Programme** 3. **To significantly strengthen the information, education and communication programmes** 4. **To provide support to the infected and affected with a view to significantly mitigating the impact of the epidemic** 5. **To involve the youth in all AIDS programmes** 6. **To drastically reduce the high rate of STDs** 7. **To intensify surveillance of and testing HIV/AIDS** 8. **To regularly monitor and periodically evaluate NAP** 9. **To conduct baseline study/update information on stated strategic aims.**

The action plan on the following pages contains the strategies, indicators of achievement, important assumptions, as well as time schedules and financial resource requirements.

4.2 National AIDS Strategic Action Plan 2000-2003

Logical Framework

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
Outputs (Strategic Objectives) **1.** To establish structures for the effective coordination of the multi-sectoral National AIDS Programme in Lesotho.	**1.1** The multi-sectoral structure for the fight against AIDS adopted and implemented by Government of Lesotho by September 2000	**1.1.1** Progress report on operations of multi-sectoral structure	**1.1.1.1** All stakeholders are Committed **1.1.1.2** Availability of Budgets **1.1.1.3** Relevant personnel and expertise available **1.1.1.4** Funds are not Embezzled
	1.2 Operational district HIV/AIDS structures formulated and implemented at all districts by December 2000	**1.2.1**Gazetted NAC **1.2.2** Positions of LAPCA created and filled **1.2.3** Progress report On operations of multi sectoral structure **1.2.4** NAC and District stakeholders' progress report	**1.2.1.1** Commitment by political, Religious and Traditional leaders as well as the Community in general **1.2.1.2** Funds available
	1.3 Support, collaboration and coordination between HIV/AIDS programmes and support groups established by January 2001	**1.3.1** Minutes and progress report **1.3.2** Directory of HIV/AIDS services documented	**1.3.1.1** HIV/ AIDS programmes and support groups Operational **1.3.1.2** Availability of funds.
	1.4 Social structures for youth jointly coordinated by MEGYA, Ministry of Sports and Tourism, MOH & SW, MOE, MHA and Theatre Groups by September 2000	**1.4.1** Consolidated plans **1.4.2** Minutes of meetings	**1.4.1.1** Availability of funds **1.4.1.2** Government remains commitment to youth activities

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
2. To mobilize adequate Resources for the National AIDS Programme (Ministry of Finance, Ministry of Development Planning, Ministry of Public Service, NAP, Donor Community)	**2.1** A survey of all existing resources in AIDS work in Lesotho conducted nation wide From Sept - Oct 2000	**2.1.1** Submitted survey report	**2.1.1.1** All AIDS programmes Cooperate **2.1.1.2** Availability of funds **2.1.1.3** Capacity is available
	2.2 Potential sources of funding for AIDS Programmes in Lesotho identified between Sept – Oct 2000	**2.2.1** Catalogue of potential sources	
	2.3 Resource Mobilization Plan formulated by the LAPCA by November 2000	**2.3.1** The resource mobilization plan	**2.3.1.1** The proposed multi-sectoral structure is approved and operational
	2.4 Project Proposals for AIDS Programme funding submitted through NAC on November annual basis	**2.4.1** Submitted project proposals	**2.4.1.1** AIDS programmes have capacity in proposal writing
	2.5 A fund for training staff in HIV/AIDS in Lesotho lobbied for with a view of incorporation in the Governmental annual budget by November, annually	**2.5.1** The annual Government budget	**2.5.1.1** Government remains Committed to NAP
	2.6 2% of NAPs budget generated on an annual basis through fundraising activities locally	**2.6.1** NAP's accounts	**2.6.1.1** Public cooperates with NAP
	2.7 Hold regular meetings with resident donors to solicit their support in HIV/AIDS related issues by 2001	**2.7.1** Minutes of the meetings **2.7.2** Public Sector Investment Programme	**2.7.1.1** Commitment from donor□s forthcoming
	2.8 Incentives given to the private sector to contribute	**2.8.1** Finance circulars **2.8.2** Legislation in place	**2.8.1.1** Private sector willing to cooperate

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
3. To significantly strengthen the information education and communication (IEC) programmes for social mobilisation and advocacy in Lesotho	**3.1** Needs assessment for IEC messages for various target groups conducted by June 2001	**3.1.1** Needs assessment report	**3.1.1.1** Availability of funds **3.1.1.2** Availability of expertise
	3.2 20 trained Health Educators recruited, deployed, followed up and supported in Lesotho by December 2001 - Reports written and followed up	**3.2.1** Establishment list **3.2.2** Nominal Roll for agencies	**3.2.1.1** Availability of funding
	3.3 Culturally sensitive IEC material for different groups developed, pretested and mass produced by June 2001	**3.3.1** Availability of materials **3.3.2** Baseline material available by March 2001	**3.3.1.1** Availability of funds
	3.4 IEC material distribution plan formulated by March 2001	**3.4.1** Distribution plan **3.4.2** Distribution mechanism in place	
	3.5 Television and radio air-time slot for HIV/AIDS increased to at least 3 times a week for 15 minutes by August 2000	**3.5.1** Monitoring TV and radio programmes	**3.5.1.1** Commitment from the Radio and TV staff/Management
	3.6 Continuous relay of HIV/AIDS messages throughout the plan period	**3.6.1** Records of the events	**3.6.1.1** Expertise and funds available **3.6.1.2** Availability of infrastructure
	3.7 Public gatherings used as a means of disseminating HIV/AIDS Information at all levels throughout the planned period	**3.7.1** Number of public Gatherings held	**3.7.1.1** Commitment of chiefs, Political and other Community leaders
	3.8 Research data (National, Regional and International) relating to HIV/AIDS and safe sex compiled and distributed to stakeholders quarterly.	**3.8.1** Availability of Research report	**3.8.1.1** Reporting system improved **3.8.1.2** Expertise for compiling
	3.9 Training manuals and	**3.9.1** Manuals and	**3.9.1.1** Funds available

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
	guidelines for use by health educators drawn and used by December 2000	guidelines	
	3.10 Mass education on voluntary counselling, foster care, half way homes orphanages and testing commenced by August 2001	**3.10.1** Progress report on number of sessions and workshop	**3.10.1.1** Availability of funds and expertise
	3.11 Educational program on parent to child expanded and sustained throughout the planned period	**3.11.1** Progress report **3.11.2** Availability of infrastructure	**3.11.1.1** Expertise and funds available
	3.12 HIV/AIDS peer education improved throughout plan period	**3.12.1** Youth newsletter **3.12.2** Educational movies	**3.12.1.1** Fund are available **3.12.1.2** Human and financial resources are available
4. To provide support to the infected and affected.	**4.1** Adequate protective materials (gloves, plastic aprons) purchased, received, and distributed quarterly to all AIDS care programmes in Lesotho (clinical and home based) throughout the plan period, with priority to the needy	**4.1.1** Reliable Records House hold survey report	**4.1.1.1** Availability of funds
	4.2 Adequate supportive, prophylactic drugs, and supplementary feeding commodities purchased, received and distributed quarterly to all HIV/AIDS care programmes (clinical and home-based care) in Lesotho throughout the plan period, with priority to the needy	**4.2.1** Reliable records House hold survey report	**4.2.1.1** Availability of funds
	4.3 Significant number of	**4.3.1** Membership list	**4.3.1.1** Community capacity enhanced

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
	support clubs for PLWHAs, infected and affected people to be established per district by December, 2000	**4.3.2** Progress Report	
	4.4 Trained personnel available at all levels of HIV/AIDS care programmes in Lesotho by Dec 2003.	**4.4.1** Survey report **4.4.2** Site visits reports	**4.4.1.1** Commitment of the responsible agencies. **4.4.1.2** Funds available
	4.5 20 trained volunteer psycho-social orphan care givers ***per district*** functional by December 2001	**4.5.1** Certificates **4.5.2** Training report **4.5.3** Volunteer reports	**4.5.1.1** Volunteers forthcoming for training **4.5.1.2** Volunteer commitment **4.5.1.3** Support fromLAPCA
	4.6 HIV/AIDS diagnostic, clinical counselling and home-based care services structured, strengthened, intensified and expanded throughout Lesotho for the planned period	**4.6.1** Counselling and home based care services **4.6.2** Progress report	**4.6.1.1** Availability of Funds **4.6.1.2** Availability of volunteers
	4.7 2-5 Voluntary counselling and testing centre per district, for HIV/AIDS, established and functional throughout the country for HIV/AIDS prevention of mother to child HIV transmission and PLWHAs, throughout the plan period	**4.7.1** Presence of voluntary counselling and testing centres	**4.7.1.1** Availability of funds **4.7.1.2** Availability of Equipment **4.7.1.3** Availability of infrastructure
	4.8 Education plan and emotional stress alleviation measures for services providers at all levels formulated and implemented as from June 2001	**4.8.1** Counselling plan **4.8.2** Counselling session reports **4.8.3** Continuing education reports **4.8.4** Presence of groups	**4.8.4.1** Availability of funds **4.8.4.2** Availability of expertise **4.8.4.3** Commitment by all stakeholder
	4.9 Community based care such as orphan care and	**4.9.1** Reports from community based care structures	**4.9.1.1** Funds available **4.9.1.2** Donor s continued support

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
	support foster homes, hospice, half way homes, improved starting June 2001 throughout the plan period **4.10** Supportive legislation for infected and affected, including orphans, formulated and in place for orphan care by June 2002 **4.11** Review Human Resources Management policies, procedures and legislation relating to recruitment, development and utilisation within the civil service by Dec 2002 **4.12** Review project preparation guidelines to ensure that HIV/AIDS related issues are included by December 2001	**4.10.1** Legislation in Place **4.11.1** Legislation in Place **4.12.1** Submitted project proposals	**4.10.1.1** Funds availability **4.10.1.2** Commitment **4.10.1.3** Availability of staff **4.11.1.1** Funds are available **4.11.1.2** Ministries fully cooperate with each other **4.12.1.** Line ministries willing to cooperate
	4.13 Review and develop conditions of service and employee benefits that are supportive to employees living with HIV/AIDS by December 2002 **4.14** Facilitate creation of relevant positions that deal with HIV/AIDS (Lab Technicians, Health Educators, etc.) by December 2002 **4.15** Establish two experimental community based houses to care for 5 children each by December 2000 (Lesotho	**4.13.1** Regulations in place **4.14.1** Establishment list **4.14.2** Nominal roll **4.15.1** Progress reports **4.15.2** Financial statement	**4.13.1.1** Human and financial resources available **4.13.1.2** Ministries fully cooperate **4.14.1.1** Funds are available **4.14.1.2** Ministries fully cooperate **4.15.1.1** Funds are available **4.15.1.2** Donor s continued support **4.15.1.3** Community willing to participate

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
	Save the Children) **4.16** Development of basic guidelines/evaluation system for HIV/AIDS care programme by December 2001	**4.16.1** Evaluation reports **4.16.2** Guideline documents	**4.16.1.1** Stakeholders cooperation and collaboration
5 To involve the Youth in all HIV/AIDS Programmes	**5.1** HIV/AIDS/STI activities integrated into 10 district youth centres/adolescent corners by June 2001	**5.1.1** Adolescent corners/youth centres report **5.1.2** Progress Report	**5.1.1.1** Youth organisations will cooperate
	5.2 Network of youth clubs and organizations established in Lesotho by the end of Dec 2001.	**5.2.1** Record of communication **5.2.2** Youth newsletter **5.2.3** Inventory of youth clubs	**5.2.1.1** Communication and information gathering system is established from centre level to grassroots level **5.2.1.2** Commitment of youth clubs and organizations
	5.3 Action plan formulated in collaboration with NAP and youth clubs by August 2001 and evaluated annually	**5.3.1** Integrated plan of action	**5.3.1** Commitment of Youth Clubs
	5.4 Recreational facilities established at all youth centres and existing facilities upgraded in Lesotho by the end of the plan period	**5.4.1** Site visit report **5.4.2** Survey report	**5.4.1.1** Funds available **5.4.2.1** Funds available
	5.5 Curriculum containing adequate and relevant HIV/AIDS issues for tertiary and learning institutions developed and	**5.5.1** Copy of the Curriculum	**5.5.1.1** Funds are available **5.5.1.2** Expertise is available **5.5.1.3** Commitment of tertiary institutions and other learning

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
	implemented by November 2001 **5.6** Capacity of families to discuss sex and sexuality built throughout the plan period	**5.6.2** Evidence of increased discussion about HIV/AIDS within homes, at the community level, media and other forums	institutions **5.6.1.1** A conducive environment for cultural and attitudinal change exist within the country

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
6. To drastically reduce the high rate of STI/HIV/AIDS in Lesotho by 5% by March 2003	**6.1** One reference centre for monitoring, distribution, storage, purchase and quality control of the condoms established at NDSO Mafeteng by February 2001	**6.1.1** Biannual purchasing report **6.1.2** Quality control Certificate for Each purchase **6.1.3** Quarterly distribution report	**6.1.1.1** Availability of funds **6.1.1.2** Commitment from NDSO management **6.1.1.3** All co-ordinating structures in place
	6.2 Condom distribution and supervision points identified and operational in all ten districts by January 2001	**6.2.1** Distribution of reports quarterly	**6.2.1.1** Availability of human and financial resources **6.2.1.2** All co-ordinating structures in place
	6.3 Condom markets and promotion Intensified and extended by January 2001	**6.3.1** Number of markets **6.3.2** Distribution records	**6.3.1.1** Availability of human and financial resources **6.3.1.2** All co-ordinating structures in place
	6.4 2,000,000 STI education pamphlets produced and distributed annually by HIV/AIDS/STI programme throughout the plan period	**6.4.1** Record of distribution	**6.4.1.1** Availability of funds
	6.5 Six 3 days courses on STI syndrome management and DOTS conducted annually for doctors, nurses, nurse assistants and other service providers over 3 years starting November 2000	**6.5.1** Courses reports	**6.5.1.1** Expertise and funds Available
	6.6 500,000 patient sets of STI drugs purchased and distributed annually	**6.6.1** Order form **6.6.2** Delivery form from NDSO	**6.6.1.1** Availability of funds **6.6.1.2** Commitment from NDSO management
	6.7 Study on STI and TB drugs resistance conducted every 5 years at Queen Elizabeth II national referral hospital	**6.7.1** Study report	**6.7.1.1** Funds available

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
7. To intensify HIV/AIDS surveillance and testing in Lesotho	**7.1** HIV testing guidelines developed and approved by June 2001	**7.1.1** HIV testing guideline available	**7.1.1.1** Availability of human and financial resources
	7.2 Two laboratory technicians trained per regional centre for HIV testing by July 2001	**7.2.1** Training records	**7.2.1.1** Funds available
	7.3 Three referral HIV testing sites opened by September 2000 in the three district of Maseru, Mohale's Hoek and Leribe	**7.3.1** Submission of reports from new testing centres	**7.3.1.1** Availability of funds
	7.4 HIV testing equipment and reagents procured and installed in three referral centres (Maseru, Mohale's Hoek and Leribe) by September 2001	**7.4.1** Delivery note from equipment supplier	**7.4.1.1** Funds available
	7.5 HIV Sentinel Surveillance on ANC, STI and TB resumed and sustained at least in 5 sites (Maseru, Leribe, Mafeteng, Maluti and Quthing) by September 2000 to March 2001.	**7.5.1** HIV Sentinel Surveillance report	
	7.6 18 laboratory technicians recruited and deployed in all hospitals by June 2002	**7.6.1** Establishment list **7.6.2** Nominal roll	**7.6.1.1** Availability of qualified candidates
	7.7 Expand HIV/AIDS surveillance in all hospitals by January 2001	**7.7.1** HIV/AIDS Annual surveillance report	**7.7.1.1** Commitment from Hospital management and central programme personnel **7.7.1.2** Trained personnel retained **7.7.1.3** Government remains Committed to decentralise referral services
	7.8 Expand to 3 the	**7.8.1** Biannual blood	**7.8.1.1** Commitment from management

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
	number of site HIV/AIDS for surveillance at blood transfusion services (Maseru, Mohale's Hoek & Leribe) by December 2001	donor HIV surveillance report	and central program personnel. **7.8.1.2** Government remains committed to decentralizing referral services **7.8.1.3** Availability of human and financial resources
	7.9 HIV testing quality control conducted quarterly by central laboratory and by regional network	**7.9.1** Quality control certificate	**7.9.1.1** Availability of funds **7.9.1.2** Commitment from **7.9.1.3** Trained personnel retained
8. To conduct baseline study/update information on stated strategic aims (LAPCA, Sectoral AIDS Programmes)	**8.1** Baseline study on strategic Aims conducted by June 2001	**8.1.1** Study report	**8.1.1.1** Funds available
	8.2 Relevant research on priority areas in HIV/AIDS conducted by December 2001	**8.2.1** Study report	**8.2.1.1** Availability of human and financial resources
	8.3 Research on drugs that prolong the lives of PLWHA conducted, in collaboration with SADC, throughout the plan period	**8.3.1** Study report	**8.3.1.1** Availability of human and financial resources
9. To regularly monitor and periodically evaluate NAP (LAPCA, Sectoral AIDS Programmes)	**9.1** National HIV/AIDS activities monitored throughout the plan period	**9.1.1** Monitoring and Evaluation Reports	**9.1.1.1** Funds available **9.1.1.2** Expertise available
	9.2 Current NAPCP evaluated by December 2000	**9.2.1** M&E reports	**9.2.1.1** Human Financial resources available
	9.3 National Aids Programme evaluated by September 2003 **9.4** Budgets for monitoring and evaluation of programmes involving HIV/AIDS activities		

Narrative Summary	Objectively Verifiable Indicators of Achievement	Means of Verification	Important Assumptions
	incorporated in sectoral annual budgets beginning April 2001		