



**GOVERNMENT OF LESOTHO**

# **National HIV & AIDS Policy**



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**Ending AIDS by 2030**

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## Foreword

The weakest link in the chain of development in Lesotho is HIV/AIDS, which indiscriminately affects every level of our society. It shakes the foundations of social-economic development through loss of productive labour force, imposing various threats to the education and social development of children as it robs them of their parents, teachers and guardians through death and/or incapacitation. Twenty-five years ago, the Government of Lesotho took a decision to scale up the National Response to the HIV/AIDS pandemic in the country. The noble impact of this decision is evidenced by, among other things, the increasing number of people who know their HIV status, the increasing number of people who access and adhere to ART and the increasing number of people living with HIV that are virally suppressed and the reduction in AIDS-related deaths.

I note with concern that the incidence of HIV remains high, which calls for renewed investment in HIV prevention programming and removal of bottlenecks and structural barriers. It is my honour to launch this policy which sets the direction for coordination and management of the HIV/AIDS response in Lesotho. This policy has been revised to be comprehensive, inclusive and to embrace the fast growing segments of vulnerable groups and high risk populations.

The complexity and changing environment of the HIV/AIDS landscape demands a multi-focus response that effectively and efficiently addresses the various emerging and competing priorities. Thus, the national response must be guided by a sound and comprehensive regulatory policy, hence the revision of 2006 National Policy for HIV/AIDS.

The policy seeks to create an enabling environment that will guide the state and non-governmental stakeholders to develop and implement sector policies, strategies and programs that will translate into behavioural change, reduction of new infections and improved well-being of people living with HIV at the workplace and in the community. The policy further aims to mobilise resources in order to facilitate the implementation of respective programs that will lead to the elimination of HIV by 2030.

This policy clearly reflects the socio-economic and governance situation within which it is being developed. It is cognisant that due to numerous and diverse variables such as gender, age, sexual orientation, socio-economic status and level of disability, the impact of HIV/AIDS differs among Basotho.

I therefore invite and urge all stakeholders to ensure that we implement this policy with passion and commitment. Let us all implement this policy with the openness and transparency that reflect government commitment in all our actions.

A handwritten signature in black ink, which appears to read 'Leshoboro Mohlajoa', is written over a horizontal line. To the right of the signature, there are two small arrows pointing to the right.

Hon. Leshoboro Mohlajoa  
Minister in the Prime Minister's Office



## Preface

The previous Lesotho HIV/AIDS policy was developed in 2006. In the last decade, the pandemic has evolved and the landscape has changed. However, the prevalence has remained high and the HIV incidence is persistently high indicating a continually high rate of transmission. At the same time, HIV infection has been identified as the main driver of TB.

The evolution of the pandemic has led to a national response that requires a national policy guidance. As a result, the National Policy on HIV/AIDS (2006) had to be reviewed and revised. This new policy provides general inclusive provisions that establish a framework within which specific targeted sector policies and strategies can be developed.

The Policy gives strategic direction to our efforts related to the management of the pandemic. It encapsulates the vision, mission, core principles, goals, objectives and the implementation framework. Thus, it lays a foundation for a national response that is multi-faceted, multi-sectoral, decentralised and taps on the synergies of all stakeholders.

I acknowledge all ministries that availed documents for information and officers to participate in the review and development of this Policy. Furthermore, our thanks go to Government Ministries, Non-Governmental Organisations, the Private Sector, the Media, Faith-based Organisations, the Academia and Development Partners for their contributions and technical support during this process.

The policy was produced through a comprehensive consultative process that comprised all sectors and drew representation from all the ten districts. The policy was debated and accepted by the National Multi-sectoral Steering Committee, Technical Working Group, the NAC Board and approved by the Cabinet.

Together let us work hand in glove to ensure achievement of the vision embodied in this policy.

A handwritten signature in black ink, appearing to read 'Tseliso', is written over a horizontal line. The signature is stylized and cursive.

Reverend Tseliso Simeon Masemene  
Chairperson – Board of Commissioners  
National AIDS Commission



## Acknowledgements

The National AIDS Commission (NAC) takes this opportunity to acknowledge with appreciation the contribution by all stakeholders in the review process which culminated in production of this policy that provides strategic guidance on the National HIV and AIDS Response.

The policy was developed with the inputs of stakeholders from; Government, Civil Society, Faith Based Organizations, Vulnerable Populations, Academia and the Private Sector. Through multi-sectoral input.

and expertise, the priorities were identified for best outcome. I also wish to recognise and appreciate commitment and dedication of the multi-sector Technical Working Group on Policy development for; providing information, technical oversight and ensuring the successful completion of the Policy. The joint financial and technical support from UNAIDS and UNFPA towards the development of this policy is highly appreciated.

A handwritten signature in black ink, appearing to read 'K. Thabana', is written over a horizontal line. The signature is fluid and cursive.

Keratile Thabana  
Chief Executive Officer  
National AIDS Commission



## Acronyms

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
AJR	Annual Joint Review
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CCHAC	Community Councils' HIV/AIDS Committee
CGPU	Child and Gender Protection Unit
CHAL	Christian Health Association of Lesotho
CHEAL	Comprehensive HIV Epidemiological Analysis for Lesotho
CSO	Civil Society Organisation
DHAC	District AIDS Committee
DHIS2	District Health Information System 2
DHMT	District Health Management Team
DHS	Demographic Health Survey
EPI	Expanded Program on Immunization
ESP	Essential Services Package
FAO	Food and Agriculture Organisation
FBO	Faith Based Organisation
FP	Family Planning
FNCO	Food and Nutrition Coordinating Office
FSW	Female Sex Worker
GBV	Gender Based Violence
GDP	Gross Domestic Product
GOL	Government of Lesotho
HIV	Human Immunodeficiency Virus
HTS	HIV Testing Services
IBBS	Integrated Biological and Behavioural Study
IC	Infection Control
IEC	Information Education Communication
ILO	International Labour Organisation
IMR	Infant Mortality Rate
IOM	International Organisation for Migration
KYS	Know Your Status
LB	Live Birth
LBTS	Lesotho Blood Transfusion Services
LePHIA	Lesotho Population Based HIV Impact Assessment
LVAC	Lesotho Vulnerability Assessment Committee
MAM	Moderate Acute Malnutrition
MDG	Millennium Development Goal
M & E	Monitoring and Evaluation





MOAFS	Ministry of Agriculture and Food Security
MOCST	Ministry of Communication Science and Technology
MODP	Ministry of Development Planning
MOET	Ministry of Education and Training
MOF	Ministry of Finance
MOFA	Ministry of Foreign Affairs and International Relations
MOHA	Ministry of Home Affairs
MOGSYR	Ministry of Gender, Sport, Youth and Recreation
MOH	Ministry of Health
MOJHRCS	Ministry of Justice Human Rights and Correctional Services
MOLE	Ministry of Labour and Employment
MOLGC	Ministry of Local Government and Chieftainship Affairs
MOPS	Ministry of Public Service
MOSD	Ministry of Social Development
MOU	Memorandum of Understanding
MMC	Male Medical Circumcision
MMR	Maternal Mortality Ratio
MTCT	Mother To Child Transmission
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NACS	Nutrition Assessment Counselling and Support
NGO	Non-Governmental Organisation
NISSA	National Information System for Social Assistance
OPD	Outpatient Department
PEP	Post Exposure Prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother To Child Transmission
PrEP	Pre-Exposure Prophylaxis
RMNCAH&N	Reproductive Maternal New-born Child Adolescent Health and Nutrition
SADC	Southern African Development Community
SBCC	Social Behaviour Change Communication
SDG	Sustainable Development Goal
SOP	Standard Operating Procedure
SRHR	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
U5MR	Under Five Mortality Rate
UHC	Universal Health Coverage
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNESCO	United Nations Educational Scientific and Cultural Organisation



UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
URTI	Upper Respiratory Tract Infection
VHW	Village Health Worker
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WFP	World Food Programme
WHO	World Health Organisation



## Executive Summary

The Government of Lesotho (GOL) with the support of its partners has put in a lot of effort and resources towards controlling the pandemic. However, not all expected outputs and outcomes have been attained as evidenced by the continued new infections and low level of comprehensive knowledge of HIV/AIDS. The results show that there are populations that do not yet have access to preventive services, which exposes them to a greater vulnerability. The policy sets the strategic direction for the country response and indicates the commitment by the GOL and its partners to attain the goals.

The population of Lesotho has increased since the last HIV policy was developed in 2006. Poverty has increased in extent and depth. Thus, vulnerability has also increased. This is accompanied by a low level of comprehensive knowledge of HIV as indicated in the Modes of Transmission Study. At the same time, the incidence is persistently high indicating high level of transmission. The factors fuelling the pandemic are established and have remained the same - the high HIV/TB co-morbidity. Stigma and discrimination even at service delivery levels still persist, especially for vulnerable groups and key populations which are also criminalised. Gender-based violence is still widespread and women and girls have not been effectively empowered, which means human rights violations are yet to be effectively addressed.

Other problems that need to be addressed revolve around stigma, illegal sex work and men who have sex with other men. These problems are exacerbated by lack of appropriately skilled professionals in these areas, which amounts to inaccessibility of services in some areas, improper service delivery in others and violation of human rights of these populations. Prevention of HIV among migrants is limited by legality in host countries and those countries that do not have any policies nor statutes that protect and defend the rights of the migrants.

Prevention of HIV among migrants is limited by legality in host countries and those countries that do not have any policies nor statutes that protect and defend the rights of the migrants.

The 2019 HIV Policy's vision is that Lesotho shall be AIDS free with zero new infections, zero AIDS deaths, and zero HIV/AIDS related discrimination by 2030. The country has set itself the Mission to ensure healthy lives and promote well-being for all. The goal of this Policy is attainment of the 95-95-95 target and ending the HIV pandemic by 2030, while the General Objective consists in creating an enabling environment for the effective and high-impact HIV response and interventions.

In line with the Goal and General Objective, the Specific Objectives of the policy aim at reducing new HIV infections, improving the quality of life and increasing life expectancy, promoting and protecting the human rights, including sexual and reproductive health rights of PLHIV, vulnerable groups and key populations<sup>1</sup> to ensure a decisive, inclusive and accountable leadership in revitalising and intensifying the HIV response. The overall objective

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<sup>1</sup> Vulnerable population include women, adolescent girls and young women, adolescent boys and young men, while key populations FSW, MSM, Inmates, Factory Workers and Migrants, TGs, etc.



also consists in engendering and utilising strategic information in order to avail equitable and equal access to the interventions.

Several policy measures have been identified towards these objectives and this indicates the priorities and provides the framework for the national response.



## **PART I: LESOTHO HIV CONTEXT**

### **1. Lesotho Background Information**

#### **1.1 Country Topography, Demography and Administration**

The Kingdom of Lesotho is an entirely landlocked country situated in the southern part of Africa. The country covers an area of 30,350 km<sup>2</sup> and lies between 29°30' South Latitude and 28° 30' East Longitude. It is a temperate and highly mountainous country with the lowest elevation at 1,500 meters above the sea level. Topographically, it is composed of 4 ecological zones (Lowlands, Foothills, Mountains and the Senqu River Valley) and 10 administrative districts. The Head of State is His Majesty the King, the Head of Government the Prime Minister, and the Executive arm of Government the Cabinet of Ministers. The government is decentralised through the District and Local Councils even though it has not yet been fully decentralised in all aspects of governance.

The 2016 census estimates the Total Population of Lesotho at 2,007,201 with a population growth rate of 0.682% and a female-male sex ratio of 51:49. The population comprises of 34% urban population and 66% rural population. Lesotho is a patriarchal country which has a dual legal system of customary law (Laws of Lerotoli) recognised by the constitution and the common law. The customary law negatively affects gender and social equality, as well as livelihoods and economic opportunities for Females (women and girls). The country is ranked 57 out of 144 countries on Gender Inequality.<sup>3</sup>

The predominant religion is Christianity, and the official languages are Sesotho and English, although there are other minority languages that collectively form 0.3% of the general population.

#### **1.2 Country Socio-Economic Status**

The country is classified a Lower Middle Income country ranked number 159 of the 187 countries on the Human Development Index (0.5204). The Life expectancy at Birth is 56 years (51.7 males and 59.5 females). Adult literacy rate is 87% (79.7% male and 93.6% females) whilst Infant Mortality Rate (IMR) is 53.3/1000 Live Births (LB). The Under 5 Mortality Rate is 80.2/1000 LB and Neonatal Mortality Rate 34/1000 LB. The Total Fertility Rate (TFR) is 3.3 per Woman and the Maternal Mortality Ratio 618/100,000 Live births. The orphan and vulnerable children population is estimated at 210,712.<sup>4</sup>

Agriculture and Industry each contribute 7.7% and 31.32% of the Gross Domestic Product (GDP) [UN Data 2018], respectively. Wealth varies by topographic zones and the level of

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<sup>3</sup> UNDP 2018: Human Development Report

<sup>4</sup> Bureau of Statistics Lesotho Population Census 2016



education increases with the wealth index (DHS 2009). According to the 2016 census, the proportion of the population using improved water sources was estimated at 88.1% while the proportion using improved sanitation was 43.6%.

### 1.3 Country Health and HIV Status

In Lesotho, the reported main causes of inpatient mortality among children, men and women include Malnutrition, Tuberculosis (TB) and AIDS<sup>5</sup>. The HIV-related mortality has declined from 10345 to 4908 people from 2007 to 2017. Tuberculosis (TB) remains a key cause of morbidity among adults with a TB-HIV co-morbidity of 72%. The Lesotho Population Based HIV Impact Assessment (LePHIA) reports that 7.1% of the participants had been diagnosed with TB in their lifetime. The TB infection rate among those who were HIV positive was 46% and 22.6% among those who were HIV negative; overall 96.8% had received treatment. The Lesotho Vulnerability Assessment finding was that malnutrition among PLHIV was 8%-13%.

The LePHIA report further indicates a high HIV incidence of 1.1 among the population 15-59 years, higher in females (1.2) compared to males (1.0) and a high incidence among Adolescents and young people at 0.8 and highest among adolescent and young girls at 1.5. The HIV prevalence 15-49 years persists at a high level of 24.6% (females 29.7%, males 18.6%) and varies per districts.<sup>6</sup> The prevalence is also high for vulnerable groups: migrants 29.8-31.8%, Men who have sex with Men (MSM) 31.1-35.4% and Female Sex Workers (FSW) 70-73.3%.<sup>7</sup> FSW and MSM face stigma, discrimination and intimidation as they are afraid to access health services. The ANC attendance is 97.1%. 95.6% knew their HIV status during pregnancy and 98.5% of them received ART during pregnancy. The HIV/TB Integrated Biological and Behavioural Study (IBBS) report indicates that the mineworkers' vulnerability to HIV and TB is high and is exacerbated by the oscillating migration. The HIV prevalence among the sending communities was up to 20.7%, highest for females aged 30 years and above, unmarried, females of low education and the unemployed. Self-reported TB (symptoms) was high at 75.6% and 55.1% for females.<sup>8</sup>

The LePHIA reports that vulnerable sexual behaviour is still high and comprehensive knowledge of HIV is poor. The total Male Medical Circumcision rate is 36% and condom use 69.7%. Physical force to sex was reported by 7.5% of the women 15-59 years old and the stigma level is 11.3-11.6%. The IBBS indicates the age of sexual debut is 18.24 years and 19.6% of the females had age disparate relationship of up to 10 years. Use of condoms was 53.5-64.8% but there was reluctance to their use even for those who knew they were HIV positive. Gender Based Violence (GBV) that includes forced sex was high

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<sup>5</sup> Ministry of Health, Annual Joint Review 2017

<sup>6</sup> Ministry of Health, The Lesotho Population-Based HIV Impact Assessment , 2018

<sup>7</sup> Sweitzer, s., Rolfe, J., Ketende, S., Gross, A., Baral, S. (2015). Characterizing HIV Prevention, Treatment and Care Needs Among Men who have Sex with Men and Female Sex Workers in Lesotho: Estimates of HIV Prevalence, Vulnerable Behaviour, and population Size,

<sup>8</sup> Internal Organisation for Migration (IOM), The HIV and TB Integrated Biological and Behavioural Study for Migrant Mine Worker Sending Communities in Lesotho 2016-2017



with 13.5-15.8%. It should be noted at this point that, in the context of HIV/AIDS, violence increases the risk infection in women. This is due to the compounding effect of both the physiological and psychological trauma generally suffered by women. In the same regard, uninfected women are more likely to contract HIV from their infected partners and vice versa. While it is true that, from a biological point of view, women are more vulnerable to infection, forced sex further increases the risk of HIV transmission. This is due to tears and lacerations, particularly in adolescent girls.

The Stigma Index 2014 detailed the issues that surround stigma for People Living With HIV (PLHIV). These includes social exclusion (41.1%), loss of jobs (43%), refused employment because of their HIV status (15%) with 5% having had to change residence. While 1% was denied access to schools, 6% was denied health care services. A significant proportion of PLHIV had internalised stigma. Up to 10% of the PLHIV had had violations of their rights but only 25% of them had sought legal redress.<sup>9</sup>

The Contraceptive Prevalence Rate (CPR) among married women has progressively improved from 37% in 2004, 47% in 2009 to 60% in 2014. It has similarly increased among the sexually active unmarried women from 48% in 2004, 58% in 2009 to 73% in 2014.<sup>10</sup> The unmet need for family planning is 18.4% for married women and 22.2% for unmarried women. The IOM study on the Partnership on Health and Mobility in East and Southern Africa (PHAMESA) reported 86% use of modern contraceptives at last sexual intercourse, 87% HIV testing last 12 months, 90% knew their HIV status and high level of satisfaction with the migration-sensitive health services received (87%).<sup>11</sup> The report on the evaluation of ALAFA Interventions indicated a high HIV prevalence of 42.7% overall but highest (52.6%) among the 30-34 year old age group, higher among migrants than non-migrants and those with lower levels of education. While the knowledge on HIV prevention was high, up to 20% (1 in 5) had 2 or more sexual partners.<sup>12</sup>

The Lesotho National Social Protection Strategy acknowledges the pervasive poverty in Lesotho that has not changed over the past decade and has increased in depth.<sup>13</sup> Among the findings of the UNICEF study in 2014 was that Social Protection Programmes improved access to treatment and care outcomes but did not necessarily meet the needs of households and in some cases were limited by related factors. The study found that the key policies and strategies related to social protection addressed wider issues on vulnerability and not HIV/AIDS explicitly.<sup>14</sup> The 2018 Lesotho Vulnerability Assessment

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<sup>9</sup> Lesotho Network of People Living With HIV and AIDS (LENPWA), The People Living With HIV Stigma Index, 2014

<sup>10</sup> Ministry of Health, Lesotho Demographic Health Survey 2014

<sup>11</sup> International Organisation for Migration (IOM), Access to SRHR Services in Migration-Affected Communities of East and Southern Africa: Evidence from Migration and health Programmes

<sup>12</sup> Apparel Lesotho Alliance to Fight AIDS (ALAFA), ALAFA Interventions in the Lesotho Garment Industry, progress and outcomes, 2012

<sup>13</sup> Government of The Kingdom of Lesotho, National Social Protection Strategy 2014/15 – 2018/19

<sup>14</sup> UNICEF, Quantitative Study on HIV Sensitive Social Protection in Lesotho, 2014



Committee (LVAC) report on nutrition indicates that protein food consumption was higher in urban areas compared to rural areas, and the experience of shocks was highest for high food prices (23.8%), crop failure/bad weather (9%) and loss of employment (15.6%). The SDG Target 1.2 recognises the fact that child deprivation affects the physical and emotional development of children and if carried across childhood into adulthood perpetuates vulnerabilities across generations. It is reported that in Lesotho, 31% of the children are multi-dimensionally deprived, 8% monetarily deprived, while 33% are both multi-dimensionally and monetarily deprived. The biggest predictors to deprivation were early pregnancy (90% compared to 70%) and early (<18 years) marriage (95%).<sup>21</sup>

The CHEAL Report indicates several weaknesses in the current interventions to effectively address the HIV pandemic, including policy and regulatory deficiencies, managerial inadequacies, programme gaps, health systems inadequacies, lack of accountability, stigma and illegality of FSWs and MSM coupled with few appropriately skilled professionals, and human rights violations. Prevention among migrants is limited by legality in host countries and lack of policies nor statutes that protect and defend the rights of the migrants. The role players for some vulnerable groups and key populations are limited and there is no policy for media support nor tools as well as support for social programmes.

In relation to the 90-90-90 target, Lesotho has attained a score of 81-91.8-87.7 with higher scores for females compared to males and increasing by age. The children and young people notably scored 74-98-74 at 0-14years.

#### **1.4 Review Findings and Observations of the Lesotho HIV Policy 2006**

The Lesotho HIV Policy 2006 was reviewed to assess the extent of its implementation, whether implementation of interventions was in compliance with it and whether it adequately addresses the HIV situation in 2019. The review findings are indicated below.

##### **1.4.1 Country Context**

Poverty and vulnerability are increasing and are accompanied by a low level of comprehensive knowledge of HIV. At the same time, the incidence is persistently high indicating high level of transmission. The factors fuelling the pandemic have remained the same and the HIV/TB co-morbidity is high. Geographical locations and underserved populations which are yet to be reached have been identified.

##### **1.4.2 Prevention**

There has not been any guiding policy nor tools for actors in advocacy and SBCC nor for media support. However, there has been progress on the Lifeskills-Based Sexuality Education (LBSE) (Comprehensive Sexuality Education) for schools.

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<sup>21</sup> UNICEF, Child Poverty in Lesotho: the Challenge and Possible Responses





The PMTCT has met the goals to a large extent except that there are still some children who miss testing. Furthermore, once diagnosed and put on ART, the viral suppression for a significant proportion is not satisfactory. However, the FP coverage is much lower with high unmet need.

There is a very low level of comprehensive knowledge on HIV/AIDS for women, men and youth, coupled with high levels of vulnerable behaviours and inadequate protection. The level of utilization of prevention services such as VMMC and condom use are also low. The key condom distribution points are Health Facilities and some outlets tailored along social marketing. Efforts to distribute condoms at community level have also been made. The quantities of condoms distributed has declined for women but increased for men. Young women are further affected by issues of power imbalances, lack of negotiation skills and GBV.

While HIV testing coverage has progressively improved, it is not yet universal since a significant number of people are still not aware of their status, and even among the people living with HIV, not all of them are on treatment. In the attempt to control HIV, this highlights the importance of STI management in the country. The Lesotho Blood Transfusion Services (LBTS) is the sole organisation that recruits donors, collects blood for transfusion and distributes to health facilities, mainly hospitals. All blood is screened for infections and the blood that is tested positive is discarded.

The 2016 MOH guidelines on prevention and treatment of HIV have clearly addressed the universal precautions objective of preventing transmission of HIV, Hepatitis B and other blood borne pathogens from health provider to patient and vice versa. The rationale and methods are covered in detail in the guidelines, including descriptions of the processes. While attention has been paid to universal precautions, outside public education and occasional interface between the health providers and the groups identified, there are no standards nor guidelines for procurement of the injecting and skin piercing instruments nor for facilities offering such services. The Post-Exposure Prophylaxis (PEP) objective has been met in accordance with the provisions of the guidelines however, it has been reported that health facilities and law enforcement officers do not necessarily comply. This, therefore, poses a problem.

### **1.4.3 Treatment, Care and Support**

Anti-retroviral Therapy (ART) is available in all public and Christian Health Association of Lesotho (CHAL) facilities as well as some private facilities under a Memorandum of Understanding (MOU) with the Ministry of Health (MOH). The Government of Lesotho (GOL) has across time modified the guidelines in line with WHO recommendations and the country now follows the Test and Treat model. The GOL bears most of the cost for ARVs and medicines. The country allows nurses to prescribe Anti-retroviral medicines (ARVs) and follow up patients only referring complicated cases. The ART coverage among adolescents and young people, with differences between males and females, is however low and Viral Load Suppression (VLS) among children is unsatisfactory.



The professional Councils and the MOH continue to regulate health professionals and health facilities, including Traditional Healers. Advertising, misinformation and exploitation of patients especially in the non-formal sector is continuing. The MOH is limited by a weak legal instrument that does not empower intervention beyond a scope defined by the Public Health Order 1970. The Bill was drafted in 2011 and is regularly updated. However, it is yet to be promulgated into law.

#### **1.4.4 Impact Mitigation**

Stigma and Discrimination persist, even at service delivery points, especially for vulnerable groups and key populations which are also criminalised. The human resource limitations further limit access to services. Gender Based Violence is still widespread and women and girls have not been effectively empowered. Prevention among migrants is limited by legality in host countries and countries that do not have any policies nor statutes protect and defend the rights of the migrants. There is lack of capacity to mainstreaming gender equality, human rights and sexual and reproductive health rights to AIDS interventions, while the legal environment is also unfavourable, which means human rights violations are still prevalent as they still have to be addressed effectively.

Malnutrition is still widespread especially amongst children. Key policies and strategies related to Social Protection address wider issues on vulnerability and not HIV/AIDS explicitly.

#### **1.4.5 Protection, Participation and Empowerment of PLWHAs**

The discrimination against PLHIVs is still significant. Many of the 2006 policy statements are yet to be addressed.

#### **1.4.6 HIV in the Workplace**

The effort and environment of the workplace varies across sectors and location. The prevalence among workers remains high but there had been positive changes with the implementation of workplace and cross border programmes.

#### **1.4.7 M&E, Data Sources and Information Products**

The M&E frameworks that are in place facilitate, to a large extent, the tracking of the country response. Special surveys and research studies have also been conducted to provide missing or special information in tracking the progress to the 2020 targets and eliminating HIV by 2030. The DHIS2 now includes the HIV module. The weakness is that due to inadequate capacity in electronic record keeping country-wide, even with use of unique identifier, it is still a challenge to ensure that there be no duplication of some of the data. The LOMSHA is also in place at community level.



#### **1.4.8 Multi-sectoral Coordination**

Since its establishment in 2004, the NAC has faced challenges that led to its dissolution in 2011 as it had an equivocal operational structure that blurred its role in the fight against HIV/AIDS.

Due to lack of capacity at the Local Councils level and limitations in decentralisation, the Gateway Approach and implementation of the Essential Services Package (ESP) faced challenges such as the delay in training of Community HIV Action Committees (CHACs) who were then working as implementers. In the same context, there was also shortage of medicines, resources and capacity for the Councils and Councillors.

The AIDS fund and Levy anticipated in the 2006 policy was not implemented and the 2% sector reservation of their budgets to HIV/AIDS seems to have fizzled off. The Government has not yet met the Abuja 15% expenditure on health and there have been no special funding mechanisms set up for HIV. At the same time, NAC is not resourced for effective coordination.

#### **1.4.9 HIV/TB Co-infection and Hepatitis B**

At the development of the Lesotho HIV Policy 2006, the MOH was already engaged in TB and HIV Control as separate programmes but their interrelationships were not fully understood. The Current MOH guidelines include HIV/TB co-infection, which means HIV/TB patients receive integrated HIV/TB treatment. Blood for donation is screened for Hepatitis and the Expanded Programme on Immunization (EPI) programme includes vaccination against Hepatitis B.<sup>15</sup>

### **1.5 HIV/AIDS Constraints, Challenges and Gaps**

#### **1.5.1 Constraints**

While Lesotho has registered successes and gains in the HIV/AIDS response, it faces several constraints. These are both structural and operational and include the following:

- Inadequate policies and specific strategies in support of the prioritised interventions, especially for vulnerable groups and key populations;
- Policy and Legal environment barriers for comprehensive implementation of programmes for vulnerable groups and key populations;
- Inadequate human resources and limited technical capacities and skills for interventions;
- Paucity of guidelines and Standard Operating Procedures (SOPs) for some of the interventions;
- Inadequate financing and logistics;
- Inadequate capacities at community and local government level to spearhead interventions;

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<sup>15</sup> NAC and UNAIDS, Review Lesotho HIV Policy 2006, 2019



- Weak national Civil Society Organisation (CSO) capacity and lack of funding for existing CSOs.

### 1.5.2 Challenges

The key HIV challenges that Lesotho faces are as follows:

- The high HIV incidence of 1.1 among the population aged between 15-59 years - higher in females (1.2) compared to males (1.0). The incidence among Adolescents and young people is high at 0.8 and is highest among adolescent and young girls at 1.5;
- The district variance in prevalence indicating underserved and unreached geographical areas;
- The high HIV prevalence among adolescents and young people which is higher for girls (19.9%) than boys (5.1%);
- The last mile in the PMTCT response to ensure that all those who have tested positive receive ART and that all those who are on ART attain viral suppression. This is indicative of the need for an even greater exertion by the health sector;
- While the country has to extend and further strengthen the HIV response to improve from the 81-91.8-87.7 performance to the 90-90-90 target by 2020 and 95-95-95 target by 2030, the lower male score compared to females requires deliberate efforts targeting men. The children and young people notably scored 74-98-74 at 0-14years, indicating intensified services for children, compliance with ART guidelines and ensuring that youth are brought into the cascade of test-treat-viral suppression;
- While there is high HIV/TB co-infection, there is still weak linkages between the two programmes.
- There is also a weak linkage between HIV/SRHR programmes except for PMTC;
- Weak performance in prevention, especially the low total rate of Medical Male Circumcision, which is at 36%, and condom use which is at 69.7%;
- The legal environment surrounding GBV and social and economic empowerment of women;
- Persistent stigma level of 11.3-11.6%.
- Poverty and migration and high HIV prevalence of 29.8-31.8% among this migrant;
- High HIV prevalence among vulnerable groups and key populations coupled with illegality of FSWs and MSM, few appropriately skilled professionals to deliver services to these population, inadequate access to services, and stigma and discrimination as well as violation of their human rights.

### 1.5.3 Gaps

Documented gaps and weaknesses in the response are as follows:

- Lack of policy specifics for men and women;



- Lack of a regulatory framework and incentives;
- Own systems' designs and lack of accountability of organisations involved in the HIV response;
- Weak workplace programmes;
- Paucity of materials to improve knowledge for the specially identified populations;
- Lack of enforcement of succession laws as they relate to women due to societal and perceived cultural issues and lack of structures for enforcement;
- Unclear strategies on testing of discordant couples and inadequate human resources for the house to house service delivery;
- Inadequate information dissemination on new interventions e.g. Pre-Exposure Prophylaxis (PrEP) and PEP;
- Legality and lack of policies and statutes to protect and defend the rights of migrants and this limits their access to HIV prevention and treatment;
- Limited role players for some groups and lack of policy for media support and tools as well as support for social programmes;
- Inadequate safe water, exposure to infections due to improper sanitation and hygiene, particularly among children as they are prone to infections, in particular viral hepatitis that augments the HIV problem. Viral Hepatitis Control is yet to be instituted as a programme within the HIV response.

## **1.6 Key Government Policies, Strategies and Guidelines (Frameworks) on HIV/AIDS, and Sustainable Development Goals (SDGs)**

The HIV and AIDS response has been aligned to and guided by international, regional and national commitments, policies, strategies and guidelines as indicated below.

### **1.6.1 International Frameworks**

- United Nations, Transforming Our World: The 2030 Agenda for Social Development (A/RES/70/1);
- United Nations General Assembly 70/266 Political Declaration on HIV/AIDS: On the Fast Track to Accelerating the Fight against HIV and Ending the AIDS Pandemic by 2030;
- UNAIDS 2016-2021 Strategy on the Fast-Track to end AIDS;
- UNAIDS Fast-Track Commitments to End AIDS by 2030;
- UNAIDS Social Protection; a Fast-Track Commitment to End HIV, Guidance to Policy-Makers and People Living with at Vulnerable of or Affected by HIV;
- UNAIDS on the Fast-Track to end AIDS 2016 -2021;
- UNAIDS Social Protection Guidance;



- UNDP 2018: Human Development Report;
- UNESCO, CSE Scale Up in Practice Case Studies From Eastern and Southern Africa, 2017;
- World Health Organisation, Policy Brief: Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection, November 2015;
- World Health Organisation, Global Health Sector Strategy on HIV 2016-2021, Towards Ending AIDS, June 2016;
- World Health Organisation, Policy Brief: Consolidated Guidelines on Prevention, Diagnosis, Treatment and Care for Key Populations, 2016 Update.

### **1.6.2 Regional Frameworks**

- Organisation of African Unity, African Summit on HIV/AIDS, Tuberculosis, and Other Related Infectious Diseases, Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (OAU/SPS/Abuja/3 Southern African Development Community, The Maseru Declaration 2002;
- SADC, Maseru Declaration on the Fight Against HIV/AIDS in the SADC Region, 2003.

### **1.6.3 National Frameworks**

- Bureau of Statistics, Lesotho Population and Housing Census 2016;
- Ministry of Health, Annual Joint Review 2018;
- Ministry of Development Planning, Lesotho National Strategic Development Plan 2018 - 2023;
- Government of Lesotho, The National Policy on Social Development 2014/15 – 2024/25;
- Government of Lesotho/National AIDS Commission, Lesotho Output Monitoring System for HIV/AIDS (LOMSHA) Operational Manual 2017;
- National AIDS Commission (NAC) and Ministry of Health (MOH), Lesotho HIV Prevention 2020 Roadmap, For Accelerating HIV Prevention to Reduce New Infections by 75%, 2018;
- Government of Lesotho/National AIDS Commission, National HIV/AIDS Strategic Plan 2018/19 – 2022/23;
- Government of Lesotho/National AIDS Commission, National HIV/AIDS Monitoring and Evaluation Plan 2018/2019 – 2022/2023;
- The Kingdom of Lesotho, National Coordination Framework, 2015;
- The Kingdom of Lesotho/National AIDS Commission, HIV/AIDS mainstreaming in the Public Sector, Guidelines, 2016;



- National AIDS Commission, Lesotho 2017 HIV/AIDS Progress Report, Submitted to SADC Secretariat of Social and Human Development, 2018
- Global Fund for AIDS Tuberculosis and Malaria;
- Lesotho Country Operation Plan 2018, PEPFAR;
- Government of Lesotho/Ministry of Health, National Guidelines on The Use of Anti-Retroviral Therapy for HIV Prevention and Treatment, April 2016;
- Ministry of Health, Lesotho National HIV Testing Services Strategy 2018 – 2023;
- Ministry of Health and Ministry of Finance, Ending AIDS in Lesotho, the Lesotho Investment Case, 2014;
- Ministry of Health, Scaling Up Voluntary Male Medical Circumcision for HIV Prevention 2012/13-2016/17;
- Ministry of Health, National Sexual, Reproductive, Maternal, New-born, Child and Adolescent Health and Nutrition (SRMNCAH & N) Strategic Plan 2018 – 2022.



## PART II: LESOTHO NATIONAL HIV POLICY

### 2.1 Vision, Mission, Core Values and Guiding Principles

#### Vision

Lesotho shall be an AIDS free nation with zero new HIV infections, zero AIDS deaths, and zero discrimination.

#### Mission

To ensure healthy lives and promote well-being for all at all ages.<sup>16</sup>

#### Core Values

The Policy abides by the Political Declaration 2016 to which Lesotho is signatory. The Political Declaration 2016 reaffirms the Sustainable Development Goals (SDGs), the Universal Declaration of Human Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the Declaration on the Elimination of Violence Against Women, and the Convention on the Rights of persons with Disabilities.

#### Guiding Principles

**Political Commitment:** The priorities of the Government of Lesotho shall be in line with the commitment to poverty reduction, economic development, accomplishment of the SDGs, and the Political Commitment 2016.

**Good Governance, Transparency and Accountability:** Government shall ensure that there be appropriate policies and strategic frameworks in place, provide effective oversight, build coalitions, regulate the interventions, attend to systems design and account for inequitable outcomes.

**Universal Health Coverage:** Government of Lesotho shall follow the principles and endeavour to attain Universal Health Coverage (UHC) for its citizens, with emphasis on the underserved and unreached populations. The GOL shall provide essential health care that is universally accessible, available and affordable to all Basotho. Services shall include community-based interventions, taking into consideration services that require a sensitive approach and/or changing.

**Equity:** There shall be parity to HIV services for the residents of Lesotho. Particular attention will be paid to the under-reached and underserved populations.

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<sup>16</sup>United Nations, Sustainable Development Goal 3





**Equality:** Every person in Lesotho shall be treated the same without discrimination based on gender, sexual orientation, religion nor social status. Special attention shall be paid to the most vulnerable groups and key populations.

**Affordability:** The Services shall be free of charge or charges shall be subsidised such that populations only incur minimal costs to access services. The Government will liaise with the Private Sector and CSOs and mobilise their full involvement.

**Community Involvement:** Communities shall be actively encouraged, supported and empowered to participate in the planning, implementation and monitoring of the Response.

**Integrated Approach:** HIV response interventions shall follow a similar approach and common front to halt the pandemic. The health service provision shall be holistic, encompassing management of communicable and non-communicable diseases, nutrition, healthy lifestyles, hygiene and sanitation.

**Sustainability:** HIV response shall always assess and be cognisant of the ability for an intervention to continue into the future.

**Efficiency of Resources:** Allocation of resources shall be prioritised to where the benefits shall be greatest based on universally recognised and recommended interventions as well as regular cost-effectiveness analyses.

**Multi-sectoral Collaboration and Partnership:** Government and non-Government sectors will be consulted and involved in the planning, implementation, monitoring and evaluation of the HIV response using effective collaborative mechanisms.

**Quality:** National norms and guidelines and standards of services shall be reviewed, formulated, updated and applied to ensure that services delivered be of the requisite content and quality.

**Gender Balance:** Gender sensitivity and responsiveness shall be applied in HIV service planning and implementation. Special consideration shall be accorded to women and girls due to their cultural and economic vulnerability as well as all adolescents and young people. The services shall also be tailored to the special needs of men and vulnerable groups and key populations.

**Ethics and Human Rights:** All stakeholders shall exhibit the highest level of integrity, honesty and trust guided by ethical guidelines and professional councils. Legislation for reinforcement shall be augmented and/or revised accordingly.

**Involvement of People Living with HIV/AIDS:** People living with HIV/AIDS shall be consulted and participate in the development of all HIV policies, plans, and implementation of the response.



## **2.2 HIV/AIDS Response Goals and Objectives**

### **Goal**

The goal of the policy is to attain the 95-95-95 target and end the HIV pandemic by 2030

### **General Objective**

Lesotho shall have an enabling environment for the effective and high-impact HIV response and interventions

### **Specific Objectives**

In line with the goal and general objective, the specific objectives of the policy are as follows:

- To reduce new HIV infections;
- To improve the quality of life and increase life expectancy;
- To promote and protect the human rights, including sexual and reproductive health rights of PLHIV, vulnerable groups and key populations;
- To ensure a decisive, inclusive and accountable leadership in revitalising and intensifying the HIV response;
- To engender and utilize strategic information towards equitable and equal access to the interventions.

## **2.3 Policy Measures and Specific Objectives**

The policy shall be operationalised and measured through the specific objectives indicated below.

### **2.3.1 Specific Objective 1: To reduce new HIV infections**

- Lesotho shall further reduce HIV/AIDS related Mortality and reduce the high incidence and level of transmission of HIV. This is in the context of high poverty levels and increased vulnerability, low levels of comprehensive knowledge on HIV, high practice of risky behaviour, pockets of key vulnerable groups and key populations that are either underserved or unreached, and the stigma and discrimination including criminalisation of some of the vulnerable groups and key populations. Women, including adolescent girls and young women, and key populations are more affected by HIV and are subject to GBV with little respect for their reproductive and human rights.



Lesotho shall:

- Address the structural, social, economic, cultural and legal drivers of the pandemic;
- Accelerate and scale up interventions for best impact;
- Enhance equitable, accessible, affordable, comprehensive, quality, inclusive and sustainable services;
- Improve on the efficiency of the interventions based on evidence, focusing on geographic locations and populations at higher vulnerability of HIV infection through proven high/greatest impact service delivery models, innovations, and programmes;
- Improve comprehensive knowledge and promote behavioural change for all populations, including vulnerable groups and key populations.

### **2.3.2 Specific Objective 2: To improve the quality of life and increase life expectancy**

Poverty is interlinked with health. The poor have reduced access to information, lack adequate nutrition and cannot afford the costs associated with seeking health care (transport and service payments). TB co-morbidity is high and the population faces increased morbidity from both communicable and non-communicable diseases. HIV/AIDS mortality has shown a reduction subsequent to the expansion of the ART coverage. In order to improve the population's quality of life and life expectancy, Lesotho shall adopt the means indicated below:

- Holistic and systematic delivery of quality integrated services to all without stigma and discrimination to vulnerable groups and key populations. The adopted means include elimination of GBV to ensuring community participation and involvement (attain Universal Health Coverage [UHC and PHC approach]);
- Community enhancement, community engagement and community based organisation participation;
- Strengthened Faith Based Organisations' (FBOs) engagement;
- Promotion of integrated, inclusive, comprehensive systemic and sustainable approaches that respect human, sexual and reproductive rights;
- Improved mechanisms and systems for sustainable Social Protection to reduce vulnerabilities for HIV infected and affected people as well as their families.



### **2.3.3 Specific Objective 3: To promote and protect the human rights, including sexual and reproductive health rights, of PLHIV, vulnerable groups and key populations**

Human rights for PLHIV, vulnerable groups and key populations are not respected. GBV, stigma and discrimination are common as they are not always included in the design and delivery of services. There is need for reinforced meaningful engagement of these groups. In the same regards, human and reproductive rights shall be mainstreamed and integrated into the HIV response.

Lesotho shall:

- Adopt a human rights approach in the implementation of SRHR and HIV service interventions;
- Promote synergies between HIV programmes and poverty eradication efforts;
- Review legal and policy frameworks to eliminate stigma and discrimination against PLHIV, vulnerable groups and key populations;
- Promulgate laws and policies that allow free movement of PLHIV. Laws and policies should give migrants full access to HIV services at entry, as quasi-residents. Residence restriction should not be based on their HIV status. Policies should further advocate for non-discrimination at the workplace.

### **2.3.4 Specific Objective 4: To ensure a decisive, inclusive and accountable leadership in revitalising and intensifying the HIV response**

The HIV response includes input by inter alia Government Sectors, Non-Governmental Organisations (NGOs), Community Based Organisations (CBOs), Faith Based Organisations (FBOs), Traditional Leaders and Institutions, the Private Sector, Development Partners and vulnerable groups and key populations (and their organisations). The responses are at community, district and national levels. The response demands an all-encompassing and multi-sectoral approach that is effectively coordinated with accountable leadership. The response requires political commitment that enables operating systems to be transparent and efficient. Considering the large donor support that Lesotho currently enjoys, the country should also increasingly contribute towards the response and ensure expandable and sustainable success in its efforts.

Lesotho shall:

- Capacitate and allocate resources for coordination and implementation of the response interventions in addressing the enablers;
- Institute sustainable funding mechanisms and improved domestic funding of the response;



- Build capacity for enhanced response and accountability at governmental level, organisational level and within local communities;
- Decentralise services;
- Foster transparency and accountability for HIV funding.

### **2.3.5 Specific Objective 5: to engender and utilize strategic information towards equitable and equal access to the interventions**

The response should be monitored and all have access to the HIV services.

Lesotho shall:

- Innovatively obtain data to inform the interventions;
- Institute and avail strategic information for the response.



## **Part III: Implementation Framework of the Lesotho HIV Policy**

The Framework enunciates the institutional arrangements for an efficient and effective coordination, and defines the roles and responsibilities as well as linkages of the different stakeholders and coordinating structures. It is anticipated it will also contribute to good governance, accountability and transparency and promote ownership of the response by stakeholders and communities.

### **3.1 National Level**

The organisation of the HIV/AIDS response recognises that the underlying causes to the high HIV, TB and associated infections are multifaceted. Thus, they require a multi-sector and varied stakeholders' response involving government agencies, civil society organisations, faith-based organisations, traditional leaders, the private sector, the academia and the communities themselves. Development partners provide the support. It re-emphasises the key coordination role for the success of the response, both between and within sectors and stakeholders. It further acknowledges that while the country faces a generalised pandemic, there are pockets of concentrated pandemic and key populations within the general population that need to be addressed. In line with the current knowledge and recommended key effective actions, it recognises the key role played by the health sector and that Universal Health Coverage (quality, comprehensive, equitable, human rights compliant, recognition of vulnerable groups and key populations) is key to the success of the response. The essential shift of approach to integrated and people-centred interventions and the respect for human rights and gender equity underpin all interventions.

#### **3.1.1 The Office of the Prime Minister (OPM)**

- In line with its mandate, The Office of the Prime Minister shall provide political and government leadership and commitment. The office shall advocate, authorise and lead the efforts to sustainability of the response through adequate sustainable financing, national and community ownership. The OPM gives the NAC the mandate to oversee the implementation of the policy to the letter. The role played by MOH and key stakeholders shall consist in providing quality, affordable health and HIV/TB/SRHR services to the populations that are left behind. The OPM shall also ensure an enabling social, policy and legal environment for the response.

#### **The Cabinet Sub-Committee on HIV/AIDS**

The Cabinet Sub-Committee on HIV/AIDS is chaired by the Deputy Prime Minister and comprises of Ministers of Health, Finance, Social Development, Gender, Education, and Local Government. The Committee shall:

- Review NAC programme and management policy documents and proposals;
- Advise the Office of the Prime Minister;



- Advocate for continued prioritisation of HIV/AIDS response on the national social, economic and political agenda;
- Oversee NAC's compliance with the stipulations of the National Strategic Plan (NSP), NAC Act, National HIV/AIDS Policy, other policies and laws;
- Advocate for sustainable financing of the national multi-sectoral response undertaken in collaboration with Government and Development partners.<sup>17</sup>

### **The National AIDS Commission (NAC)**

The NAC includes the Commissioners and the National AIDS Secretariat. The NAC as a unit shall:

- Coordinate, oversee and ensure prioritisation of HIV prevention, treatment and care, social protection and mitigation interventions and strengthening of the enabling environment in collaboration with MOH, MOLGC, MOET, MOSD, MOF and other sector leads;
- Steward mainstreaming of HIV into public, civil society, faith-based and private sectors;
- Provide a neutral and unbiased leadership for the management of the HIV response;
- Work with the cabinet subcommittee on AIDS and Ministry of Finance to ensure adequate domestic resource mobilisation. This includes meeting goals and objectives stipulated in the Abuja Declaration as well as channelling the 2% portion of the budget from other ministries towards HIV;
- Motivate the MOH to integrate HIV and TB fully into the universal health coverage agenda towards 2030;
- Mobilise financial and human resources, strengthen the HIV response management capacity, communication as well as information systems.

### **The NAC Secretariat**

The NAC Secretariat will be capacitated through deployment of requisite human and other resources as well as financing towards an effectively coordinated and efficient response. The NAC Secretariat shall:

- Serve as the secretariat to NAC Board of Commissioners and follow up as well as implement the decisions of the NAC;
- Build the capacity for CSOs;
- Screen, supervise and control (from entry) the CSOs, NGOs, and international implementers;

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<sup>17</sup> Government of Lesotho, National HIV and AIDS Strategic Plan 2018-2019 and 2022-2023



- Map out and allocate actors to avoid duplication and foster collaboration;
- Oversee quality control with regard to the interventions;
- Monitor progress against targets from all implementers (all data including community-based and financial implementers)
- Lead Social Mobilisation and Communication on HIV;
- Advocate for and facilitate sustainable financing of the response;
- Establish the AIDS fund, follow up on funding and its utilisation including donor funding;
- Facilitate networking and information sharing among stakeholders;
- Coordinate Development and subsequent reviews of the National HIV/AIDS policy, The National Strategic Plan and the M&E plan;
- Organise quarterly fora to update stakeholders utilising the quarterly dashboard and to report on progress;
- Support the sectors in the development and implementation of their HIV/AIDS programmes;
- Compile, publish and disseminate annual and quarterly reports;
- Coordinate with development partners on resource prioritisation, mobilisation and tracking;
- Lead on knowledge management and innovation.

### **Food and Nutrition Coordinating Office (FNCO)**

The FNCO coordinates nutrition in Lesotho. The FNCO shall:

- Integrate HIV and TB into nutrition policies, strategies and plans;
- Monitor the nutrition response to HIV;
- Build the capacity of nutrition actors in nutrition and HIV and TB.

### **3.1.2 Stakeholder/Sector Response**

The stakeholders for the response shall include the public sector, civil society organisations, community-based organisations, faith-based organisations, private sector, the academia, media, development partners, traditional leaders and beneficiary communities.

Public sector institutions will take the overall sector lead in coordination, collation of information and reports and channel them up to the NAC.

#### **3.1.2.1 Public Sector**

Government institutions involved in the response include the parliament, line ministries, local authorities, parastatal organisations, and other semi-autonomous government





agencies. Government ministries have identified focal persons to facilitate HIV/AIDS workplace programmes.

### **Inter-Ministerial Committee**

The Government of Lesotho established an Inter-Ministerial Committee for Coordinating HIV/AIDS response in the public sector with the Ministry of Public Service as the Secretariat. The mandate of the committee is to promote and support HIV/AIDS mainstreaming, including in finance, human resources, policies and development of interventions. All sectors would be capacitated in coordination and management of the sector response and in facilitating an efficient system for HIV/AIDS workplace services delivery. The Ministry of Health is singled out to design and develop health based programmes.

### **Ministry of Health (MOH)**

The Ministry of Health has the mandate to spearhead, coordinate and manage the health sector HIV response in biomedical prevention, treatment and care, as part of the national multi-sectoral response.<sup>18</sup> The MOH shall:

- Regulate, formulate and review health sector policies, strategic plans, Standard Operating Procedures (SOPs), protocols and guidelines on biomedical HIV prevention, treatment and care;
- Facilitate capacity building for the health sector;
- Strengthen, avail and ensure quality control of the health system including infrastructure and equipment, human resources at the level of health facilities; pharmaceuticals, vaccines, health equipment and other technologies, and procurement and supply chain management;
- Adequately budget and allocate finances for HIV within the health sector;
- Ensure adequate laboratory systems;
- Mobilise resources from Government and Partners for the health sector;
- Manage the Health Information Management System (HMIS);
- Ensure scaling up and access to services by the general population, PLHIV, people affected by TB, vulnerable groups and key populations;
  
- Set and monitor standards for health sector interventions on HIV and TB within the Quality Assurance System;
- Coordinate monitoring and evaluation of the health sector response to HIV/AIDS and TB;
- Develop strategic partnerships and alliances for health;
- Coordinate health research;

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<sup>18</sup> Government of Lesotho, National HIV and AIDS Strategic Plan 2018-2019 and 2022-2023



- Provide technical assistance to other health sector-based implementing partners;
- Provide nutritional counselling, measuring nutritional status and linking severely acute malnourished PLHIV and TB patients to relevant implementers (including Ministry of Social Development [MOSD], Ministry of Agriculture and Food Security [MOAFS]) and health facilities;
- Review and update the protocol and related tools on integrated management of acute malnutrition;
- Ensure that Nutrition Assessment Counselling and Support (NACS) is integrated into ART and TB care programmes:
  - implementation of NACS in all health facilities;
  - management of acutely malnourished ART and TB patients;
  - mobilisation of resources for procurement of specialised nutritious food supplements for treatment of malnutrition;
  - Compilation of information education materials on nutrition;
- Establish a referral system between health facilities and communities (CSOs, other Government structures present at community level) for nutrition and food security services;
- Support supplementary and complementary feeding programs (including provision of super cereals to Moderate Acute Malnutrition [MAM]), and advise PLHIV, Orphans and Vulnerable Children (OVCs) and the elderly on how to prepare supplementary food provided by partners, while monitoring its correct use;
- Advocate for harmonisation of the data systems with neighbouring countries for effective monitoring of emigrants and immigrants.<sup>19</sup>

### **Ministry of Education and Training (MOET)**

The MOET shall:

- Facilitate HIV mainstreaming in learning institutions;
- Develop examinable HIV/AIDS curriculum from Primary to Tertiary Institutions;
- Enhance prevention among children and young people including through CSE delivery, promotion of HIV prevention and treatment services and product uptake;
- Ensure Social Protection of Children in Schools.

### **Ministry of Social Development (MOSD)**

The MOSD shall:

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<sup>19</sup> Government of Lesotho, National AIDS Commission, Coordination Framework



- Identify poor and ultra-poor persons at different life-course stages, including those living with HIV/AIDS, and facilitate their enrolment into social assistance programmes;
- Facilitate strengthening of coordination among social protection stakeholders and establishment of strong referral mechanism between them to ensure that those in need of assistance are directed to appropriate service providers;
- Improve the HIV/AIDS sensitiveness of existing social protection interventions and introduce new ones where necessary (Integrate HIV/AIDS issues into social protection interventions);
- Improve access to sustainable livelihoods for poor and vulnerable people, including those receiving social assistance;
- Strengthen existing and introduce new mechanisms for integrating street children into their families;
- Improve coordination between social protection and HIV/AIDS stakeholders for better HIV/AIDS outcomes for beneficiaries of social protection interventions;
- Introduce and operationalise mechanisms for promoting and protecting the rights of all citizens and residents, including the poor and vulnerable;
- Collaborate with NAC to coordinate identification and targeting of vulnerable individuals at different social levels;
- Collaborate with NAC to coordinate Social Protection Strategy.

### **Ministry of Labour and Employment (MOLE)**

The MOLE shall:

- Integrate all HIV program interventions and policies in the workplace and surrounding communities, including in the formal sector and among migrants, factory workers, and seasonal workers;
- Provide social security to vulnerable individuals in collaboration with MOSD and other implementers;
- Update and implement the HIV Workplace Policy 2006.

### **Ministry of Finance (MOF)**

The MOF shall:

- Allocate progressively improved funding to HIV, in collaboration with NAC, under the supervision of the cabinet subcommittee on AIDS;
- Enforce the requirement for contribution of 2% of budgets by ministries to the HIV response;



- Commit to the Abuja Declaration of 15% of government expenditure in health;
- Institute a tax levy and other mechanisms e.g. social insurance, for funding health;
- Facilitate a progressive decrease of out-of-pocket expenses for health, especially for vulnerable groups and key populations;
- Develop a Sustainable Financing Strategy for HIV/AIDS.

### **Ministry of Justice, Human Rights and Correctional Services (MOJHRCS)**

The MOJHRCS shall:

- Link inmates living with HIV to MOH, MOSD and Ministry of Local Government and Chieftainship (MLGC) structures;
- Avail comprehensive HIV/TB & SRHR Services equivalent to those provided for the general public;
- Institute adaptation programmes for newly incarcerated inmates, to reduce new HIV infections during incarceration;
- Collaborate with the Ministry of Law and Constitutional Affairs and the Ministry of Gender, Youth, Sports and Recreation to repeal discriminatory laws against PLHIV and key populations and promulgate laws that enforce respect of the human rights and equality for key populations and other vulnerable people;
- Ensure that all HIV Legal Frameworks are harmonised and complementary.

### **Ministry of Agriculture and Food Security (MOAFS)**

The Ministry of Agriculture and Food Security (MOA) shall:

- Train PLHIV, Adolescent and Young People (AYP) and other vulnerable groups, key populations and communities, through Council Action Groups (CAGs) to promote food security;
- Provide seeds and farming implements to the most vulnerable people;
- Promote and support supplementary and complementary feeding programs and assist PLHIV, OVCs and the elderly to prepare supplementary food provided, while monitoring its correct use;
- Conduct positive deviance studies to improve food security across the country, prioritising the most vulnerable communities;
- Avail its human resources including District Agricultural Officers, Nutritionists and Area Technical Officers throughout the country to promote nutrition and provide assistance including in sustainable social protection.



### **Ministry of Local Government and Chieftainship (MOLGC)**

The MOLGC instituted the Gateway Approach and Essential Services Package (ESP) to respond to HIV in a more coordinated and effective manner. This Ministry supported communities and supervised District AIDS Committees and Coordinators at community level.

The Ministry of Local Government and Chieftainship shall:

- Coordinate district and community-based HIV/AIDS interventions on behalf of Government;
- Foster the establishment of Village Multi-sectoral Focal Points and Committees;
- Strengthen District and Community AIDS Committees to efficiently coordinate the response on behalf of government;
- Capacitate the local authorities and chiefs to best support vulnerable groups.

### **Ministry of Development Planning**

The Ministry of Development Planning is responsible for providing the strategic direction for the country through the NSDP. The MODP shall:

- Ensure HIV and TB are integrated into the analysis and strategies for economic growth, infrastructure development, enhanced skills base, innovation and technology adoption for accelerated growth;
- Improve the planning capacity and prioritisation of HIV and TB;
- Mainstream HIV and TB into all development plans;
- Facilitate the integration of HIV and TB into sector plans.

### **Ministry of Gender, Youth, Sports and Recreation (MOGYSR)**

The Ministry shall:

- Advance gender equity and equality;
- Enhance sporting excellence as part of and in support of healthy lifestyles;
- Advocate for respect for women and youth and enhance human rights of women and youth;
- Ensure that development efforts positively impact on both females and males by integrating them into the country's socio-economic and political development.

Through the Departments of Gender and Youth, the Ministry shall:



- Implement and scale-up initiatives that build on the Lesotho National HIV Policy;
- Integrate HIV interventions including the empowerment of out of school girls and boys, men and women, into the national and district policies, programmes, plans and projects and monitoring and evaluation frameworks;
- Monitor the progress and evaluate the gender indicators in relation to HIV, TB, and SRHR.

### **Ministry of Communications, Science and Technology (MCST)**

The Ministry has the mandate and resources to communicate HIV related messages and mobilise communities for HIV Prevention, Treatment and Care, and Social Protection. The MCST shall:

- Provide reliable and standard information, in line with the guidelines on the advocacy and communication for HIV, TB, Hepatitis and SRHR, through print and electronic media;
- In collaboration with the other Ministries, ensure information is disseminated on a timely and regular manner in response to the HIV situation in the country;
- Advocate for and support technological innovations and scientific research for the advancement of HIV interventions.

### **Ministry of Public Service (MPS)**

The MPS has the responsibility for recruiting, deploying, determining the terms of services, discipline and firing of all civil servants.

The MPS shall:

- Analyse the status of the health and relevant workforce to meet the health and HIV needs of the country;
- Develop and follow a plan for the development of the health human resources;
- Advocate with the MOH and MOF for quality health services through a well-functioning health system;
- Mainstream HIV into the Public Sector;
- Ensure that HIV work is appraisable.
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### **Ministry of Home Affairs (MOHA)**



The MOHA is responsible for providing the identity and travelling documents for Lesotho citizens as well as regulating movement of citizens and migrants in and out of the country. The MOHA shall:

- Advocate for cross-border collaboration at national, provincial and local and/or municipality level;
- Regularise the status of migrants.

### **Ministry of Foreign Affairs and International Relations (MOFA)**

The MOFA is responsible for diplomatic relations and High Commission and/or Ambassadorial and Consular services. The MOFA shall:

- Capacitate missions in neighbouring countries (Consular services) in support of emigrants and their access to services.

#### **3.1.2.2 Civil Society**

With the experience gained in the HIV response, the Political Declaration 2016 stipulates that 30% of all service delivery should be community-led by 2030 and that 6% of HIV resources should be allocated for social enabling activities. Civil society organisations include Non-Governmental Organisations (NGOs), Faith- Based Organisations (FBOs), Community -Based Organisations (CBOs), Media Groups, Youth Groups, Women Groups, Men Groups, Organisations of People Living with HIV/AIDS, and Organisations of key populations<sup>20</sup>. They essentially operate in close contact with communities and individuals as they are best placed to reach people left out to attain the targets set for 2020 and 2030 in the HIV response.

##### **3.1.2.2.1 NGOs and CBOs**

The NGOs and CBOs shall:

- Organise themselves and be coordinated for best impact under one umbrella body;
- Advocate for priority interventions, especially the needs of PLHIV, key populations and vulnerable groups as well as underserved areas, with Government, Development Partners and Donor Agencies at national level;
- Encourage Government to commit to reliably allocate resources (finance, human resources including VHWs, 2% funds to Government ministries) for community based interventions;
- Commit to national monitoring framework. This also includes monitoring of communities and CSOs for transparency and accountability;

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<sup>20</sup> UNAIDS, Best Practices on Effective Funding of Community-Led HIV Responses, 2018



- Empower communities with knowledge and capacity to access services;
- Mobilise communities for HIV, TB, Hepatitis and SRHR;
- Undertake outreach responses especially in service provision, human rights and law reforms, reduction of stigma and discrimination;
- Be the voices on the needs of the marginalized and those left behind.

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### **3.1.2.2.2 Faith Based Organisations**

The Faith based Organisations shall:

- Promote the dignity, equity, equality and rights of all people, especially those living with HIV regardless of faith, religion, gender, sexual orientation, socioeconomic status, race, ethnicity or political belief;
- Commit to strengthen the capacity of their Faith Leaders on SRHR, TB and HIV;
- Discuss openly and accurately the basic facts and evidence-based information about HIV/AIDS, including all effective means of HIV prevention and treatment;
- Enhance efforts for elimination of the root causes of the HIV/AIDS pandemic, including gender inequality, harmful social and cultural practices and norms;
- Break the silence, stigma, discrimination, denial and fear regarding HIV/AIDS;
- Denounce all HIV/AIDS related misconceptions;
- Advocate for expanded and equitable distribution of resources towards HIV/AIDS programming;
- Support and contribute towards research to identify more effective means of prevention and treatment;
- Promote 'universal access for all in Lesotho' - for effective HIV response.<sup>21</sup>

### **3.1.2.2.3 Traditional Leaders**

Traditional Leaders are the repository of culture and exert influence on the public perception on a wide area of issues including their health and rights. Chiefs are the village authority and exert a level of influence on communities.

Traditional Leaders shall:

- Lead the mobilisation response for HIV, TB, and SRHR at community level;
- Pursue a change of attitudes and perceptions including denouncing of stigma and discrimination towards PLHIV, vulnerable groups and key populations;

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<sup>21</sup> This information has been collected from the interviews and focus group discussions held with Faith-Based Organisations





- Advocate for the promotion and protection of human rights, including gender equality and denunciation of GBV;
- Provide oversight to the Village Multi-sectoral Committees (Village Chiefs);
- Coordinate HIV implementers at the community level.

#### **3.1.2.2.4 Private Sector**

The engagement of the Private Sector and Business is critical since HIV mainly affects the working population, reduces productivity and labour supply, increases operating costs and reduces productivity. The Private Sector should be interested in their own well-being and that of the communities they serve.

The Private Sector shall:

- Institute HIV education at workplace and for communities through partnerships;
- Institute workplace programmes for their staff and families;
- Promote and create an enabling environment for addressing the underlying causes to HIV and TB and promote human rights as well as SRHR;
- Mobilise private funds for HIV.

#### **3.1.2.2.5 Academia**

Academic institutions train the human resources required for the response. They also have the expertise for research.

The Academia shall:

- Review and update their curricula regularly for their graduates acquire expansive content knowledge required to respond to the challenges posed by HIV and TB;
- Develop an HIV research agenda and conduct research;
- Partner with key stakeholders in planning, reviews and evaluation of HIV/AIDS programs;
- Facilitate in-service training on HIV;
- Provide HIV/AIDS services.

#### **3.1.2.2.6 Media**

The media organisations and Individuals inform communities and disseminate information through print, audio visual and electronic channels. The media shall:

- Seek appropriate information on HIV and include it in their regular dissemination;



- Provide reliable and standard information in line with the guidelines on the Advocacy and Communication for HIV, TB, Hepatitis and SRHR and GBV;
- In collaboration with other stakeholders, disseminate information on a timely and regular manner in response to the HIV situation in the country;
- Capacitate their members and staff to acquire extensive content knowledge required to respond to the challenges posed by HIV and TB.

#### **3.1.2.2.7 United Nations (UN)**

The UN agencies shall in alignment to the defined country priorities provide support individually and through the UN Development Assistance Framework (UNDAF). "Delivering as one" they shall develop a joint programme and provide effective support to the country HIV, TB and SRHR response based on country priorities and gaps, agency mandates and the UN's comparative advantage.

#### **3.1.2.2.8 Donors and International Partners**

The donors shall align their country support to the identified priorities and ensure sustainability through involvement of local service providers and stakeholders. They shall also support innovations and technology and research in support of the country needs. They shall allocate resources transparently, monitor their use and share reports with relevant government ministries and departments.

### **3.2 District and Local Level**

#### **3.2.1 District HIV/AIDS Committee**

District HIV/AIDS Committees (DACs) were instituted in every district under the auspices of NAC with a mandate to coordinate and facilitate district level planning, programme development and monitor and evaluate of HIV/AIDS. The committees also facilitated networking and sharing of information and experiences. These committees shall be resuscitated and shall incorporate TB, Hepatitis and SRHR.

The DACs, under the auspices of NAC, shall:

- Facilitate joint and participatory district level planning;
- Facilitate technical, financial and material support to community level organisations;
- Identify capacity needs of communities and facilitate capacity development;
- Develop and implement plans targeting vulnerable groups and key populations;
- Assess, develop and implement plans for geographically neglected and underserved communities;



- Report adequately to the National AIDS Commission using relevant forms and templates.

### **3.2.2 District Health Management Team (DHMT)**

The DHMT is the leader and authority on health in the districts.

The DHMT shall:

- Coordinate the implementation of the district integrated HIV/AIDS, TB, SRHR and Hepatitis annual plans;
- Identify underserved areas and design plans for their coverage;
- Deliver services through outreach programmes including house to house visits in prevention, treatment and care, thus adopting proven high impact interventions;
- Regularly monitor performance and take corrective measures;
- Institute measures to ensure that implementing partners be accountable and transparent. DHMT shall also advocate for accountability and good governance;
- Regularly report to the Local Government structures;
- Represent the Health Sector in the DHAC.

### **3.2.3 Public Sectors, Civil Society and Business at District Level**

The roles of the organisations at this level shall consist in developing plans, implementing, monitoring progress and support rendered to community level organisations in accordance with their mandate and areas of expertise.

### **3.2.4 Community Organisations and communities**

A coordination committee cascading from the DAC shall be constituted around the Community Councils' HIV/AIDS Committee (CCAC).

The CCAC shall:

- Advocate for priority interventions at district level and with Government and partners;
- Identify and build the capacity of community actors;
- Identify, together with communities their needs and advocate for implementation of interventions to meet their needs;



- Identify vulnerable members of communities and link them to social protection programmes;
- Empower communities with knowledge and capacity to access services;
- Mobilise communities for HIV, TB, Hepatitis and SRHR;
- Monitor interventions at community level and be the watchdog;
- Monitor acts of violence and abuses of human rights, gender inequality and Gender-Based Violence and produce written reports on such violations;
- Collaborate with relevant institutions to advocate for punitive measures to be taken against such violation of human rights.



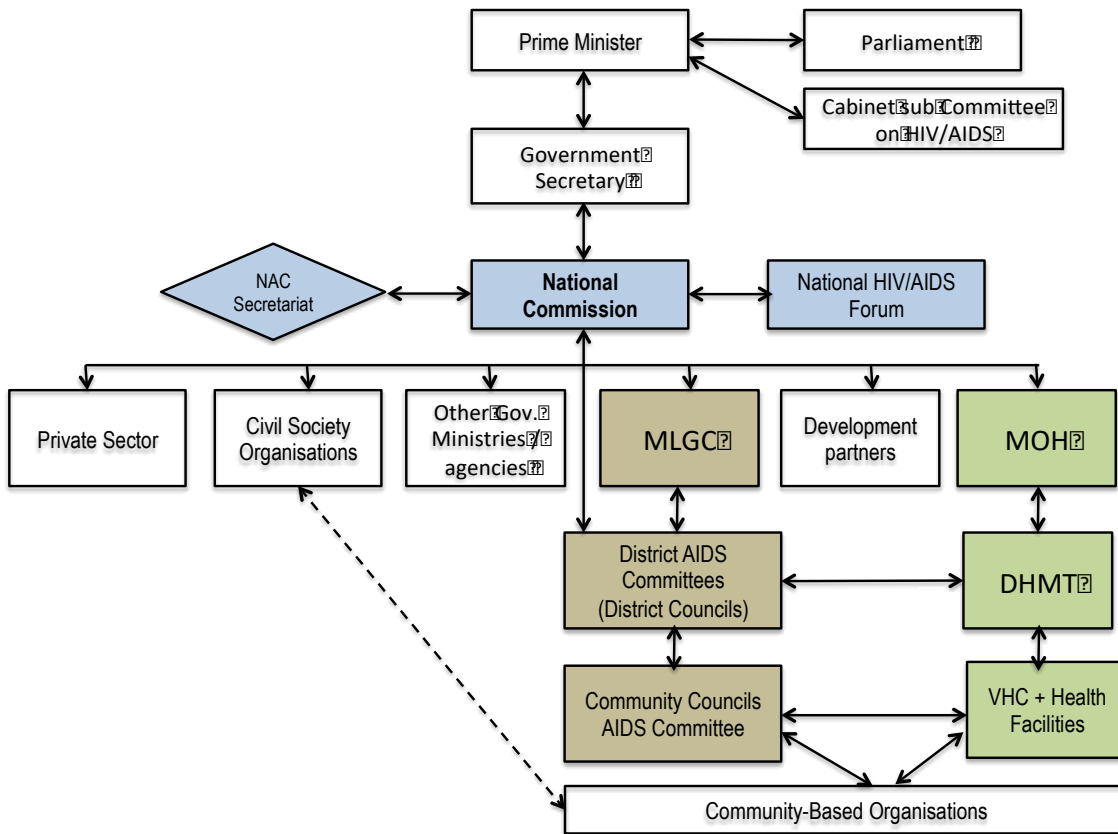
## **Part IV: Operational Steps for implementation**

The following shall be the operational steps to ensure the policy is implemented:

- Adopt and promulgate the National HIV Policy;
- Adopt and implement the National HIV Strategic Plan and Implementation Plan;
- Develop, update and disseminate relevant protocols, guidelines, and SBCC messages;
- Evaluate capacity needs (pre and in-service);
- Develop training modules and educational materials, disseminate them;
- Strengthen the Health Systems;
- Strengthen capacities of service providers at all levels;
- Mobilise and provide financial resources;
- Promulgate and/or update relevant laws and regulations, mechanisms for enforcement and monitor compliance;
- Support regular follow-up and tracking of progress;
- Undertake regular monitoring and evaluation.



**IMPLEMENTATION STRUCTURE**





## **Part V: Monitoring and Evaluation**

The multi-sectoral team coordinated by NAC and with technical support of the MOH shall periodically monitor performance against the set targets. Sectors shall in return assess their own performance. The response shall be evaluated at regular intervals and policy level interventions instituted accordingly.

### **Impact Indicators**

- HIV incidence;
- HIV related Mortality differentiated by age and sex;
- Morbidity and HIV-TB co-infection morbidity;
- Maternal Mortality Ratio.



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