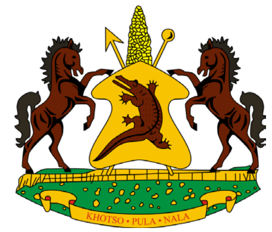

Lesotho:HIV and social protection assessment report

November 2019

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Foreword

The Government of Lesotho is committed to achieving the targets of international and regional agreements by setting ambitious goals within national policies and strategies. Lesotho is a signatory to the United Nations 2030 Agenda for Sustainable Development as well as to the 2016 Political Declaration on Ending AIDS, 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.

There is recognition that AIDS responses are most effective when they operate against a background of strong social protection programmes. Social 'drivers' of HIV risk, such as gender and income inequalities and social exclusion make it difficult for people to access HIV services and other health services. Lesotho intends to strengthen national social and child protection systems to ensure that by 2020, 75% of people living with, at risk of or affected by HIV benefit from HIV-sensitive social protection programmes based on Paragraph 62(i) of the 2016 Political Declaration on HIV and AIDS, which contains a social protection target. This will be done in line with the UNAIDS Fast-Track approach, which seeks to frontload investments and reduce new HIV infections and AIDS-related deaths to fewer than 500,000 per year globally, and to achieve the 90-90-90 testing, treatment and viral suppression targets and zero AIDS-related discrimination targets by 2020. Attaining these targets would put the world on course to ending the AIDS epidemic as a public health threat by 2030.

The increasing consideration of social protection programmes demonstrates the government's commitment to improving the living conditions of the most vulnerable people in society. Lesotho's National Social Protection Strategy (NSPS) was developed in 2017 with the purpose of ensuring linkages between all social protection programmes for increased efficiency and effectiveness and to integrate and harmonise operational systems for effective implementation. The Government of Lesotho also developed the Social Development Policy in 2014 and has established and rolled out the National Information System for Social Assistance (NISSA) to offer vulnerable families social assistance support.

The information gathered from the assessment described in this report is intended to support decision-making in strengthening the HIV-sensitivity of social protection programmes to better reach people living with, at risk of, or affected by HIV. The findings will also help in the implementation of national strategies and programmes, including the National HIV and AIDS Strategic Plan for 2018/19–2022/23 and National Social Protection Strategy, HIV investment cases, concept notes for funding and other social protection programmes.

I therefore urge all sectors, government ministries, development partners, private and civil society organisations to join hands in the implementation of the recommendations emerging from this assessment in order to ensure that social protection programmes are HIV-sensitive. I would also like to thank all those who participated in the HIV and social protection assessment process, as it shows joint efforts and collaboration in contributing to building strong HIV-sensitive social protection programmes.

Hon. Leshoboro Mohlajoa
Minister in the office of the Prime Minister

Acknowledgements

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Keratile Thabane (Mrs)

Chief Executive - NAC

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Acronyms and abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
CGP	Child Grant Programme
CSO	Civil society organisation
CSW	Commercial sex worker
DHS	Demographic and Household Survey
DMA	Disaster Management Authority
ECCD	Early childhood care and development
HIV	Human Immunodeficiency Virus
LePHIA	Lesotho Population Based HIV Assessment
LGBTQI	Lesbian, gay, bisexual, transgender, queer or intersex
M	Lesotho Meloti
MoH	Ministry of Health
MoSD	Ministry of Social Development
MSM	Men who have sex with other men
NAC	National AIDS Commission
NISSA	National Information System for Social Assistance
NSPS	National Social Protection Strategy
OAP	Old Age Pension
OVC	Orphans and vulnerable children
PA	Public Assistance
PLHIV	People living with HIV
PWD	People living with disabilities
STI	Sexually transmitted infections
TB	Tuberculosis
TVET	Technical and vocational education and training
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WFP	World Food Programme

Executive summary

There is increasing recognition that social protection can play a role in the HIV response in many countries. By addressing some of the driving factors – including poverty and reliance on negative survival strategies such as transactional sex – social protection can ensure access to the necessary services and treatments needed to reduce the incidence of HIV and to help prevent AIDS-related deaths. In addition, social protection can contribute to the economic and social empowerment of beneficiaries, helping to reduce the stigma and discrimination faced by people living with HIV (PLHIV).

But people living with, at risk of or affected by HIV need to be able to access such social protection programmes, and the various schemes should be HIV-sensitive. In other words, the programmes must be inclusive of people living with, at risk of, or affected by HIV, and must take their needs and realities into account in terms of both design and implementation.

Within this framework, the Joint United Nations Programme on HIV/AIDS (UNAIDS) has developed the HIV and Social Protection Assessment Tool to enable the identification of population groups – among people living with, at risk of or affected by HIV – facing the most significant barriers to accessing social protection programmes, and of the specific barriers themselves. The tool also identifies policy options for reducing such barriers and developing more HIV-sensitive social protection programmes.

This report presents the findings of an HIV and Social Protection Assessment conducted in Lesotho. The findings are based on discussions and an assessment workshop held with key stakeholders in Maseru in October 2018, a validation workshop held in Maseru in November 2018 and a rapid desk review of the literature.

Key findings

The assessment finds that the social protection landscape in Lesotho has the potential to make significant contributions to the Government of Lesotho's HIV response. Numerous schemes exist that address a wide range of vulnerabilities relevant to people living with, at risk of or affected by HIV. These schemes include the Worker's Compensation Programme, which requires employers to insure their employees in case of injury or death; voluntary and community-led burial schemes; and the civil service pension scheme for public service employees.

There are also non-contributory social assistance programmes in Lesotho that provide cash benefits to large sections of the population. Examples include: (1) a child grant programme (CGP) that covers school-related costs for children who have lost one or both parents (although not all eligible beneficiaries are part of the programme); (2) a public assistance scheme that provides a monthly cash transfer to eligible households; (3) a public works programme (although the supply of employment opportunities is lower than

the demand); (4) an old-age pension scheme for those over 70 years; (5) free services at primary health facilities; (6) bursaries for tertiary education; and (7) country-wide free primary education.

There are also social protection programmes that provide in-kind benefits targeted at a wide range of population groups, which implicitly include many population groups living with, at risk of or affected by HIV. Examples include supplementary feeding intervention aimed at children and pregnant women, and a school feeding programme providing all children in early childhood development centres and public primary schools with supplementary nutrition.

Many groups among people living with, at risk of or affected by HIV face barriers to accessing social protection programmes, however. These groups – identified during the assessment workshop – include PLHIV, prisoners, people living with disabilities (PWDs), people aged 50 years and above, commercial sex workers (CSWs), factory workers in textile and apparel industries, orphans and vulnerable children (OVCs), men who have sex with men (MSM), adolescent girls and young women, and herd boys and men. Each group faces particular barriers to specific schemes, while some populations face barriers to all schemes.

The most significant barriers to accessing social protection services relate to the limited coverage of individual schemes and insufficient availability of many key services. In turn, this limited coverage results in a lack of awareness of such schemes, which may prevent many groups from seeking access in the first place. Older citizens, PWDs, adolescents, prisoners and PLHIV were also found to face discrimination and/or a lack of sensitivity when seeking access to healthcare systems. Stigma towards vulnerable populations (including PLHIV, CSWs and MSMs) means that many individuals do not seek out social protection services.

The most significant barriers to accessing non-contributory schemes are the high opportunity cost in terms of time spent away from wage-earning activities, and transport costs associated with travelling to access services. Limited awareness of the schemes is also an important barrier.

Access to education is constrained not only by transport costs, but also by the cost of uniforms. Adolescent girls and young women face numerous additional barriers to accessing education, such as child marriage and sexual assault in schools. OVCs have been found to have high school dropout rates as many of this group have to take on caregiving roles.

PWDs face significantly more barriers to accessing all of the social protection schemes as many programmes lack the infrastructure necessary to meet their specific needs. Further, as many PWDs need help to access health services, this group are at a higher risk of compromised confidentiality.

Policy recommendations

The above findings were presented at the validation workshop to consider how Lesotho's social protection system can be more HIV-sensitive. Specific policy recommendations emerged from the workshop and consultations with key focal groups.

1) People living with, at risk of or affected by HIV need to be meaningfully engaged at all levels in the design and implementation of social protection schemes by both local and national governments in Lesotho. Efforts need to be made to:

- ensure that new schemes are designed to meet the needs of PLHIV and that existing schemes are adapted to increase outreach to vulnerable populations
- ensure implementation of programmes does not unintentionally construct barriers to vulnerable populations (e.g. the cost of transport to clinics, clinic waiting times)
- allocate funding to enable meaningful participation and input from key populations, including allowances for transport costs and lost earnings.

2) Coverage of existing social protection schemes should be expanded to reach a greater share of the population. Increasing eligibility for cash transfer schemes beyond older people and children to other vulnerable populations could play a key role in improving access to services. Improvements to Lesotho's National Information System for Social Assistance (NISSA) should be accelerated to ensure that non-poor households are not the main beneficiary of programmes, and to ensure no poor household is completely excluded. Targeting criteria for existing programmes should be improved and the focus should move away from discretionary home assessments and self-identification. Furthermore, making finance available for PLHIV to start and sustain small-scale projects (thus including a livelihood component into social protection) would provide a long-term route out of poverty.

3) Efforts should be made to address supply-side challenges to the provision of healthcare and education services. This will require increasing funding to social protection overall and at the local level, particularly in remote areas. Schools will require teachers trained in dealing with the needs of children with disabilities; law enforcement and key community officers should be trained in dealing with reports of sexual violence; investment is needed in mobile health outreach services (e.g. mobile health clinics or travelling health workers) for vulnerable populations such as herd boys; and night clinics need to be set up so that textile factory workers can access health and education services without the risk of losing their jobs.

4) Training and public campaigns are needed to combat stigma around HIV and AIDS and to raise awareness of social protection schemes. Such approaches include investing in training for healthcare staff and school teachers on the importance and methods of maintaining confidentiality. Training is particularly important when dealing with PWDs, CSWs, people who are lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI), MSM and adolescents. Campaigns to raise public awareness around HIV and AIDS and to reduce stigma should combat the myths around how HIV is transmitted, sensitise communities on the cost of social isolation for PLHIV and raise the positive profile of individuals living with HIV and AIDS. A substantial part of this will also include reviewing laws that criminalise key vulnerable populations such as CSWs.

5) Better coordination is required between vertical and horizontal levels of government on social protection. As a first step, available social protection services should be mapped out with information on geographical distribution to indicate which areas are marginalised and which may have an oversupply of services. Currently, social protection functions are dispersed between different authorities; therefore these institutions need to coordinate their activities to ensure they are working towards a consistent set of priorities and not duplicating efforts. Coordinated operations, strategies and financing could ensure that social protection services reach the grassroots level and that shared objectives are met.

1. Introduction

There is increasing recognition of the role that social protection can play in advancing the HIV response, particularly in ensuring access to services to prevent transmission, and to treat and care for people living with, at risk of or affected by HIV. Synergies between HIV and social protection programming have already been identified and explored in Lesotho – where an estimated 306,000 people of a population of 2.3 million are living with HIV (ICAP/CDC/MoH, 2017) – but vulnerable populations continue to face particular barriers that limit the opportunities for co-programming.

HIV-sensitive social protection refers to the range of policies and programmes – including legal reforms, economic empowerment programmes, cash transfers and contributory social protection schemes, among others – which have been found to have the potential to address some of the drivers or causes of HIV infection and to reduce the exclusion of people living with HIV (PLHIV). The United Nations Joint Programme on HIV/AIDS (UNAIDS) has advanced the concept of HIV-sensitive social protection in their 2016–2021 Strategy, where they note that 'social protection programmes can reduce risk behaviour, including transactional and age-disparate sex, improve access to HIV services and enhance the effectiveness of HIV programmes' (UNAIDS, 2015: 70).

In this context, this assessment aims to identify the barriers faced by people living with, at risk of or affected by HIV to accessing social protection and healthcare schemes on the ground in Lesotho, and to develop recommendations for improving the sensitivity of social protection programmes to HIV. This report is based on findings from an assessment workshop that brought together key stakeholders (see Annex II) involved in social protection, healthcare provision and HIV in the country. The findings were complemented by a rapid review of the literature and key regional consultations on the barriers faced by key and vulnerable populations to accessing social protection schemes.

The report is structured as follows. In section 2 we outline the analytical framework and methodology, before providing an overview of the HIV situation and the social protection and healthcare landscape in Lesotho in section 3. Findings from the government-led assessment workshop and the literature review are presented in section 4 for each of the social protection and healthcare schemes operating in the country, along with an introduction to the key populations identified as vulnerable to HIV and the barriers to accessing social protection and healthcare schemes. We then discuss the institutional challenges for HIV-sensitive social protection in section 5, before presenting a set of overarching policy recommendations for developing HIV-sensitive social protection in Lesotho in section 6.

2. Analytical framework and methodology

2.1 Analytical framework: social protection and HIV

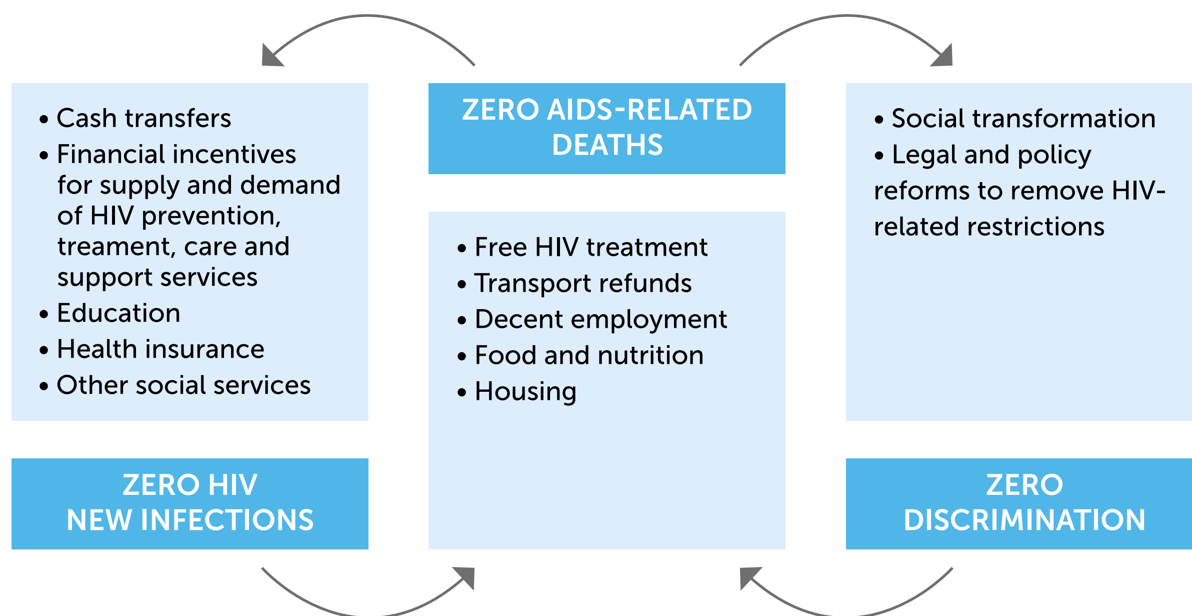
UNAIDS plays a leading role in the global response to the HIV epidemic, having launched a 'fast track' approach to set the course for ending the AIDS epidemic as a public health threat by 2030. This strategy involves catalysing and strengthening efforts to reduce new HIV infections to fewer than 500,000 globally, and to eliminate HIV-related stigma and discrimination, all by 2020. In order to reduce AIDS-related deaths, UNAIDS has set '90-90-90 targets' for 2020, whereby at least 90% of all HIV positive persons are aware of their HIV-positive status; at least 90% of all people living with HIV are enrolled on antiretroviral therapy; and at least 90% of all persons on HIV treatment are virally suppressed. Social protection in Lesotho is expected to contribute to the realisation of these goals through strengthening national social and child protection systems to ensure 75% of people living with, at risk of or affected by HIV access HIV sensitive social protection benefits.

UNAIDS, as well as other UN agencies working on HIV and social protection-related issues, have recognised the key role that social protection can play in achieving the above targets. Within the UNAIDS assessment tool, social protection is understood broadly as programmes that aim to alleviate poverty and inequality and to reduce barriers to accessing basic services. These include cash and social transfers such as food and vouchers, but also economic empowerment programmes, social and health insurance, employment assistance schemes, programmes aimed at improving access to education and healthcare services including fee waivers, and social care programmes targeted at particularly vulnerable groups such as orphans and vulnerable children (OVC), for example (UNAIDS, 2017).

There are multiple synergies between social protection and the HIV response – Figure 1 illustrates the channels through which social protection can contribute to the HIV response.

Firstly, social protection schemes have the potential to contribute towards enabling PLHIV to live long and healthy lives, and thereby reduce the number of AIDS-related deaths (middle column in Figure 1). For example, food programmes can improve the nutritional status of PLHIV, while cash transfer programmes have also been found to have a positive impact on dietary diversity (see Bastagli et al., 2016, for example) – crucial elements when considering the importance of nutrition in the effectiveness of antiretroviral therapy (ART). Additionally, many social protection schemes have been found to improve access to services that are crucial in the treatment of HIV, particularly health services (Temin, 2010). Indeed, fee waivers and cash transfers can reduce the costs associated

Figure 1 **How social protection advances the AIDS response**



Source: UNAIDS, 2017.

with such services (including transport costs or fees) and thereby promote uptake of HIV services and retention.

Social protection can also play a role in reducing the risk of HIV by addressing some of the factors driving the risk of HIV (left-hand column in Figure 1). Similar to the above, social protection schemes can improve demand for and use of HIV prevention services by reducing or covering the potential costs associated with accessing such services. In turn, fee waivers and scholarships for education can also play an important role in keeping adolescent girls and young women in school, and thus delaying sexual debut and other risk factors faced by this particular population group. Certain cash transfer schemes and social interventions can also promote HIV testing and safe sexual behaviours. For example, HIV-testing requirements in a trial cash transfer programme targeted at adolescent girls and young women in South Africa was found to impact on the communication between the participants and their partners about HIV, with some participants also encouraging their partners to get tested (Khoza et al., 2018). Considering the interconnections between intimate partner violence (IPV), sexual concurrency and HIV risk, such interventions can potentially play a positive role in reducing the risk of HIV transmission for women. More generally, evidence from the impact evaluations of cash transfers has found that these programmes are associated with a reduction in unsafe sexual behaviour and a reduction in women having multiple sexual partners (Bastagli et al., 2016).

Finally, social protection schemes (broadly understood) can lead to empowerment and social transformation, which can reduce discrimination against PLHIV. For example, numerous countries have implemented legislation that aims to prevent discrimination against PLHIV and to ensure their access to services. Similarly, cash transfers have

been found to promote social inclusion of beneficiaries and enable them to participate in social gatherings.

However, to strengthen the contribution that social protection can make in the HIV response, programmes should aim to be HIV-sensitive, which means that they are 'inclusive of people who are at risk of HIV infection or are susceptible to the consequences of HIV infection' (UNAIDS, 2017: 6) (see also Box 1).

To ensure that social protection and healthcare services are HIV-sensitive, they must have an adequate level of coverage to reach people living with, at risk of or affected by HIV. This may require:

- reforms to the design of existing schemes to enable easier identification and enrolment of relevant populations
- geographical coverage and levels of benefits that enable people to access benefits flexibly
- reforms to the implementation procedures (registration procedures, communication campaigns, etc.) of existing schemes to eliminate potential barriers for people living with, at risk of or affected by HIV
- ensuring that new schemes incorporate the needs and requirements of vulnerable population groups.

In order to assess the extent to which social protection systems are HIV-sensitive, UNAIDS has developed an HIV and Social Protection Assessment Tool (UNAIDS, 2017). The tool aims to identify which population groups face the most significant barriers to accessing social protection and health schemes, focusing particularly on groups that are living with, at risk of or affected by HIV – including, for example, adolescent girls and young women, adolescent boys, commercial sex workers (CSWs), men who have sex with men (MSM) and the elderly.

The tool further aims to identify specific barriers faced by each of these population groups to accessing social protection and health schemes. Barriers can exist both at the policy level (in terms of the coverage and priority populations) and in the implementation of the schemes (for example, the documents required to register or the strategies to communicate and raise awareness about the schemes). While there are a broad range of possible barriers, the tool identifies six overarching ones:

Box 1 What does it mean for schemes and policies to be 'HIV-sensitive'?

The term 'HIV-sensitive' refers to the degree to which people living with, at risk of or affected by HIV are considered and included in the design and implementation of social protection schemes. The degree of sensitivity can vary from no sensitivity to perfect sensitivity. Promoting HIV-sensitive social protection entails working with programmes designed for broad population groups (such as employees, the military, OVCs, households with an income below the national poverty threshold, youth, girls and women, pregnant women, people with disabilities and elderly people) and ensuring they overcome the policy and social barriers and knowledge gaps that would otherwise leave behind people living with, at risk of or affected by HIV.

Source: UNAIDS, 2017.

1. **Lack of information about available schemes:** In order for identified population groups to access social protection and healthcare schemes, they must first have access to information not only about the existence and objectives of the schemes, but also about the eligibility criteria, registration procedures and conditions (if any) of the schemes.
2. **Missing documents:** Many social protection schemes or healthcare services require potential and/or existing beneficiaries to present documentation to be able to register and/or remain enrolled in such schemes, including birth certificates, identification cards and medical documents, for example. Many people may not have access to such documents, which prevents them from accessing the programmes and services. However, it should be noted that social protection schemes exist that facilitate participants' access to documentation, as is the case of the Child Support Grant in South Africa, for example.
3. **Complicated procedures for accessing the schemes:** Enrolment and registration procedures may be lengthy and cumbersome and represent a key barrier to access.
4. **High out-of-pocket expenses involved in accessing schemes and services:** While many schemes aim to provide income support to beneficiary households or may be free at the point of use, the process for accessing them may require significant out-of-pocket expenditures, including in relation to transportation costs to access healthcare services or pay points for cash transfer schemes, as well as opportunity costs in terms of foregone wages. Similarly, while some services may be free (particularly ART), other related services may not be, including testing or drugs for opportunistic infections.
5. **Poverty and inequality:** Poverty acts to further entrench the barriers related to the costs of accessing services, as noted above. In turn, inequality may lead to the exclusion of certain population groups from certain schemes: for example, many contributory schemes cover mainly (wealthier) employees in the formal or public sector, while poorer, non-formal workers are excluded.
6. **Stigma and discrimination:** People living with, at risk of or affected by HIV may be discriminated against when seeking services, particularly if they belong to population groups that face particular levels of discrimination, including CSWs or people who inject drugs. Others may self-stigmatise, which means that they may exclude themselves from society and refrain from seeking out the services to which they may be eligible.

Many of these barriers are not specific to people living with, at risk of or affected by HIV, but these groups may experience these barriers more acutely than others.

2.2 Methodology

The aim of this HIV and Social Protection Assessment in Lesotho was to provide a tailored analysis on HIV and social protection in the country and to obtain available information on:

- existing social protection programmes and schemes in Lesotho, including their locations, purpose, eligibility criteria and coverage
- whether PLHIV, young women and girls at high risk of HIV infection, key populations and others are eligible for existing social protection benefits and if they are accessing these social protection programmes already
- populations that are eligible but are excluded, or face barriers to accessing existing social protection benefits, and what needs to be done to include these populations.

Information gathered through the assessment is intended to support decision-making in strengthening the HIV sensitivity of social protection programmes and implementation of the new National Social Protection Strategy 2018–2023. The assessment makes recommendations on how to increase the country's capacity to effectively develop programmes towards meeting the 2016 Political Declaration target and the Fast-Track Commitment on Social Protection.

The following sub-sections describe the methodology used for the assessment, in line with UNAIDS' HIV and social protection guidance (UNAIDS, 2018b).

2.2.1 Mobilisation of stakeholders and desk review

The first stage of the assessment included raising awareness of key stakeholders in the country and securing high-level political commitment. This included sensitisation of the National AIDS Commission (NAC) and the Ministry of Social Development supported by the UNAIDS Country Director, and UNAIDS Technical Fast Track Advisor. High-level commitment was secured through the identification of key ministries and civil society organisations (CSOs) involved in social protection programmes in the country. A concept note (see Annex I) on the importance and timeliness of the exercise along with the tool were shared with key decision-makers to seek their input, engagement and commitment in the process of conducting the assessment.

Particular institutions were asked to identify key people to participate as part of a core team that would undertake the assessment exercise. Efforts were made to ensure a multi-sectoral representation in the core group and to include people who possessed technical know-how of HIV and social protection programmes.

Secondary data sources relevant to the assessment were also identified from government documents, existing evaluations and news reports. During the desk review process, the consultants reviewed documents that included strategies, reports and surveys issued by the Government of Lesotho.

2.2.2 The assessment workshop

Next a two-day workshop was conducted from 21 to 22 November 2018 at the United Nations (UN) hall in Maseru, where participants filled out the HIV and Social Protection Assessment Tool (UNAIDS, 2017). Participants included representatives from government ministries, CSOs and UN agencies (see Annex II).

An initial report was compiled listing the main social protection programmes operating in the country, which was circulated to the workshop participants. A subsequent list was made of gaps in data and information for further examination.

2.2.3 The validation workshop

Following circulation of the data compiled from the assessment exercise, a one-day validation workshop was held in Maseru on 11 December 2018. The participants of this second workshop comprised relevant representatives from government, the UN, donors and civil society, including people living with HIV and representatives of other key populations. Aside from verifying the information obtained by the assessment tool, this second workshop gathered further information from participants on:

- existing social protection schemes in different locations, their coverage and HIV sensitivity
- the barriers experienced by PLHIV, those affected by HIV and those at risk of contracting HIV, and possible solutions to these obstacles.

Secondary literature was found to be lacking, but we were able to obtain further information on social protection programmes through informant interviews with representatives from key departments identified in the validation workshop.

A final draft of the assessment report was compiled, which was then circulated to key stakeholders for their input and final validation.

2.3 Limitations of the exercise

Due to the limited time allocated for the assessment workshop and the complexity of the issues under discussion, it was not possible to explore all areas in depth.

While the authors aimed to fill in the gaps through the literature review, these efforts were constrained by a severe lack of documentation on social protection schemes in Lesotho and their coverage (geographically as well as the number of users). Information was also lacking on the barriers to accessing social protection and healthcare schemes faced by people living with, at risk of or affected by HIV in Lesotho.

Findings on the barriers to accessing services are based on the experiences of the individuals in the workshop and key informant interviews. While valuable, the information they provided may not necessarily reflect the experiences of an entire population group. However, the information was checked against existing literature.

Notwithstanding these limitations, the assessment fulfils its intended purpose of providing a rapid and overarching view of the status of HIV-sensitive social protection in Lesotho.

3. National context

3.1 HIV in Lesotho

Lesotho has one of the highest prevalence rates for HIV in the world. In 2017 there were 306,000 PLHIV aged 15 to 59 years in the country of a population of 2.3 million, representing a prevalence rate of 25.6% (ICAP/CDC/MoH, 2017). HIV prevalence in females peaks five years earlier than among males (49.9% in females aged 35 to 39 years and 46.9% in males aged 40 to 44 years) (ibid). In addition, 13,000 children aged 0 to 14 years are living with HIV. This is more than five times higher than the average for sub-Saharan Africa, but is in line with Botswana, South Africa and Swaziland, where rates average between 19% and 28%.

In 2017 the annual incidence of HIV infection among people aged 15–59 years in Lesotho was 1.10% (1.22% among females and 1.00% among males), which corresponds to almost 10,000 new cases of HIV infection annually among this population (ibid.).

Surveys conducted by Stahlman et al. (2015) of key and vulnerable populations estimate HIV prevalence at 71.9% among female CSWs, 43.3% among factory workers, 32.9% for MSM and 31% among prison inmates.

The Government of Lesotho's National HIV and AIDS Strategic Plan 2018/19–2022/23 identifies AIDS as the leading cause of both mortality and morbidity in the country, even though the incidence rate has decreased from 2.7% in 2004 to 1.9% in 2015 (NAC, 2018).

3.2 Social protection in Lesotho

The Government of Lesotho has a number of social protection programmes operating in the country. In 2016, the country was spending 9.6% of gross domestic product (GDP) on social protection programmes, which is greater than the 1% to 2% allocated by most low-income countries (Davis et al., 2016). In the same year, the number of beneficiaries of social protection programmes was estimated to be 636,288, equivalent to 28.8% of the total population at that time.

Although piecemeal social protection programmes existed in Lesotho for most of the last decade, a National Social Protection Strategy (NSPS) was only developed in 2015 to provide a coordinating framework for a fragmented social protection system (MoSD, 2015). The NSPS recognises that social protection should be conceptualised and adopted as an inclusive life-course strategy. To this end, the National Information System for Social Assistance (NISSA) was developed to serve as a single registry for all social assistance and social security programmes in the country. There are plans to link NISSA directly to Lesotho's new national identity biometrics system rolled out by the Ministry of Home Affairs.

3.2.1 Contributory schemes

Workers compensation programme: The Workmen's Compensation Act No. 13 of 1977 requires an employer to insure their employees against: (i) injury or death in an accident arising

out of and in the course of his/her employment; and (ii) contracting a disease emerging from the industrial environment, from which they subsequently die. Payments or compensations are made for death, permanent/total incapacity, permanent partial incapacity or temporary incapacity. The Act excludes a large swathe of workers, including casual workers, sub-contractors, domestic workers, etc.

Under the Act workers are entitled to 12 days of sick leave annually after a period of six months of employment with the same employer. After 12 months' continuous employment with the same employer an employee is entitled to sick leave on full pay for up to 12 days and thereafter to sick leave on half pay for up to 24 days in each period of 12 months' continuous employment. There is no data on the degree to which PLHIV take up this leave and/or do not avail of the opportunity.

At present the Ministry of Labour is drafting a Bill on Social Security that covers the informal sector. This sector is excluded from the present Labour Code that governs the legal environment in the workplace and the Bill (expected in 2019) aims to cover this gap.

Community burial scheme: Such schemes are voluntary and exist at the village level. Members must contribute to a joint fund on a monthly basis (typically 50 Lesotho Meloti (M), equivalent to USD 2.6) and upon a bereavement the fund can be drawn upon to meet funeral and burial expenses (either by the member or the member's relatives). If a member is unable to contribute their membership is terminated.

Civil service pension: This scheme exists for public sector employees. Up until 2012 it was non-contributory but has since become contributory, at 5% of the salary of a civil servant. Workers can take early retirement at age 45 if they have at least 10 years of service at that point. Otherwise workers retire at 60 years of age.[1]

3.2.2 Non-contributory schemes

a. Direct income support

Child Grant Programme (CGP): The CGP is an unconditional social cash transfer programme that targets poor households with children. The aim is to break the inter-generational transmission of poverty through investments in human capital, especially in health and education, and to alleviate current poverty through a monetary transfer to poor households. As of 2018, the programme covered 108,412 adults and 138,000 children from 38,000 households, according to the United Nations Children's Fund (UNICEF) (pers. communication, Mookho Thaane, Social Policy Officer, UNICEF Lesotho, 2019).

Eligible households must be identified as poor both by the NISSA registry and the local community in order to be enrolled in the programme. Once registered, quarterly transfers are made in cash by a payment agency (namely the Standard Lesotho Bank and the G4S security company). Depending on the composition of the household, the payment amount varies as follows:

- 1–2 children: 360 M/quarter (equivalent to USD 19)
- 3–4 children: 600 M/quarter (equivalent to USD 32)
- 5+ children: 750 M/quarter (equivalent to USD 40).

1 The pension is calculated based on an individual's salary and grade. There is also death gratuity, which is calculated based on salary per month multiplied by 12 months.

OVC Bursary Programme: The OVC programme aims to provide indirect income support to OVCs to enable them to remain enrolled in education levels not covered by free primary education. OVCs are defined as children who have lost one or both parents; have a sick, disabled or incarcerated parent; or children who are considered needy. The programmes include community-based early childhood care and development (ECCD), senior secondary school and technical and vocational education and training (TVET). The bursaries cover the cost of school fees, uniforms, books, stationery, supplementary feeding for qualifying students at the senior secondary level, partial fees for ECCD and full fees for TVET. The programme currently covers 38,738 households and about 108,883 children (UNICEF, 2018). Due to limited programme resources, not all eligible households can become beneficiaries. For all programme components, households must have applied and been accepted to an eligible institution in order to qualify to receive benefits.

Public Assistance (PA) grant: The PA grant provides a monthly allowance that amounts to 250 M (equivalent to USD 12.8) per household. Eligibility is based on a home assessment, with the following categories of individuals eligible for the grant:

- orphans (0 to 18 years)
- severely disabled
- severely ill and incapacitated
- the destitute
- the elderly (60 to 69 years)

A Social Development Officer can recommend an increase in the amount allocated to a household depending on their personal assessment of the family's socioeconomic situation. Those who are considered fit to engage in income-generating activities can be put on short-term PA for a maximum of one year, while PA over the long term is given to those who are unable to work. This programme is one of the oldest social protection programmes in Lesotho, but it remains very small in terms of coverage, with only 12,684 beneficiaries country-wide (pers. communication, Ministry of Social Development (MoSD) participants at validation workshop, Maseru, December 2018).

Public works programmes (known locally as Fato Fato): The Lesotho Ministry of Forestry and Land Reclamation operates the Integrated Watershed Management Programme, which employs people for one month to plant trees and carry out environmental conservation work at village level. Participants are selected by local authorities, including councillors and chiefs (Ulrichs and Mphale, 2016). The programme works on a first-come, first-served basis and only one household member can participate at a time.

Another programme is the Food Assistance for Asset programme run in the lean seasons in collaboration with the World Food Programme (WFP), although the programme is only funded until June 2019 (WFP, 2019). These projects employ community members to create soil and water conservation assets. The Ministry of Forestry provides technical supervision while WFP delivers cash transfers, non-food items and technical assistance on targeting, quality assurance in the creation of assets as well as monitoring and evaluation.

Pension: The Old Age Pension (OAP) is a tax-based scheme for all older people. This non-contributory social pension also benefits other household members, particularly children. All citizens of Lesotho over 70 years of age are entitled to a monthly pension benefit of 750 M (equivalent to USD 40). The OAP is the largest regular cash transfer in Lesotho, covering about 83,550 people (4.5% of the population)

(pers. communication, MoSD participants at validation workshop, Maseru, December 2018).

Disability grant: Lesotho's NSPS sets out a commitment to provide a grant of 250 M (equivalent to USD 12.8) per person per month to all those with severe disabilities, phased in over four years and with the transfer value indexed to inflation. However, at present, this grant has not been implemented well and the social protection sector does not provide criteria to identify those who are eligible for the grant.

Free healthcare: The Government of Lesotho provides free healthcare services at primary healthcare facilities and centres. This includes free HIV testing, counselling and ART, services which have been expanded to cover almost every area in the country. At present there are 372 health facilities in the country, with the ratio of doctors to population at 0.9 per 10,000 and the ratio of nurse and midwives to population at 10.2 per 10,000 (MoHSW, 2016).

Bursaries for tertiary education: The Loan Bursary Fund (LBF) was established in 1978 to provide funding for soft and highly subsidised loans to Lesotho citizens who were eligible to pursue higher education. This was intended to ensure human capital with graduate skills in order to meet the demands of Lesotho's economy. Currently, the programme provides a bursary to any citizen with academic competency who attends selected institutions of higher education, whether in Lesotho or abroad. The scheme pays the fees and living expenses of the sponsored students.

A participant at the assessment workshop noted that the total sums paid annually in respect of each student in Lesotho institutions range from 8,000 M to 80,000 M, while for students in South Africa it is between 80,000 M and 140,000 M. The support is treated as a loan in theory, but in reality part of it is repayable and part is a non-repayable grant. The programme is not targeted at poor people specifically, as even those who can afford to pay for their education have access to the programme. As a result, it has been estimated that only 1% of the scheme's benefits go to the extreme poor.

Free primary education: Lesotho implemented its Free Primary Education policy in most of its primary schools in 2000, while the policy later became mandated by law in all schools in 2010. A recent study found that although the policy increased enrolment of primary school-age children by 19.1% between 1999 and 2002, it has had a negative effect on relative grade attainment (Moshoeshoe et al., 2019).

Disaster emergency response: The Disaster Management Authority (DMA) of Lesotho sits under the Office of the Prime Minister and coordinates international humanitarian partners in providing relief to citizens in the aftermath of natural disasters. Until 2017, the Government of Lesotho had reached a total of 466,563 beneficiaries through humanitarian interventions (Office of the Resident Coordinator, 2017). Targeting is typically done on a geographical basis depending on the location of a natural disaster. Participants at the workshop expressed concerns that, at times, the intervention reached households that were being targeted for votes. Participants were unable to confirm if there was a reserve fund that existed under the DMA at any given time.

b. In-kind support schemes

Supplementary feeding programme:
The Government of Lesotho provides supplementary feeding interventions through the Ministry of Health (MoH) and other ministries, as well as through development partners such as WFP, the World Health

Organization (WHO) and the Food and Agriculture Organization of the UN (FAO) through interventions targeted at children from 6 to 23 months as well as pregnant and lactating women (see Box 2). However, the programme was put on hold in 2018 due to funding challenges.

School Feeding Programme (SFP): The SFP is implemented by the Ministry of Education in partnership with the WFP and reaches 450,000 beneficiaries (OPM, 2018a). The objective is to provide all children in early childhood development centres and public primary schools with supplementary nutrition to improve health and educational outcomes. The programme is guided by the School Feeding Policy 2015, and currently provides school meals to 1,126 public primary schools across the country. Children receive a substantial lunch under the government-funded part of the SFP, while the WFP supports schools in remote areas of Lesotho by providing dry rations of food to be cooked on the school premises (WFP, 2018).

Box 2 Details of supplementary feeding programmes under the MoH

- In all districts the MoH has refurbished homes where pregnant women nearing their due dates are living and has provided them with daily meals while awaiting delivery.
- All health facilities have provided pregnant mothers who attend antenatal care with mother baby packs containing micronutrient supplements (ferrous sulphate, folic acid and vitamin A).
- Infant and young child feeding curriculum and guidelines have been made available in all health facilities to guide child feeding and care practices.
- Complementary foods and 'ready to use therapeutic food' have been given to inpatients and have been used for blanket feeding in communities. These are imported through the National Drugs Supply Organization.

Source: UNAIDS, 2017.

4. Findings on key vulnerable groups and barriers to social protection

This section outlines the barriers faced by vulnerable groups to accessing the various social protection schemes. In the sub-sections below, we first briefly present key indicators for each of the vulnerable population groups (among people living with, at risk of or affected by HIV) identified during the assessment workshop. We then discuss the specific barriers that these groups face in accessing social protection services, which were also identified by workshop participants (and were triangulated through secondary data).

4.1 Key vulnerable groups

People living with HIV (PLHIV): Lesotho has one of the highest HIV prevalence rates for adults globally, as discussed above. Significantly, women are disproportionately affected by HIV and AIDS in the country: in 2017, HIV prevalence among women stood at 29.2% compared to 18.9% among men (UNAIDS, 2018a).

Prisoners: HIV prevalence among the prison population was at 31.4% in 2017, considerably higher than the general population (UNAIDS, 2018a). Workshop participants noted that the inmate population is exposed to sexual abuse, which in turn leads to a greater chance of contracting HIV. Therefore, HIV testing among this population is usually high, at 80% in the year running up to 2012 (MoH, 2012).

People living with disability (PWDs): MoSD participants at the assessment workshop indicated that the government does not have complete data on how many people have disabilities in the country, which partially accounts for the delay in implementing the disability grant. The latest available data comes from the 2011 Demographic Survey, which estimates that 2.6% of the population has a form of disability (BOS, 2013). The survey also showed that a higher proportion of children with disabilities had attained primary level education than children without disabilities, but this trend reverses for secondary and subsequent education, while children with disabilities are more likely to have no education than their peers without disabilities overall (ibid). In turn, people with disabilities are less likely than their peers without disabilities to be in paid employment, which 'underscores

a continued marginalisation and lack of independence within the society' (ibid: 284).

People aged 50 years and above: According to the 2016 Population and Housing Census, the population aged 50 years and over represent 11.5% of the population of Lesotho (BOS, 2016). A World Bank report notes that Lesotho has a high proportion of elderly people compared to its neighbours 'reflecting the outmigration of young people and the beginnings of a demographic transition' (Smith et al., 2013: 34). The report also states that poor households usually include more elderly members, while food poverty is higher among households containing people aged 59 and over than the overall population. In turn, a majority of maternal and double orphans live with their grandparents (BOS, 2013), placing this group in a situation of vulnerability.

Commercial sex workers (CSWs): HIV prevalence among sex workers was estimated at 71.9% in 2017 (UNAIDS, 2018a). A study cited in the 2015 Global AIDS Response Progress Report conducted in Maseru and Maputsoe found 55% and 68% of female sex workers, respectively, had tested for HIV at least once (MoH, 2015).

Factory workers in the textile and apparel industry: The textile and garment industry employs roughly 460,000 workers (mostly women), and a study commissioned by the Apparel Lesotho Alliance to Fight AIDS in 2008 found that the prevalence of HIV among this population was 43.2% (Tanga et al., 2017). This population was identified as vulnerable by workshop participants because of the preponderance of young women in the workforce who often leave home when they are young to seek employment in the industrial centres. In the time before they find employment, many engage in transactional sex to survive, which in turn can lead to contraction of sexually transmitted infections (STIs). Even after they are employed in factories, some of the women continue to work as CSWs to supplement their earnings. Workshop participants also indicated that education levels among this group is below the national average for women.

Orphans and vulnerable children (OVCs): The 2017 Lesotho Population Based HIV Assessment (LePHIA) indicates that the prevalence of HIV among children aged 0 to 14 years is 2.1%, reaching 2.6% for girls and 1.5% for boys (ICAP/CDC/MoH, 2017). In turn, between 88,000 and 140,000 children aged 0 to 17 are orphans due to AIDS (UNAIDS, 2018a). As such, AIDS represents one of the biggest drivers of orphanhood in the country (MoH, 2012). HIV treatment coverage for children stood at 56% in 2015 and is improving, but it remains below recommended coverage levels (UNAIDS, 2016).

Men who have sex with men (MSMs): It is estimated that HIV prevalence among men who have sex with men stands at 32.9%, while 82.2% of MSM are estimated to be aware of their HIV status (UNAIDS, 2018a). The National HIV Prevention Strategy for Multi-Sectoral Response to the HIV Epidemic in Lesotho for 2011–2016 estimated that this group likely contribute 3% to 4% of annual HIV infections (NAC, 2011).

Adolescent girls and young women: According to the 2014 Demographic and Health Survey, HIV prevalence among young women aged 15 to 24 is at 13%, while prevalence among their male peers stood at 6% (MoH and ICF International, 2014). A range of factors contributes to the higher prevalence of HIV among young women than men. For example, assessment workshop participants noted that young women are particularly vulnerable

because the physical and social dominance of men often translated into sex without the use of a condoms. The Demographic and Health Survey also identified that 8% of young women aged 15 to 19 years had had sex with a man 10 years older than them or more (compared to 1% among young men) (MoH and ICF International, 2014). In turn, only 37.6% of young women were able to correctly identify the ways in which HIV transmission can be prevented in 2014 (MoH, 2012). However, access to HIV testing services has increased significantly in the last decade, and 66% of young women who had sexual intercourse in the past year had been HIV-tested in 2014, compared to 7% in 2004 (MoH and ICF International, 2014).

Herd boys: Lesotho's herd boys were identified by workshop participants as a vulnerable and marginalised group. Herd boys are typically male children from as young as 10 years old who tend to livestock in remote mountain areas, meaning they have almost no access to health and education services. While there is no accurate data on this population, in 2007 UNICEF estimated there to be some 15,000 herd boys around the country (UNICEF, 2007). The same report also noted that a 'lack of knowledge and awareness about the modes of transmission' of HIV put increases the risk of contracting HIV (ibid). While an outreach programme (funded by international donors in conjunction with the Ministry of Education) providing night classes for herd boys was active in the highlands for a year or so, workshop participants were unable to confirm if it was still in place. The country office of the Pact organisation, in a comment on an earlier draft of this report, indicated that it was working to expand education initiatives to herd boys.

Men: While the prevalence of HIV is higher among women than it is among men, men living with HIV are less likely than women to be diagnosed. Indeed, 76.6% of HIV-positive men aged 15 to 59 years know their status compared to 84% of HIV-positive women of the same age (ICAP/CDC/MoH 2017). Among men and women living with HIV who know their status, relatively equal shares are also on treatment and virally suppressed. Participants in the workshop noted that this may partly be explained by the fact that in Lesotho, men are less likely to utilise existing HIV services at health facilities. Participants in the workshop expressed the view that men's negative health-seeking behaviour is a result of their perception that clinics are more women- and child-friendly and that they face discomfort when accessing services provided by female health workers.

4.2 Barriers to social protection faced by key vulnerable populations

Workshop participants and responses from regional consultations indicated that the most significant barriers for key vulnerable populations were: (a) limited coverage of social protection schemes and healthcare services; (b) issues with targeting; (c) high out-of-pocket expenditures and opportunity costs; (d) sexual violence; (e) limited contributory capacity; (f) stigma and discrimination; (g) compromised confidentiality; and (h) complicated procedures. These barriers are discussed in more detail below.

4.2.1 Limited coverage of social protection schemes and healthcare services

Affected populations: all key populations

A significant barrier to all social protection programmes that is faced by all of the key vulnerable populations is limited coverage, which leads to high levels of exclusion. This relates to the restricted geographical spread

of some of the schemes, which particularly affects the health-seeking behaviour of PLHIV.

Health: Resource barriers to healthcare in Lesotho are numerous and include low recruitment and retention of health staff, a lack of accurate and timely laboratory diagnosis and patient monitoring, and a lack of ownership and participation in service delivery by the communities most affected by HIV. The NAC was disbanded in 2011, and although it was reformed in 2015, its absence disrupted the country's HIV response during this time, which has had repercussions to this day.

In the demographic and health survey (DHS) conducted in Lesotho in 2014, 38% of respondents in rural areas reported they had to walk for two hours before reaching the nearest health facility, compared to 3% in urban areas (MoH and ICF International, 2014). For patients on ART, the distance acts as a barrier and interrupts their treatment, which in turn has a direct impact on the success of the treatment.

Key consultations with informants revealed the presence of only one health centre in a particular district; however, it would compensate patients for their transport costs when they travelled to obtain drug refills. While the travel costs were reimbursed, the distance to the health facility was still a huge concern if a patient had travelled to obtain test results that would enable them to move on to the next level of care, only to find that their results were not available on the given date.

Workshop participants noted that all tertiary healthcare centres were located in Maseru instead of being spread around the country. Triangulation with other sources indicated that, to overcome this barrier, attempts have been made to establish community adherence groups to assist patients receiving ART in collecting their medication on a rotational basis – no individual member has to go to a health centre every month as members collect drugs for the whole group.

Although prisoners are a high-risk population, there are only three ART clinics among the 13 prisons in the country, which thus limits access for this vulnerable group. For patients with tuberculosis (TB), there is poor provision of isolation rooms, which in turn increases the risk of contagion to a highly vulnerable population.

PWDs also face limited access to healthcare, not just in terms of accessing transport to get to health centres, but also due to the absence of staff who are trained to address the different needs of PWDs. Workshop participants felt that the lack of any disability rights legislation hampered the protection and promotion of disability rights.

Geographical distance from healthcare facilities is also a salient issue for herd boys, who spend most of the year herding animals in the mountains where social protection services are scarce.

Education: There is a dearth of schools in Lesotho that meet the needs of children with disabilities. Many schools do not have accessible entrances and/or toilet facilities, and there is also a shortage of teachers who are trained to handle children with disabilities in the classroom. The restricted educational opportunities for disabled children in turn limits their earning potential as adults and makes them vulnerable to poverty and the associated risks to life events.

Pension: Many OAP recipients must walk a long way to collect their cash transfer from the established pay points. The Government of Lesotho is trying to address this through mobile payments; however, at the time of writing, there

was little information on how this is being done and how many people have been reached.

Public works: According to workshop participants, the public works programme has more eligible participants than the resources available to accommodate them. At present the programme works on a rotational basis so as to allow a maximum number of eligible people the chance to participate; however funding and capacity is not enough to cover all those in need.

Public assistance: The public assistance programme is hard to access for people living in the highlands, since government services often do not extend into these remote areas. In times of need, a helicopter must be deployed to cater to the needs of this population. Workshop participants noted government financial and asset constraints as a major reason for the marginalisation of people in the highlands.

4.2.2 Issues with targeting

Affected populations: all key populations

Key consultations indicated that non-health programmes often used very subjective criteria to judge eligibility for social protection programmes at the community level. Service providers were reported to judge people on their appearance. One participant was told at a job-seeking service: 'Such a pretty lady like you has come to apply for support, go and find a job'.

Workshop participants also noted that both the public assistance scheme and the public works programmes in Lesotho relied on home assessments and selection by local officials, thus relying on the discretion of individuals for who to select. This plays into local politics and can lead to nepotism and favouritism with regards to the selection of beneficiaries.

While the single registry system – NISSA – is meant to be used for targeting vulnerable populations, at present only international development organisations such as WFP are using it. The MoSD uses it for the OVC bursary, the CGP grant and the public assistance scheme in only three community councils (United Nations in Lesotho, 2018).

Workshop participants also noted that people above the age of 60 were not considered for the OAP, despite the fact that they are considered too old to be part of the workforce by most employers even while they continue to be caregivers for young people in their households. The public works programme considers people up to the age of 69 years; however, demand for the programme outstrips supply.

Similarly, the age criteria for the pension scheme (over 70 years) means that people aged 60 to 70 years who have trouble finding employment because of their age do not qualify for the OAP and are left heading a household without social protection assistance.

As noted earlier, at times public assistance programmes require recipients to engage in income-generating activities, which makes them unsuitable for PWDs unless the livelihood opportunities are attuned to their needs. The consultations indicated that service providers often require PWDs to nominate a family member to fulfil the work requirement in such instances. Participants in the workshop noted that this arrangement meant that PWDs would divide the amount of assistance they received with the person they nominated to fulfil the work requirement, which considerably diminished the amount available for their own daily expenses. The

public assistance scheme was also criticised for providing an amount of assistance that is too low to cover basic commodities.

4.2.3 High out-of-pocket expenditures and opportunity costs

Affected populations: all key populations

Health: Although HIV care is currently free at point of delivery in MoH clinics in Lesotho, out-of-pocket expenditures continue to represent a significant barrier for healthcare access and ART in the country.

Workshop participants noted that healthcare services were often not free, as patients were asked to pay for a health book at a cost of 15 M (equivalent to USD 0.8). Added to this are travel expenses due to the geographical spread of health facilities, as well as other expenses such as scans (to the tune of 300 M, equivalent to USD 16). Delays in the availability of test results creates additional costs as patients are required to make multiple trips to a clinic. Fee waivers are only applicable at the primary healthcare level, while referrals involve treatment costs and further transport costs. Reimbursements for transport costs are only available to patients obtaining treatment for TB under a MoH fund supported by donors.

Education: Participants at the workshop noted that although primary education is free in Lesotho, there are high out-of-pocket expenditures such as transport to schools and the opportunity cost for children going to school instead of working or engaging in caregiving roles at home. A lack of information around fee waivers added to the perception of education as a high-cost enterprise. Dropout rates for OVCs were noted by workshop participants as being very high, as children within this group often have to take on caregiving roles.

4.2.4 Sexual violence

Affected populations: prisoners, women, CSWs, PWDs

Despite the provision of condoms and education around HIV transmission in prison, prisoners are often forced to have unprotected sex, which makes them vulnerable to HIV and other STIs.

Similarly, many female sex workers report experiences of sexual violence and harassment, including rape and physical aggression. Male partners will often not use a condom, which increases CSWs' risk of HIV infection.

The Lesotho National HIV Strategic Plan 2018–2023 reports that 'there is a persistent culture of gender-based, including intimate partner violence in society' (OPM, 2018b:62), and that 62% of women have experienced sexual violence, while 10% of women and girls have been forced to have sex. In turn, 'HIV prevalence is 58% higher among women and girls aged 15 to 24 who have been raped' (ibid).

4.2.5 Limited contributory capacity and poverty

Affected populations: all key vulnerable groups

The lack of contributory capacity has a large effect on PLHIV. The Lesotho Stigma Index (2014) notes that more than 50% of respondents living with HIV reported having spent a day or more without enough food and 63% of PLHIV were unemployed (LENEPWHA, 2014). Among those who experienced stigma and discrimination because of their HIV status, 43% experienced loss of jobs or other sources of income and 15% were refused employment (ibid.).

Consultations with workshop participants indicated that caregiving responsibilities at home often push adolescent women into commercial sex work in order to generate income to take care of their families.

OAP allocations may be insufficient to meet the needs of an elderly person and/or their dependents.

Contributory pension: The Ministry of Labour indicated that a Bill was currently being drafted regarding a pension for workers in the informal sector. However, key informants noted that, given the requirement for contributions, it is likely that many informal workers may not engage in the pension due to their limited contributory capacity.

4.2.6 Stigma and discrimination

Affected populations: all key vulnerable groups

The Lesotho Stigma Index (2014) found that gossip, verbal and physical abuse, and exclusion from social, religious and family gatherings or activities were the main forms of HIV-related stigma and discrimination experienced by PLHIV. The percentage of survey respondents reporting such discrimination ranged from 6.7% to 41.1% (LENEPWHA, 2014).

Children who live with disabilities: Workshop participants and key consultations indicated that parents often hide children with disabilities at home for fear of experiencing stigma. This results in a lack of access for children to essential services such as education, and access to food and nutrition programmes (through school feeding programmes).

CSWs: In the face of stigma, CSWs will isolate themselves and practice negative health-seeking behaviours. Since commercial sex work is illegal in Lesotho, many CSWs experience both physical and financial harassment by police who exploit such workers. The law on sex work also means that CSWs are too afraid to access health services or raise complaints about police behaviour for fear of being exploited further.

MSM and lesbian, gay, bisexual, trans, queer or intersex (LGBTQI): Similarly, MSM experience various forms of abuse and exploitation. Rejection by their families and friends due to their sexual orientation can cause isolation and means that many MSM avoid social protection services.

There is uncertain and conflicting evidence on Lesotho's legal environment for LGBTQI people. Some sources cite a change to the law in 2012, removing explicit mention of sodomy as a punishable act and effectively decriminalising same-sex sexual relations (amongst consenting adult males). Others argue that the act of sodomy is still prohibited as a common-law offence. At present the law in Lesotho does not contain an anti-discrimination provision to protect people from being discriminated against based on their sexual orientation and/or gender identity.

This legal confusion – coupled with entrenched social attitudes against homosexuality – results in a situation where MSM and people who are LGBTQI face discriminatory attitudes in homes, communities and workplaces. A survey carried out among LGBTQI people in Lesotho found the majority (76.2%) had experienced human rights abuses, and more than half (59.8%) had been verbally or physically harassed because of it (Meer et al., 2017). These attitudes prevent many from accessing healthcare, including services for HIV prevention and treatment.

Workshop participants noted that stigma against LGBTQI people was rooted in cultural

attitudes and lack of education, with one participant recalling a community meeting where LGBTQI orientation was seen to be a result of 'a foreign diet, anal sex and/or immoral behaviour of the mother'.

4.2.7 Compromised confidentiality

Affected populations: prisoners, PWDs

While workshop participants noted that confidentiality was maintained by government workers for most vulnerable groups, this wasn't true for prisoners and PWDs.

The close quarters in which inmates live within prisons and the presence of a security guard at health appointments means that inmates have no privacy and fear their HIV status being revealed.

Similarly, because of the lack of staff training at health centres to accommodate PWDs and the need for community assistance, key consultations indicated that PWDs also have their confidentiality compromised with regards to their HIV status.

4.2.8 Complicated procedures

Affected populations: children, parents of children, elderly

Demand for documentation was seen by workshop participants as a barrier to accessing the CGP. Participants noted that very poor and vulnerable populations often did not have access to birth certificates and/or national identity documents. As the community councils that provide these registration services are often not located in a place that is accessible to all citizens, individuals face travel costs and/or lost earnings to obtain the required documents.

For the OAP, workshop participants reported that officials at the pay points require documentation that older people do not have and that officials change the agreed pay days without providing notice to beneficiaries. The elderly also have to register for the OAP; however, workshop participants described a European Union and World Bank project that was going house to house to proactively register people.

5. Institutional challenges for HIV-sensitive social protection in Lesotho

The sections above deal with specific key vulnerable populations in Lesotho and the barriers they face in accessing different facets of the social protection system. This section describes the institutional challenges within Lesotho's social protection landscape.

While the Government of Lesotho has taken positive steps towards a social protection system through the establishment of the MoSD in 2012, there is little coordination between the different programmes operating in the country. Indeed, a study by Oxford Policy Management notes that that there is a high level of fragmentation in the programmes, which leads to duplication of effort (Kardan et al., 2017).

Workshop participants commented that this fragmentation translates into some households being over targeted (i.e. becoming beneficiaries of multiple programmes), while some households were excluded from *any* of the programmes. For instance, while the MoSD runs the CGP, the public works programme is run by the Ministry of Forestry, the OAP by the Ministry of Finance and the supplementary feeding programme by the Ministry of Education.

The development of NISSA was envisaged as establishing a central database for use by all social protection programmes which would allow monitoring and tracking of families in need. Workshop participants indicated that a revision in the entry system was ongoing, and thus NISSA was currently not being used. However, at the time of writing, participants were not clear on the exact steps being taken to upgrade the system. Participants also pointed out that NISSA did not have any categories to gather information on HIV and AIDS-related indicators, thus limiting the sensitivity of data to PLHIV.

Moreover, there is a *tradition of piecemeal programmes,* often funded by international donors, which proceed in parallel to existing government initiatives without any clear linkages. Workshop participants mentioned a number of such programmes (e.g. a food subsidy programme, an infant grant, an education programme for herd boys and emergency programmes under the DMA).

Although the role of the MoSD is to coordinate between the different actors within Lesotho's social protection landscape, workshop participants indicated that the Social Protection Coordination Committee (which includes Cabinet-level representation), which is meant to meet three times a year, had by December 2018 not met once during that year. Indeed, there is a perception that coordination of social protection programmes is not significant or meaningful to government work in the country.

Workshop participants indicated that there was some effort to coordinate work on OVCs by the National Orphans and Vulnerable Children Coordinating Committee. However, their terms of reference were still under review and coordination was limited to one group of beneficiaries.

Participants highlighted that poor coordination between ministries and departments was endemic to both national- and local-level governments and was worsened by high staff turnover that reduced institutional learning.

In addition, a World Bank Review in 2012 found that that despite high total spending on social transfers in Lesotho, only a small share reached the poor (Smith et al., 2013). As noted in section in 3.2.2, transfers such as bursaries for tertiary education often went to non-poor households.

The *lack of systematic evaluations* on social protection programmes (with the exception of the CGP programme) prevents judgement on which programmes require concentrated resources and limits the information available on how to improve targeting. For instance, the perception of workshop participants was that poor households were only considered for social assistance programmes but not livelihood initiatives that may help the household become less reliant on social assistance in the future.

6. Policy recommendations

The following policy recommendations emerged from the stakeholder consultations. It should be noted that all measures must be tailored to reach and meet the specific needs of the vulnerable groups identified in this assessment, namely: PLHIV, prisoners, PWDs, people aged 50 years and above, CSWs, factory workers in textile and apparel industries, OVCs, MSM, adolescent girls and young women, and herd boys and men.

Ensure the meaningful engagement of people living with, at risk of or affected by HIV in policy-making for and implementation of HIV-sensitive social protection and healthcare services

People living with, at risk of or affected by HIV need to be meaningfully engaged at all levels in the design and implementation of social protection schemes by both local and national governments in Lesotho. This will:

- ensure that new schemes are designed to meet the needs of PLHIV and that the existing schemes described in this report are adapted to increase outreach to vulnerable populations
- ensure that the implementation of programmes does not unintentionally construct barriers to vulnerable populations (e.g. the cost of transport to clinics, clinic waiting times, etc.).

Meaningful participation will require the allocation of funding to enable people twho cannot reach town centres or government offices easily (either due to physical or financial difficulties or because they cannot afford to forego paid work) to be involved. Local councils and local and national government officers need to be sensitised on how to engage with and elicit inputs from vulnerable populations, and efforts need to be made to raise awareness of existing social protection programmes.

Feedback processes should be established within existing and new social protection schemes and any complaints raised by key populations interacting with social protection services must be followed up to ensure best practices are observed in programme implementation. This will be necessary to provide course correction for issues such as PWD access to health centres. One participant at the validation workshop also suggested that procedures be simplified in terms of the paperwork required to prove eligibility for a scheme.

Extend coverage of existing social protection schemes to reach a greater share of the population

Poverty presents a barrier to accessing many of the social protection and healthcare schemes in Lesotho. Broadening eligibility for cash transfer schemes beyond older people and

children will increase coverage and ensure that a greater share of the vulnerable population has improved access to essential services.

Workshop participants suggested that improvements to NISSA be accelerated and that indicators be included on PLHIV. This will ensure that non-poor households are not the main beneficiaries of social protection programmes and that no poor household is completely excluded. It was also suggested that targeting criteria for existing programmes should be improved and the focus should be moved away from discretionary home assessments and self-identification.

Furthermore, making finance available for PLHIV to start and sustain small-scale projects – thus including a livelihood component within social protection – would provide a long-term route out of poverty for many vulnerable people. Existing public works schemes should be examined closely to identify geographical areas where schemes are lacking and/or to design a scheme that utilises the high supply of available labour in a particular area. Public works programmes should be updated to provide transfers at the local minimum wage and should be led by community development units to ensure that the works established are linked to local community improvements.

Coverage can also be extended by increasing the delivery points of existing social protection schemes by, for instance, increasing the number of clinics in underserved areas such as poor and rural communities. Running a shuttle service from such areas to the closest health centre and schools could also ensure older people, people and children with disabilities, and people who cannot afford transport are not discouraged from using health and education services. Similarly, special clinic times for older people could also help to reduce the waiting times for the elderly.

Workshop participants suggested setting up a voluntary saving system for workers in the informal sector, with some financial support from the government.

Address supply-side challenges to the provision of healthcare and education services

Increased funding is needed for social protection overall and at the local level, particularly in remote areas. Schools require teachers who are trained in dealing with the needs of children with disabilities.

Workshop participants suggested training law enforcement and key community officers on dealing with reports of sexual violence and asked that gender-based violence programmes be included in the overall social protection approach in Lesotho. Participants suggested that the MoSD and CSOs coordinate implementation of such programmes.

Supply-side health interventions for vulnerable populations such as herd boys will require investment in mobile outreach services (e.g. a mobile health clinic or travelling health workers). Since herd boys have specific places such as cattle stations where they break their travel, such stops can be used as points of delivery for social services. Similarly, workshop participants recommended setting up night clinics to enable textile factory workers to access health and education services without losing their jobs due to absence from work.

Workshop participants observed that the national budget is high on treatment for HIV and AIDs and other diseases, but focuses less on prevention. They recommended that the commitment to HIV prevention should be

scaled up and the MoSD should engage with the NAC on social protection planning.

Workshop participants also recommended the establishment of a separate unit where vulnerable populations could safely report abuse by police enforcement officers and/or other government workers.

Improve coordination between vertical and horizontal levels of government on social protection

At different points in the validation workshop participants reflected on the lack of knowledge about existing programmes, figures on programme outreach or information on whether a programme was working successfully or not. Participants recommended that available social protection services should be mapped out with information on geographical distribution to indicate which areas were marginalised and which may have an oversupply of services.

Currently, social protection functions are dispersed between different authorities; therefore these institutions need to coordinate their activities to ensure they are working towards a consistent set of priorities and are not duplicating efforts. Coordinated operations, strategies and financing could ensure that social protection services reach the grassroots level and that shared objectives are met. Workshop participants felt the MoSD was best placed to undertake this role and recommended the use of a gateway approach where the MoSD would use local government structures to include different communities in its coordination efforts. Participants also noted that donor-driven projects need to be coordinated better in order to be sustainable and to tie in to other longer-running projects.

Combating stigma around HIV and AIDS and raising awareness of social protection schemes through training and public campaigns

While social protection schemes exist that include PLHIV as a whole and sometimes directly, workshop participants noted that the programmes do not have a sensitisation element in them and/or any element on how behaviour change can be affected. Participants recommended that government workers and personnel in such schemes are trained on how to approach vulnerable populations in an appropriate manner. This should include investing in training for healthcare staff and school teachers on the importance and methods of maintaining confidentiality. Training is particularly important for staff when dealing with PWDs, CSWs, MSM and people who are LGBTQI and adolescents.

A second approach involves raising public awareness around HIV and AIDS. Such campaigns would be useful through a focus on combating the myths around how HIV is transmitted, on raising awareness on the cost of social isolation for PLHIV and raising the positive profile of individuals who live with HIV and AIDS.

A substantial approach to countering society-wide stigma would include discussing and reviewing laws that criminalise key vulnerable populations such as CSWs. This could be accompanied by work with cultural and religious leaders nationally and in different communities to identify and counter – through speech and action – the root causes of stigma against vulnerable populations.

References

Avert (2018) 'HIV and AIDS in Lesotho'. Brighton: Avert (www.avert.org/professionals/hiv-around-world/sub-saharan-africa/lesotho)

Bastagli, F., Hagen-Zanker, J., Harman, L., Sturge, G., Barca, V., Schmidt, T. and Pellerano, L. (2016) *Cash transfers: what does the evidence say? A rigorous review of impacts and the role of design and implementation features*. ODI Research Report. London: Overseas Development Institute (www.odi.org/sites/odi.org.uk/files/resource-documents/11316.pdf)

BOS – Bureau of Statistics (2013) *Lesotho Demographic Survey, 2011, Vol. i*. Maseru: Bureau of Statistics

BOS (2016) *2016 Population and Housing Census*. Maseru: Bureau of Statistics

Davis, B., Handa, S., Hypher, N., Rossi, N. W., Winters, P. and Yablonski, J. (eds) (2016) *From evidence to action: the story of cash transfers and impact evaluation in sub Saharan Africa.* Oxford: Oxford University Press (www.fao.org/3/a-i5157e.pdf)

ICAP/CDC/MoH – ICAP/Centers for Disease Control and Prevention/Ministry of Health (2017) 'Lesotho population-based HIV impact assessment, LePHIA 2016–2017'. Summary sheet, November. Colombia: ICAP at the University of Colombia (https://phia.icap.columbia.edu/wp-content/uploads/2018/02/Lesotho-Summary-Sheet_A4.2.7.18.HR_.pdf)

Kardan, A., O'Brien, C. and Masasa, M. (2017) 'Shock-responsive social protection systems research: case study – Lesotho'. Oxford: Oxford Policy Management (https://assets.publishing.service.gov.uk/media/5a942d96ed915d57d1335914/OPMCaseStudy-2017-SRSP-Lesotho.pdf)

Khoza, M., Delany-Moretlwe, S., Scorgie, F., Hove, J., Selin, A., Imrie J. ... and MacPhail, C. (2018) 'Men's perspectives on the impact of female-directed cash transfers on gender relations: findings from the HPTN 068 qualitative study' *PLoS ONE* 13(11)

LENEPWHA – Lesotho Network of People Living with HIV and AIDS (2014) 'The people living with HIV stigma index – Lesotho 2014'. Maseru: LENEPWHA (www.stigmaindex.org/sites/default/files/reports/Lesotho%20Stigma%20Index%20draft%20report%206-%20L..pdf)

Meer, T., Lunau, M., Oberth, G., Daskilewicz, K. and Muller, A. (2017) *Lesbian, gay, bisexual, transgender and intersex human rights in Southern Africa: a contemporary literature review 2012–2016*. Johannesburg: HIVOS, University of Cape Town (https://open.uct.ac.za/bitstream/handle/11427/28329/Hivos2016_Final_report_lowres.pdf?sequence=1&isAllowed=y)

MoH – Ministry of Health (2012) *Lesotho Global AIDS Response Country Progress Report*. Maseru: Kingdom of Lesotho

MoH (2015) *Global AIDS Response Country Progress Report 2015*. Maseru: Kingdom of Lesotho

MoH and ICF International (2014) *Lesotho demographic and health survey 2014*. Maseru: MoH and Rockville, MA: ICF International (www.dhsprogram.com/pubs/pdf/FR309/FR309.pdf)

MoHSW – Ministry of Health and Social Welfare (2016) *Lesotho: national health strategic plan 2017–2022*. Maseru: Kingdom of Lesotho (www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/lesotho/lesotho_revised_nhsp_2017-22_final_draft1.pdf)

MoHSW and ICF Macro (2009) *Lesotho: demographic and health survey 2009*. Maseru: MoHSW and Maryland, CA: ICF Macro (https://dhsprogram.com/pubs/pdf/FR241/FR241.pdf)

MoSD – Ministry of Social Development (2015) *Lesotho National Social Protection Strategy* 2014/15–2018/19. Maseru: Government of Lesotho (www.social-protection.org/gimi/gess/RessourcePDF.action?ressource.ressourceId=50699)

Moshoeshoe, R., Ardington, C. and Piraino, P. (2019) 'The effect of the free primary education policy on school enrolment and relative grade attainment in Lesotho' *Journal of African Economies* (https://doi.org/10.1093/jae/ejz007)

NAC – National AIDS Commission (2011) *National HIV Prevention Strategy for a Multi-Sectoral Response to the HIV Epidemic in Lesotho (2011/12–2015/16)*. Maseru: Kingdom of Lesotho

NAC (2018) *National HIV and AIDS Strategic Plan 2018/19–2022/23.* Maseru: Kingdom of Lesotho

Office of the Resident Coordinator (2017) *Lesotho: situation update 07*. Maseru: United Nations Office of the Resident Coordinator

OPM – Office of the Prime Minister (2018a) *Lesotho zero hunger strategic review*. Maseru: Kingdom of Lesotho

OPM (2018b) *Lesotho National HIV Strategic Plan 2018–2023*. Maseru: Kingdom of Lesotho

Smith, W. J., Mistiaen, E., Guven, M. and Morojele, M. (2013) *Lesotho: a safety net to end extreme poverty*. Washington DC: World Bank (http://documents.worldbank.org/curated/en/485631468300301277/Lesotho-A-safety-net-to-end-extreme-poverty)

Stahlman, S., Bechtold, K., Sweitzer, S., Mothopeng, T., Taruberekera, N., Nkonyana, J. and Baral, S. (2015) 'Sexual identity stigma and social support among men who have sex with men in Lesotho: a qualitative analysis' *Reproductive Health Matters* 23(46): 127–135

Tanga, P., Bello, H., Makatjane, T., Tsikoane, T. (2017) 'Economic Globalization, HIV and AIDS and Gender Dimensions in the Lesotho Textiles and Garment Industry' in N. Dumais (ed) *HIV/AIDS – Contemporary Challenges*. London: IntechOpen

Temin, M. (2010) 'HIV-sensitive social protection: what does the evidence say?'. Geneva: UNAIDS (http://socialprotection-humanrights.org/wp-content/uploads/2015/10/JC1992_SocialProtection_en.pdf)

Ulrichs, M. and Mphale, M. (2016) *Lesotho country case study report: strengthening coherence between agriculture and social protection*. Rome: Food and Agriculture Organization of the United Nations (www.fao.org/3/a-i5302e.pdf)

UNAIDS – United Nations Joint Programme on HIV/AIDS (2015) *On the fast-track to end AIDS: 2016–2021 strategy*. Geneva: UNAIDS (www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf)

UNAIDS (2016) *Prevention gap report*. Geneva: UNAIDS (www.unaids.org/sites/default/files/media_asset/2016-prevention-gap-report_en.pdf)

UNAIDS (2017) *HIV and Social Protection Assessment Tool: generating evidence for policy and action on HIV and social protection.* Geneva: UNAIDS (www.aidsdatahub.org/sites/default/files/toolandguide/document/UNAIDS_HIV_social_protection_assessment_tool_2017.pdf)

UNAIDS (2018a) 'Country factsheets – Lesotho 2017'. Geneva: UNAIDS (www.unaids.org/en/regionscountries/countries/lesotho)

UNAIDS (2018b) *Social protection: a fast-track commitment to end AIDS.* Geneva: UNAIDS (http://mv.ecuo.org/wp-content/uploads/sites/4/2018/05/jc2922_social-protection-fast-track-commitment-end-aids_en.pdf)

UNICEF – United Nations Children's Fund (2007) 'UNICEF humanitarian action: Lesotho in 2007'. Country chapter. Geneva: UNICEF (https://static.unicef.org/har07/files/countrychap_Lesotho.pdf)

UNICEF (2017) ‘Social policy’. New York: UNICEF (www.undp.org/content/dam/unct/lesotho/docs/unicef/Unicef_CP_FS_Social%20Policy_FA_LR%20(002).pdf)
UNICEF (2018) *Lesotho: social protection budget brief – fiscal year 2018/19*. Maseru: UNICEF (www.unicef.org/esaro/UNICEF-Lesotho-2018-Social-Protection-Budget-Brief.pdf)
United Nations in Lesotho (2018) ‘Social protection’. Maseru: United Nations (http://ls.one.un.org/content/unct/lesotho/en/home/our-work/social-protection.html)
WFP – World Food Programme (2018) *Decentralized evaluation: evaluation of the National School Feeding Programme in Lesotho, in consultation with the Lesotho Ministry of Education and Training 2007–2017*. Evaluation Report. Rome: World Food Programme (https://docs.wfp.org/api/documents/WFP-0000073908/download/?_ga=2.66954600.730527204.1537469908-1266722792.1490354006)
WFP (2019) ‘Lesotho country brief, March 2019’. Rome: World Food Programme (https://docs.wfp.org/api/documents/WFP-0000105883/download/?_ga=2.219244369.972274699.1563316909-526612833.1532861333)

Annex I: Concept note for stakeholders

Concept note: Lesotho HIV and social protection assessment

Introduction

Lesotho is a lower middle-income economy according to World Bank classifications; with GDP per capita of USD 1,020. The economy of Lesotho is based on agriculture, livestock, manufacturing and mining industries, with workers' remittances from South Africa being another major source of inflows. Unemployment remains high at 28%, coupled with high inequality and poverty. The majority of formal sector employees are women working in the garments sector; men are mostly migrant labourers in South African mines, working under inadequate health conditions. Youth and some elderly populations are net dependents. One in 12 children dies before they attain five years of age. 33% of children were stunted, while 3% were wasted by 2014. 24% of girls get married before they attain 18 years of age, while the likelihood of getting pregnant for orphan girls is twice as high as that of girls with both parents. More than 36% of non-orphans are left in the care of grandparents and other guardians, as their parents migrate in search of work.

Poverty, unemployment and their effects – such as labour migration, dependency, intergenerational sex and acceptance of poor work conditions, risk behaviours, sexual violence and biological factors – are key promoters of the twin HIV and TB epidemics in Lesotho. The Lesotho Population-Based HIV Impact Assessment estimated HIV prevalence among adults aged 15 to 59 years at 25.6% (30.4% females and 20.8% males); more than 330,000 people live with AIDS, and incidence is still high (there are more than 13,000 new adult infections annually), with average Viral Load Suppression (VLS) rates at 67.6%. Estimated at 2.1%, paediatric HIV prevalence is among the highest in the world. Surveys of key and vulnerable populations have estimated prevalence at 71.9% among female sex workers, 43.3% among factory workers, 32.9% for MSM and 31% among prisoners. HIV and TB epidemics narrow fiscal space, undermining the government's job creation efforts while contributing in many ways to persistent poverty and inequality, for example through high numbers of partial or complete orphans, increased morbidity, low productivity and high cost of care. The government contributes significantly to the overall health sector budget (more than 76% of the recurrent budget, according to the 2017 Budget Estimate), and up to 20% of the total HIV budget, including over 70% of antiretroviral drug purchases.

Lesotho is putting effort into building a comprehensive social protection system. In 2014 the Social Protection Strategy was approved, and the Department of Social Assistance was established within MoSD to implement and coordinate social protection initiatives. In 2016, coordination within the social protection sector increased through the establishment of inter-ministerial platforms, which also include relevant development partners. Three government safety net programmes, namely the CGP, PA and OVC bursary are implemented in three community councils and the NISSA has been established to target beneficiaries. NISSA serves as a registry that stores socioeconomic data for targeting, planning, managing and monitoring social protection programmes and currently hosts information for 120,000 households (approximately 600,000 people). All cash transfer programmes are currently set using NISSA. In addition to the three government programmes, CSOs also used NISSA during the 2015–2016 El Niño response. However, there is a lack of information on the synergy between social protection and HIV, so the HIV and social protection assessment is being conducted to address this gap.

Purpose of the HIV and social protection assessment

Information gathered from the assessment is intended to support decision-making in strengthening the HIV sensitivity of social protection schemes to better reach people living with, at risk of or affected by HIV. The assessment in Lesotho will build on previous work on HIV and social protection targeting children and older people using the HIV and social protection assessment tool. Prior to implementation of this tool a qualitative assessment is needed to enable more in-depth analysis and to help focus on the key country-specific challenges and population groups. The UNAIDS 2016–2021 Strategy formulated an ambitious goal to ensure that 75% of people living with, at risk of or affected by HIV benefit from HIV-sensitive social protection by 2020. The 2016 Political Declaration includes targets related to social protection, such as eliminating gender inequality and all forms of violence against women and girls, people living with HIV and key populations, and empowering people living with, at risk of or affected by HIV to know their rights and to access justice and legal services to prevent and challenge human rights violations, including exclusion from accessing HIV-sensitive social protection services. Efforts to remove barriers to accessing HIV-sensitive social protection schemes also require targeted institutional support for social protection administration and management, referral systems and linkages between social welfare services and health service providers (UNAIDS, 2017).

The Assessment results will be used to:

- support and build synergies between HIV and social protection and strengthen the HIV sensitivity of the social protection programmes to better reach people living with, at risk of or affected by HIV
- build bridges with and mobilise partners working on social protection and other movements for ending poverty in an effort towards ending AIDS
- strengthen implementation of the new National Strategic Plan (2018–2023) and donors' social protection grant components.

Collaboration in conducting the assessment

Social protection programmes and services exist in Lesotho that are coordinated and delivered by government agencies and non-governmental actors. Predominantly the MoSD and the NAC will lead on the assessment along with education and gender sectors. These actors will be supported by the UNAIDS secretariat and co-sponsors, including UNICEF, WFP, the United Nations Development Programme (UNDP), civil society representatives, PLHIV and others. This work will add value to the collaborative work of UNAIDS, co-sponsors and other partners in Lesotho's HIV response.

Annex II: Lists of participants

Table A1 List of participants in the HIV and Social Protection Technical Working Group: core group

No.	Name and position	Agency
1	Teboho Mohlabi , NAC Coordinator	NAC
2	Merlyn Chapfunga	WFP
3	Maria Vivas, HIV specialist	UNICEF
4	Mookho Thaane-Ramasike, Social Policy Officer	UNICEF
5	Jamila Jarrakhova, Fast Track Advisor	UNAIDS
6	Nthati Lebona, National Consultant	
7	Dr Tapiwa, HIV Manager	MoH
8	Makatleho Mokholokoe, Monitoring and Evaluation Officer	MoSD
9	Mrs Makhotso Lecheko, HIV and AIDS Coordination Unit	Ministry of Education
10	Ms Kekeletso Makhalemele	Ministry of Forestry
11	Malefetsane Nkhabu, HIV Focal Person	Ministry of the Local Government and Chieftainship
12	M'e Mamolemo Phalatsi, System strengthening Specialist	Based within the Ministry of Social Development National Office
13	Ntate Boshepha Ranthithi, Programs Manager	LENEPWHA
14	Tampose Motopeng, Director	Matrix Support Group
15	Mme Mapoloko Leteka, Program Manager, (Commercial Sex Workers)	Care for Basotho

Table A2 List of participants in the validation workshop

No.	Name	Agency and title
1	More Mungati	Elizabeth Glaser Pediatric AIDS Foundation Programme Director
2	Kutloano Morienyane	M2M
3	Nthati Lebona	National consultant
4	Puleng Mosili	Lesotho National Federation of Organisations of the Disabled
5	Mapoloko Leteka	Care for Basotho
6	Makhauta Mokhethi	WFP
7	Jamila Jarrakhova	UNAIDS, Fast Track Advisor
8	Mavesi Tokho	M2M
9	Mamolemo Sekoto	Phelisanang Bophelong
10	Alti Zwandor	UNAIDS – Country Director
11	Makatleho Mokholokoe	MoSD, Monitoring and Evaluations Officer
12	M'e Mamolemo Phalatsi	Ministry of Social Development National Office, System strengthening Specialist
13	Tampose Mothopeng	Matrix Support Group, Director
14	Ratlala Montsi	NAC, Director of Programs
15	Pheello Molise	Monna ka Khomo
16	Ntate Boshepha Ranthithi	LENEPWHA, Programs Manager
17	Teboho Mohlabi	NAC, NAC Coordinator
18	Moizza Binat Sarwar	International Consultant