

Rapid Assessment of the Status of HIV and Sexual and Reproductive Health Linkages and Integration in Lesotho

*Report prepared for UNFPA Lesotho by
African Institute for Development Policy (AFIDEP)*

May 2011



Suite #29, 2nd Floor, Royal Offices, Mogotio Road, Westlands
P.O. Box 14688-00800, Nairobi, KENYA.
Phone: +254-202-039-510; +254-735-249-499; +254-716-002-059 Web: www.afidep.org

Acknowledgements

The African Institute for Development Policy (AFIDEP) wish to thank the SRH and HIV/AIDS stakeholders in Lesotho who participated in this study for taking time off their busy schedules to meet and discuss their programmes and experiences with us. Without their cooperation, this assessment would not have been possible.

We would like to thank two research assistants who supported us with data collection and transcription.

Finally, we would like to acknowledge the financial and logistical support received from the UNFPA Lesotho office that facilitated the implementation of this assessment.

Table of Contents

Acknowledgements.....	i
Acronyms	iii
Executive Summary	v
1.Introduction.....	1
1.1 Background	1
1.2 Study Rationale	5
1.3 Study Objectives	6
1.4 Study Methodology	6
1.4.1 Data Collection.....	6
1.4.2 Data Analysis	8
2.Findings	8
2.1 Meaning of Linkages and Integration of HIV and SRH.....	8
2.2 Institutional Structure for HIV and SRH Programmes in Lesotho	8
2.3 Policy Framework and SRH and HIV Linkages in Lesotho.....	9
2.3.1 Policy Framework for SRH and HIV and AIDS Linkages and Integration	9
2.3.2 Lesotho’s Legislative Framework and SRH and HIV Linkages and Integration...	13
2.4 Status of Linkages and Integration at Systems Level.....	13
2.4.1 Funding and Budgetary Support for SRH and HIV Integration.....	14
2.4.2 Partnerships	15
2.4.3 Planning, Management and Administration.....	17
2.4.4 Staffing, Human Resources and Capacity Development to facilitate Linkages	18
2.4.5 Logistics and Supply of Commodities.....	21
2.4.6 Infrastructure and Laboratory Support	23
2.4.7 Monitoring and Evaluation	23
2.5 Status of Linkages and Integration at Service Delivery Level	25
3. Discussion.....	27
3.1 Lesotho’s International Commitments to Integration.....	27
3.2 Localizing International Commitments	28
3.3 Addressing Leadership and Coordination Hurdles	28
3.4 Learning from and strengthening on-going Integration Activities in Lesotho	29
3.5 Barriers and Challenges of Integration in Lesotho.....	29
3.6 The Challenges are not Unique to Lesotho.....	32
3.7 Caution: Integration is not the Answer to all SRH and HIV Problems.....	32
4. Recommendations.....	32
4.1 Improve Leadership, Guidance and Coordination of SRH and HIV Linkages	33
4.2 Address Key System and Operational Challenges for Integration.....	34
5. Appendices	36
Appendix 1: International Statements Supporting SRH and HIV/AIDS Linkages	36
Appendix 2: Summary of Policies and Strategies Reviewed	37
References	42

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CHAL	Christian Health Association of Lesotho
CBO	Community Based Organisation
EGPAF	Elizabeth Glazer Paediatric AIDS Foundation
FBO	Faith Based Organisation
FGM	Female Genital Mutilation
FIDA	Federation of Women Lawyers, Lesotho
FIFA	Federation Internationale de Football Association
FP	Family Planning
GIZ	German Technical Cooperation (formerly GTZ)
HAS	Health Service Areas
HCBC	Home and Community Based Care
HMIS	Health Management Information System
HTC	HIV Testing and Counselling
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPI	Health Policy Initiative
ICAP	International Centre for AIDS Care and Treatment Programmes at Columbia University
IEC	Information Communication and Education
IPPF	International Planned Parenthood Federation
ITWG	Integration Technical Working Group
ICPD	International Conference for Population and Development
LDHS	Lesotho Demographic and Health Survey
LENAPHWA	Lesotho Network of People Living with HIV/AIDS
LENASO	Lesotho Network of AIDS Services Organisation y
LPPA	Lesotho Planned Parenthood Association
LOR	Lesotho Observation Record
MARPs	Most-at-Risk Populations
MCA	Millennium Challenge Account
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MOHSW	Ministry of Health and Social Welfare
MPoA	Maputo Plan of Action
MSF	Medicins sans Frontieres
MSM	Men who have sex with men
MTCT	Mother-to-Child Transmission
NAC	National AIDS Commission
NGO	Non-governmental Organisation
PAI	Population Action International
PEP	Post-exposure Prophylaxis
PEPFAR	President's Emergency Plan for Aids Relief
PIH	Partners in Health
PLHIV	People Living with HIV
PLWHA	Persons Living with HIV/AIDS

PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
RH	Reproductive Health
RTI	Reproductive Tract Infection
TWG	Technical Working Group
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on AIDS
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation

Executive Summary

HIV/AIDS and sexual and reproductive health (SRH) policy and programmes have been historically established, funded, and implemented vertically. But over the last decade or so years, the need to link and integrate HIV/AIDS and SRH responses has been widely recognized at international level as critical to ensuring universal access to SRH and HIV services. In fact, there is growing understanding that countries with high unmet need for SRH services and high HIV prevalence will find it hard to achieve the Millennium Development Goals (MDGs) if they do not ensure universal access to SRH and HIV services (WHO et al. 2009).

The overall purpose of this study was to help the government of Lesotho and key stakeholders in SRH and HIV to identify policy, system and service delivery gaps in SRH and HIV linkages and integration, and recommend ways of effectively addressing the gaps to strengthen these linkages in the country. The study was a rapid assessment of the status of bi-directional linkages between HIV and sexual and reproductive health at policy, system and service delivery levels in Lesotho. The study used the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages* developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW, Young Positives. Guided by this tool, the investigators reviewed literature and reports relating to linkages in Lesotho and interviewed policy makers, development partners, and key programme stakeholders in order to understand the status, challenges, and opportunities for intervention to improve SRH and HIV bi-directional linkages at policy, system, and service delivery levels.

The study found strong support for strengthening SRH and HIV linkages in the country. However, there is strong need to streamline policy and strategic direction and strengthen leadership on integration. At the policy level, the study found that integration commitments are fragmented in various policy and strategy documents for HIV/AIDS and reproductive health responses in Lesotho. The country lacks a universal national SRH and HIV integration policy or strategy, and there are no national integration service and supervision guidelines, except for PMTCT of HIV. The study found that there was a lack of leadership to champion the integration concept and coordinate integration activities.

At the systems level, the study found that existing systems on planning, funding, human resource capacity and development, procurement, supplies and logistics for commodities, and monitoring and evaluation do not effectively support integration as they are principally program or sector specific.

At the service delivery level, the study found that some level of integration of HIV and SRH services is occurring, but not in a structured manner due to lack of service and supervision guidelines. The integration experience has also revealed a number of system and operational challenges that need to be addressed in order to strengthen integration activities in the country. These include staff shortages and inadequate skills, poor infrastructure, weak referral systems, logistical challenges in ensuring consistent availability of SRH and HIV commodities, and weak M&E systems overlaid with numerous parallel tools to be filled out.

There are eight key recommendations from this study, which are divided into two categories. The first set addresses the need to rally relevant government units and key stakeholders to work together towards streamlining the policy framework and improving coordination and leadership on integration in Lesotho. A key element of this should be a clear demonstration of close partnership, common purpose, and joint leadership and planning of integration activities

by the Family Health Division and the HIV/AIDS and STI Unit, with strong support of this process from NAC. In order to strengthen leadership and coordination in relation to SRH and HIV linkages, we make the following specific recommendations:

1. Hold a Consultative Workshop co-led by the Family Health Division and the HIV/AIDS and STI Unit to build consensus, reflect and deliberate on the findings of this study and chart the way forward for integration in Lesotho.
2. Form a multi-sectoral Technical Working Group on integration co-chaired by Family Health Division and the HIV/AIDS and STI Unit to oversee the formulation of policies, strategies, and coordinating mechanisms for integration.
3. Develop a national strategy and operational service and supervision guidelines on integration to provide strategic and operational guidance on SRH and HIV linkages. The development process should be co-led and the strategy and guidelines co-owned by the Family Health Division and the HIV/AIDS and STI Unit
4. Consider options for long-term institutionalisation of the integration coordinating mechanism in order to have sustained leadership and coordination of integration efforts.

The second set of recommendations highlights the key system and operational challenges that need to be addressed to improve integration activities in the country. The Integration Strategy needs to provide guidance and strategies on how the country will address these challenges:

5. Enhance publicity and dissemination of integration policies and guidelines and advocacy for integration at all levels of care, including communities to galvanise broad-based support and action on SRH and HIV integration.
6. Strengthen the Human Resource Base through training and effective supervision aimed at improving the capacity of all cadres of healthcare personnel in planning for and offering integrated services, improve customer care skills, forecasting of supplies, and data capturing.
7. Strengthen M&E Systems in order to effectively monitor and evaluate integration programs and facilitate joint follow-up of patients, reduce excessive paperwork and time that healthcare workers take to fill the paper forms, and help improve data quality.
8. Improve commodity security and address supply chain hurdles to prevent commodity stockouts and enhance funding for both programs to ensure long-term commodity security.

1. Introduction

1.1 Background

Integration is defined as the provision of different kinds of SRH and HIV services together to ensure and maximise collective outcomes including referrals from one service to another (IPPF et al. 2009). *Linkages*, on the other hand, are defined as the bi-directional synergies in policy, programmes, services and advocacy between SRH and HIV, and they include a broader human rights approach, of which service integration is a subset (ibid.).

The need to link the responses to Sexual and Reproductive Health (SRH) and HIV and AIDS is recognised as important because HIV and SRH are fundamentally interconnected. Most HIV infections are sexually transmitted or are associated with pregnancy, childbirth and breastfeeding (IPPF et al. 2009), all of which are key SRH issues. The presence of sexually transmitted infections (STIs) can further increase the risk of HIV transmission or acquisition (ibid.). And, sexual and reproductive ill-health and HIV share rootcauses including poverty, limited access to appropriate information, gender inequality, cultural norms and social marginalisation of vulnerable populations (ibid.). Potential benefits of linking SRH and HIV responses include improved access to and uptake of SRH and HIV/AIDS services, which is likely to result in increased utilization and improved health outcomes, effective use of limited resources, improved service coverage of underserved and marginalised populations, improved quality of care and service effectiveness through reduced duplication of service delivery functions as well as convenience and cost savings for clients (WHO and UNFPA 2007). Also, it is argued that integration will assure that the reproductive health and rights of people living with HIV/AIDS are addressed and respected.

Linkages and integration of SRH and HIV is especially critical in developing countries which have high rates of HIV prevalence, high unmet needs of reproductive health, and limited resources in addressing these issues. Sub-Saharan African countries bear the biggest burden of HIV prevalence and deaths from AIDS, accounting for 68% (22.5 million) of all the people living with HIV (UNAIDS 2010). Although the call to integrate was first emphasized at the 1994 International Conference on Population and Development (ICPD), the last six years have seen heightened international level commitments to integrating SRH and HIV/AIDS, including the 2005 UNAIDS position paper on *Intensifying HIV Prevention and the UNGASS Review*, the *New York Call for Commitments: Linking HIV/AIDS and Sexual and Reproductive Health*, and the *Glion Call to Action for Family Planning and HIV/AIDS in Women and Children* (see Appendix 1). It has actually been argued that the Millennium Development Goals (MDGs) will not be achieved without ensuring universal access to SRH and HIV/AIDS prevention, treatment, care and support (WHO et al. 2009). At the regional level, the 2006 Maputo Plan of Action has called on African Union member states to act on the bi-directional linkages between SRH and HIV/AIDS (African Union 2006). Table 1 shows the different HIV and SRH services that can be potentially integrated.

Table 1: Possible service linkages and integration for achieving SRH and HIV synergy in prevention

Existing HIV/AIDS services + ... SRH services		Existing SRH services + ... HIV services	
VCT +	FP; STI; condoms; BCC	FP +	VCT; BCC; condoms; STI
PMTCT +	FP; condoms; BCC	ANC +	PMTCT; FP; STI
ART +	FP; condoms; BCC	Delivery +	PMTCT; STI
BCC +	STI; FP; condoms; VCT	Postpartum +	VCT; ART; BCC; FP; STI
		PAC/abortion +	VCT; BCC; FP; STI
		STI +	VCT; BCC; condoms; FP
		Post-rape +	VCT/PEP; EC; STI

Source: Askew, 2007.

The HIV prevalence in Lesotho is estimated at 23%, the third highest in the world. HIV prevalence is higher among women at 26% and lower among men at 18%. Among women, HIV prevalence is highest among the 35-39 age group, standing at 42.3%, whereas among men, HIV prevalence is highest among the 30-34 age group at 40.2% (Table 2 shows the prevalence by age and sex). The prevalence differentials between women and men could be due to biological susceptibility, age of sexual debut, and age-mixing patterns in sexual relationships (GOK 2009). Of Lesotho's population of approximately 1.9 million, 21,000 people become infected with HIV every year (GOK 2009).

Table 2: HIV prevalence by age and sex

Age (15-49)	Women	Men	Total
15-19	4.1	2.9	3.5
20-24	24.1	5.9	16.3
25-29	35.4	18.4	28.1
30-34	40.7	40.2	40.5
35-39	42.3	35.4	39.5
40-44	36.1	39.3	37.2
45-49	29.5	32.1	30.4
Total	26.7	18.0	23.0

Source: LDHS 2009

The main drivers of the HIV/AIDS epidemic in Lesotho have been identified as multiple and concurrent sexual partnerships, inter-generational and transactional sex, low and inconsistent condom use, alcohol abuse, unemployment, and low and incomplete male circumcision (GOK 2009; LDHS 2009; NAC 2006; MOHSW 2010). Migrant labour and mobility, gender inequality, gender-based violence, poverty, and food insecurity have been noted as social and structural factors that drive the epidemic (NAC 2006; MOHSW 2010). Also, the presence of STIs has been identified as another key factor fuelling the spread of HIV (MOHSW 2010).

In 2000, the Lesotho government declared HIV/AIDS a national disaster (NAC 2006). The country's response to HIV/AIDS has prioritised four areas: prevention, treatment/management, impact mitigation, and coordination of efforts (ibid.). On prevention, the country has focused on social and behaviour change, HIV counselling and testing, PMTCT services, STI treatment, condom distribution, blood safety, Post-Exposure Prophylaxis (PEP); and medical male circumcision (ibid).

While some progress has been recorded on SRH in Lesotho, much more still needs to be done as SRH indicators are not at desirable levels. According to the LDHS 2009, total fertility rate (TFR) stands at 3.3, modern contraceptive prevalence rate (CPR) is 45.6%, unmet need for FP is 23%, 92% of pregnant women receive antenatal care (ANC), but only 59% deliver in a health facility thereby losing the opportunity for key vaccinations and use of PMTCT of HIV. Maternal mortality ratio is estimated at 1,155 deaths per 100,000 live births. Only 9% of

married women using modern contraception use the male condom, meaning the remaining 91% using other contraceptive methods remain at increased risk of STI including HIV infections. Forty-two per cent (42%) of women in Lesotho do not receive a postpartum check-up (LDHS 2009), thus missing the opportunity to receive a range of healthcare services including family planning (FP). Warren et al. (2008) noted that one particularly neglected area during the postpartum period in Lesotho is FP. This study found that the health provider capability for the range of postpartum services required was weak; there were gaps in provider knowledge of appropriate FP methods for the different postpartum periods; and that many providers had not been formally trained in the provision of all family planning methods since there was no formal FP training in the country (Warren et al. 2008). The uptake of Prevention of Mother to Child Transmission (PMTCT) of HIV in Lesotho increased following the national scale-up of PMTCT from 2007 and in 2009, 71% of HIV-positive pregnant women received anti-retrovirals (ARVs) for PMTCT (NAC 2009). However, only 33% of HIV-exposed infants receive prophylactic ARVs for PMTCT (UNICEF 2010).

STIs, including HIV/AIDS, are a major public health concern in Lesotho and constitute the second most common cause of attendance at outpatient clinics (MOHSW 2008). STIs have been identified as important in the prevention of HIV and AIDS in Lesotho. The incidence and prevalence of STIs among sexually active people in Lesotho is a strong indicator of trends for HIV transmission (GOL 2009). The prevalence among people diagnosed with an STI in 2009 was 54.5% (GOL 2009).

On adolescent SRH, the age of sexual debut is early, with 8% of girls and 22% of boys having had sex by 15, and more than 50% of young people have had sex by age 18 (LDHS 2009). One in every five adolescent girls (15-19 years) are either pregnant or have already had one birth (ibid.). The Modes of Transmission (GOK 2009) analysis found that adolescents and youth are reluctant to use condoms especially when they first start to become sexually active. According to the MOHSW's records in 1997, 16.8% of all hospital deaths for females over the age of 14 years were due to abortion complications. Sexual violence and abuse among adolescents is high – almost 31% of all reported rape cases in urban areas were among the 10-19 year-olds (MOHSW 2006). See Table 3 for SRH and HIV indicators in Lesotho.

Table 3: SRH and HIV Indicators in Lesotho

Indicator	Estimate
Population	
² Total population	Total: 1,876,633 Male: 49% Female: 51%
² Reproductive age population (Male 15-54; Female 15-49)	Male: 513,779 Female: 496,202
Fertility and Contraceptive Use	
Total Fertility rate (Average number of children per woman)	Overall: 3.3% Urban: 2.1% Rural: 4.0%
Percentage married and sexually active single women using modern contraceptive	All:34.9% Married: 45.6% Single:56.5%
Unmet need for family planning among married women of reproductive age	23%
Sources of modern methods of contraception	Public: 62.7% Private: 21.4% Other: 12.7%
HIV and AIDS	
HIV prevalence rate (adults 15-49)	Total:23% Men:18% Women: 26.7%
HIV prevalence rate young people (15-24)	Total: 9.3% Men: 4.2% Women: 13.6%
³ Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	Total:51% Adult:25% Children:26%
⁴ Percentage of HIV-positive pregnant women who receive antiretroviral drugs to reduce risk of mother-to-child transmission	64%
Percentage of women and men who received an HIV test in the last 12 months and who know their results	Men:24.0% Women:42.0%
⁴ Percentage of infants born to HIV-infected mothers who are not infected	33% (UNICEF 2010)
Percentage who have ever been tested for HIV status and got results	Men:37.2 Women:65.6%
Maternal and Child Health	
Maternal mortality ratio per 100,000 live births	1,155
Under-five mortality rate	117
Percentage of pregnant women attending at least one antenatal visit	89.8%
Percentage of pregnant women attending at least four antenatal visits	Overall: 70.4% Urban: 82.5% Rural: 66.3%
Births delivered by a skilled provider	61.5%
Percentage of children aged 12-23 months who are fully vaccinated	61.7%
Percentage who know that HIV can be transmitted by breastfeeding and risk of MTCT can be reduced by mother taking special drugs during pregnancy	Women: 71.1% Men: 50.3%
⁴ Percentage of pregnant women who received HIV testing and counselling during antenatal care	50% (UNICEF 2010)
⁴ Percentage ANC facilities that provide testing and ARVs for PMTCT	86%
Sexual Behaviour	
Percentage of young people aged 15-24 who had sex before age 15	Women: 7.8% Men: 22.1%
Percentage of women and men who had sex with more than one sexual partner in the past 12 reporting that a condom was used at last intercourse (adults 15-49)	Women: 38.5% Men: 52.3 %
Percentage of young people aged 15-24 who used a condom at first sexual intercourse	Women: Men:
Percentage of young people aged 15-24 who had premarital sexual intercourse in the past 12 who used a condom at the last sexual intercourse	Women: 65.1% Men: 65.0%
Percentage of youth aged who have begun childbearing by the age of 18	27.9%

Sources: Main source: 2009 Lesotho Demographic and Health Survey; ²2006 Population and Housing Census; ³2009 NAC, MOHSW, UNAIDS, UNGASS Report; ⁴GOL 2007. PMTCT Scale-up Plan. Maseru, LS: MOHSW; ⁵UNICEF 2010. Lesotho PMTCT Factsheet

Textbox I outlines some gaps and challenges identified by recent studies on Lesotho's HIV/AIDS and SRH responses that are pertinent to SRH and HIV linkages and integration.

Textbox I: Gaps and Challenges in Lesotho's HIV/AIDS Response

- Uptake of ART was slow in both children and adults;
- There were no BCC interventions targeted at most-at risk and vulnerable populations (identified by the government of Lesotho to include people living with HIV (PLHIV), Orphans and Vulnerable Children, women and girls, prisoners, herd boys, and people in homosexual relationships); as of 2008, there were no comprehensive interventions targeting sex workers as a specific group;
- Low level of condom use in the general population; condom use is irregular among sex workers;
- Although over 90% of pregnant women attend ANC clinics at least once, too many women do not return for additional visits and still give birth outside of health facilities;
- NAC's mandate to coordinate was not universally accepted by all stakeholders and that NAC lacked adequate support and leadership on the part of key stakeholders including the office of the Prime Minister;
- Data management was extremely weak;
- There was inadequate capacity to effectively carry out monitoring and evaluation (M&E);
- Indicators were in most cases not measureable, not clearly defined, and not harmonised;
- Human resource base was weak – inadequately skilled and lacking experience, and high attrition levels;
- Collaboration between MOHSW and NAC was very weak;
- Low coverage of prevention programmes because of inadequate funding for prevention; and
- Slow pace of developing workplace HIV and AIDS programmes.

Source:

National AIDS Commission (NAC) [Lesotho] (2011). HIV Epidemiology and National Response Situation Analysis Report for the National Strategic Planning Process.

UNFPA and UNAIDS (2008). An Assessment of Sex Work in the main towns of Lesotho.

In a word, there is potential to enhance access to SRH and HIV services in Lesotho by integrating the two services. The SRH and HIV indicators presented in Table 2 show the gaps that integration could help address. For instance, the considerable small proportion of men (37.2%) who have ever tested for HIV and know their status highlights the big gap that needs to be addressed if Lesotho is to considerably slowdown the spread of HIV. More importantly, the indicators show the extent of Basotho people's contact with the healthcare system, which demonstrates the numerous opportunities for extending SRH and HIV services within the healthcare system. For instance, the almost universal access to ANC shows the huge opportunity for reaching women with comprehensive HIV/AIDS and SRH services. Integrating SRH and HIV services therefore has the potential to enable Lesotho progress towards ensuring universal access to SRH and HIV services, a goal that underlies the achievement of other national as well as millennium development goals.

1.2 Study Rationale

The strong synergy between SRH and HIV makes it important to explore and strengthen ways in which the responses to the two issues can be linked at policy, system, and service delivery levels in order to enhance the outreach of services and the efficiency of the healthcare system. Although calls for SRH and HIV integration have been made since the 1994 ICPD, many countries have not translated these into effective and appropriate policies, programmes and services. For many sub-Saharan African countries, SRH and HIV integration has only started receiving national focus in the last six years. As such, several sub-Saharan African countries are currently in the process of exploring effective ways of operationalizing the bi-directional linkages between SRH and HIV.

In Lesotho, the status of linkages and integration of SRH and HIV at policy, system and service delivery level is not well documented. As the previous section shows, there are

considerable opportunities to improve service delivery through integration in Lesotho. However, many SRH and HIV services are still administered vertically. Operationalizing the bi-directional linkages between SRH and HIV in the country has the potential to expand the reach of both SRH and HIV services and maximise the impact of limited resources. This study assesses the status of SRH and HIV linkages and integration, and the gaps and opportunities for integration at policy, system, and service delivery levels in Lesotho.

1.3 Study Objectives

The overall purpose of this study is to help the government of Lesotho identify policy, system and service delivery gaps in SRH and HIV linkages, and give recommendations on ways to effectively address the gaps. The information gathered through this assessment will also help the government to determine its priorities and contribute to the development of its plans and frameworks for facilitating and intensifying HIV and SRH linkages. The specific objectives of the study include to:

- Assess HIV and SRH bi-directional linkages at the policy, systems, and service-delivery levels
- Identify current critical gaps and opportunities for improvement in policies, programmes and services
- Synthesize the data obtained into information that can be utilized in the development of country-specific action plans to forge and strengthen SRH and HIV programmes linkages.

1.4 Study Methodology

The study assessed the status of bi-directional linkages within the Lesotho national context, at the policy, systems and service-delivery levels using the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages* (IPPF et al 2009). Guided by this tool, the investigators reviewed literature and reports relating to linkages in Lesotho and interviewed policy makers, programme managers, donors and development partners, civil society leaders and representatives, leaders and representatives of training institutions, and service managers and providers in order to understand the status of SRH and HIV linkages at policy, system, and service delivery levels.

1.4.1 Data Collection

So as to understand the linkages and integration of HIV and SRH in Lesotho, a combination of data collection methods were used, including:

Desk review and analysis - The assessment involved a broad review of literature consisting mainly of HIV and SRH policy and strategy documents, service delivery guidelines, Lesotho DHS reports, HIV and SRH related reports, and relevant published and web-based articles. Documents on the legal environment impacting HIV and SRH were also reviewed. The review provided an understanding of how each policy and sector perceives and addresses integration, and how the totality of the policies and guidelines shape the design and implementation of services. The review of policy documents enabled us to start filling out the Rapid Assessment tool's check-list on policy-level questions before carrying out in-depth interviews. Other documents reviewed include Annual Planning Operational Plans and unpublished reports from stakeholders.

Review of existing facility assessment studies and data - Due to limited resources, this rapid assessment did not conduct a facility assessment exercise or client-exit interviews. Instead, the study reviewed existing studies on facility assessment and community perception of SRH services. Specifically, two studies commissioned by MOHSW including, a qualitative study, which elicited community knowledge on reproductive health and their perspective on quality of reproductive health service delivery (MOHSW 2009) and a facility assessment of 56 government and CHAL owned health facilities (MOHSW 2011b) complemented findings from the in-depth interviews focusing on the systems and service levels.

In-depth individual and group interviews - The review carried out in-depth individual and group interviews with representatives of 26 government and non-government institutions. The interviews adopted some of the structured questions from the Rapid Assessment Tool, but also asked open-ended questions. The interviews elicited participants' perspectives on the current situation in terms of HIV and SRH bi-directional linkages and integration at policy, system and service delivery levels in Lesotho. The policy makers' instrument solicited information on the level and effectiveness of linkages between SRH and HIV-related policies, national laws, operational plans and guidelines. The programme managers' instrument sought information on the extent to which systems support effective linkages of SRH and HIV, specifically looking at partnerships, planning, management, administration, human resource capacity, logistics, laboratory support as well as monitoring and evaluation. The instrument for donors and development partners sought to understand how funding support and arrangement supports or hinders integration. The instrument for civil society leaders and representatives sought to understand the different programmes implemented by civil society and their level of integration or lack of it thereof. And the instrument for service providers sought information on the extent to which HIV services were integrated in SRH and vice versa. The interviews also generated insights on the capacity of health facilities to complement information from facility assessment studies. They also helped determine the priorities that need to be addressed to facilitate HIV and SRH linkages and integration in the country. The interviews took place between April 11-21, 2011. See Table 4 for a list of stakeholders interviewed.

Table 4: Stakeholders Interviewed

Stakeholder type	Total
Policymakers/Government <ul style="list-style-type: none"> - National AIDS Commission - Family Health Division - HIV/AIDS Unit under Disease Control Division - Director of Gender - Department of Nursing, Faculty of Health Sciences, University of Lesotho - National Drug Service Organisation - National Curriculum Development Council - HIV Coordination Unit, Ministry of Education - Directorate of Policy Research and Planning, Ministry of Finance and Development Planning 	9
Donors/Development Partners <ul style="list-style-type: none"> - UNFPA, UNAIDS, UNICEF, UNDP & WHO (group interview); UNFPA individual interview - GIZ - Clinton Health Access Initiative 	7
Non-governmental Organisations (service and non-service providers) <ul style="list-style-type: none"> - Christian Health Association of Lesotho (CHAL) - Partners in Health (PIH) - Red Cross Society - Population Services International - Lesotho Planned Parenthood Association (LPPA) - Elizabeth Glazier Paediatric AIDS Foundation (EGPAF) - Apparel Lesotho Alliance to Fight AIDS (ALAFAs) 	9

- Kick 4 Life	
- Lesotho Network of People Living with HIV and AIDS (LENAPWHA)	
Civil Society Organizations	
- Fida Lesotho	1
Total	26

1.4.2 Data Analysis

The transcriptions of the in-depth interviews were analysed thematically and synthesised with the information obtained from the desk review.

2. Findings

2.1 Meaning of Linkages and Integration of HIV and SRH

SRH and HIV stakeholders in Lesotho who participated in the study generally viewed integration as the provision of both SRH and HIV services in one place (often referred to as one-stop shop/supermarket approach), whereas linkages was viewed as having to do with referral by one service to another. Some stakeholders felt that linkages referred to the programme or system levels, where SRH and HIV programmes or systems link with each other, while integration referred to the service delivery level where both SRH and HIV services are provided in one place. Still, others felt that linkages had to do with acknowledging and addressing the relationships between SRH and HIV. The predominant term used in Lesotho is *integration* and study participants rarely referred to *linkages* during the interviews.

2.2 Institutional Structure for HIV and SRH Programmes in Lesotho

The National AIDS Commission (NAC), established in the Office of the Prime Minister by an Act of Parliament of the Government of Lesotho (GOL) in 2005, is the national coordinating body responsible for the development and coordination of national policies, strategies and programmes for combating HIV and AIDS; and for facilitating implementation, monitoring and evaluation of programmes. NAC is also responsible for provision of policy guidance to implementing structures. NAC works alongside the Ministry of Health and Social Welfare (MOHSW) in responding to the HIV and AIDS epidemic. The MOHSW provides the medical response to HIV/AIDS, specifically implementing interventions through the healthcare system in Lesotho. The MOHSW works through the STI/HIV and AIDS Directorate that was recently dissolved into a unit and put under the recently upgraded Disease Control Directorate (before the upgrade, this was a division), and the Family Health Division, in its response to HIV and SRH, respectively. Textbox II provides information on the MOHSW structure.

Healthcare services in Lesotho, including HIV and SRH services, are delivered by the MOHSW, the Christian Health Association of Lesotho (CHAL) and other private for-profit and not-for-profit institutions. CHAL is the biggest non-state provider of healthcare services, accounting for 38% of healthcare facilities countrywide (MOHSW 2011a). CHAL has a Memorandum of Understanding with the MOHSW to provide healthcare services and as such the government reimburses its expenditures. Also, the MOHSW plans for, rehabilitates and maintains CHAL health facilities. The MOHSW's main partners in health delivery in Lesotho include CHAL, Lesotho Planned Parenthood Association (LPPA), Partners in Health (PIH), and the Lesotho Red Cross Society (MOSHW 2011a). In the interviews, Elizabeth Glazer

Paediatric AIDS Foundation (EGPAF) was reported as MOHSW's main partner in the provision of PMTCT, while LPPA was noted as the main (non-government) SRH service provider in the country.

Textbox II: MOHSW Functions and Structure

The new MOHSW policy (MOHSW 2011) states that central level units of MOHSW structure will concentrate on policy, strategic planning, supervision as well as M&E, while implementation will be carried out by the district level. Further, the policy noted that the health services are undergoing a process of decentralization to place decision making authority at the district level. Under this new system, districts will be responsible for budgeting, planning, implementing projects, managing health centers, and tracking resources, while the MOHSW will retain management of hospitals. The MOHSW is also responsible for resource mobilization, advocacy and partner coordination, and provision of a regulatory framework for all health care providers.

The MOHSW business is administered by two Principal Secretaries (one for Health and the other for Social Welfare), assisted by a Deputy Principal Secretary. The Director General of Health Services oversees technical matters of health through Directorates of Primary Health Care, HIV/AIDS and Clinical Services. The DGHS reports directly to PS Health. A directorate of Planning and Statistics directly under the Principal Secretary serves to provide leadership in policy, planning, monitoring and evaluation and research coordination. Regulatory bodies comprising of Medical Council (which includes oversight on Dental and Pharmaceutical disciplines), the Nursing Council and the Traditional Healers Council regulate respective practice areas.

Source: MOHSW 2011.

2.3 Policy Framework and SRH and HIV Linkages in Lesotho

2.3.1 Policy Framework for SRH and HIV and AIDS Linkages and Integration

Lesotho's policy response to HIV and SRH is captured in various policy documents including: the National Health and Social Welfare Policy of 2011; the HIV and AIDS Policy of 2006; HIV and AIDS Strategy of 2009; and the National Reproductive Health Policy of 2008 and strategy (in draft form), among others. Lesotho does not have a specific universal HIV and SRH linkages and integration policy or strategy. Lesotho is party to a number of regional and international agreements which call for integration including the 1978 Alma-Atta Declaration on Primary Health Care, 1994 ICPD programme of action, 2006 SADC SRH Strategic Plan of Action and African Union's 2006 Maputo Plan of Action (MOHSW 2008).

The following sub-section provides an in-depth review of Lesotho's policies, strategies and guidelines as they relate to SRH and HIV linkages and integration.

(i) General Health and Gender Policies

The *Lesotho National Health and Social Welfare Policy 2011* provides the national framework for addressing health issues and identifies HIV, STI and TB; and SRHR/FP as priority health issues. The policy emphasizes a multi-sectoral approach to managing HIV and AIDS and calls upon all agencies implementing the HIV and AIDS policy to articulate areas for mutual collaboration so as to attain maximum impact on HIV prevention and impact mitigation. Although the policy does not mention HIV and SRH integration per se, it identifies key areas of focus in the response to HIV to include changing risky attitudes and behaviour and PMTCT of HIV. On SRHR, the policy commits to ensuring the PMTCT of HIV, and to providing adolescent SRH information and services including prevention of HIV and STIs.

The *Lesotho National Adolescent Health Policy 2006* aims to protect the health, development and rights of all adolescents in Lesotho. The policy commits to adopting a 'multi-sectoral, multi-disciplinary and holistic approach' in addressing adolescent health

issues (MOSHW 2006). It requires the MOHSW to create linkages with other ministries, non-governmental organisations, the private sector, religious and cultural institutions in enhancing adolescent health programmes, and to provide and increase comprehensive and integrated quality adolescent friendly health services. Policy commits to, among others: promote responsible behaviour among adolescents regarding contraception, safe sex and prevention of STIs, HIV and AIDS, address domestic and sexual violence.

The *Gender and Development Policy 2003* seeks to ensure equality of all opportunities among women, men, girls and boys so that development efforts have an equal impact on all gender. The policy commits the government of Lesotho to ensuring the provision of accessible and affordable SRH care, including FP information and services, maternal and obstetric care and prevention of STIs/HIV/AIDS, and addressing gender-based violence.

(ii) HIV and AIDS Policies and Guidelines

Lesotho's *National HIV and AIDS Policy 2006* and *National HIV and AIDS Strategic Plan 2006-2011*, both developed by NAC, provide the overall framework for the country's HIV response. They both lay out the country's multi-sectoral approach to fighting HIV/AIDS and commit to mainstreaming HIV into all government sectors. Although the two do not explicitly and deliberately commit to HIV and SRH integration, they commit to various aspects of SRH and HIV linkages approach including PMTCT of HIV; management of STIs; protection and fulfilment of the rights of all vulnerable populations (women and girls, PLHIV, people involved in homosexual relationships, and sex workers); ensuring equal access by all to prevention, treatment, care and support, and impact mitigation services; empowerment of women and girls, gender mainstreaming and addressing gender-based violence and sexual abuse; establishment of youth friendly sexual and reproductive health services; and ensuring that PLHIV are not discriminated against in access to healthcare and related services, and that respect for privacy and confidentiality is upheld. The two documents commit to promote the use of condoms as a dual means of contraception and protection against STIs. As part of PMTCT, the strategy commits to ensuring increased access to FP for HIV-positive mothers.

The *National HIV Prevention Strategy for a Multi-Sectoral Response to the HIV Epidemic in Lesotho* (undated draft), developed by NAC, emphasizes the integration of HIV prevention services into the existing healthcare system such as specialty clinics (e.g. STI, Maternal and Child Health clinics), community health services, and both acute and primary health care facilities, so that every encounter with the health system is optimally utilised for preventing HIV infections. It notes that Lesotho is currently in the process of strengthening its RH/FP and HIV integration linkages, highlighting that HIV infected women who receive PMTCT and Positive Prevention services are referred to FP services. It identifies opportunities such as linkages between HTC and RH/FP services and HTC offered in FP clinics. It also commits to integrate male involvement into all HIV prevention initiatives.

The *Health Sector Policy on Comprehensive HIV Prevention 2010*, developed by the MOHSW, aims to integrate HIV prevention activities into all activities of the Lesotho healthcare system. The policy commits to linking and integrating of HIV/AIDS with poverty reduction strategies including a broader focus on SRH, comprehensive and appropriate sexual education for young people, life skills, school-based education and linkages with existing programmes in all sectors. To implement the policy, *Operational Guidelines for Comprehensive HIV Prevention Interventions within the Health Sector* have been developed and they specify the HIV prevention packages to be integrated in other services (including STI, male circumcision, MCH, adolescent friendly services, etc.) at the different

levels of the healthcare system. Notably, the guidelines emphasize condom promotion solely for HIV prevention and not for dual protection from STIs and unwanted pregnancy.

The *National HIV and AIDS M&E Plan 2006-2011* is the M&E tool for the national HIV/AIDS policy of 2006. The tool only monitors two SRH-HIV linkage/integration related indicators i.e. the percentage of ANC facilities offering PMTCT, and the percentage of designated facilities surveyed with drugs for STIs in stock and no stock-outs in the last 12 months.

The *Minimum Package for HIV Prevention among adolescents*, developed by the Ministry of Gender, Youth, Sports and Recreation, addresses HIV/AIDS challenges among adolescents and young people in Lesotho. SRH is one of the areas where the package commits to provide information and services, specifically focusing on ‘knowing your body, sex and sexuality – contraception, condoms, homosexuality, STIs, and TB’.

(iii) SRH Policies and Guidelines

The *National Reproductive Health Policy of 2008* explicitly commits to ensuring the integration of HIV/AIDS into SRH. The policy’s SRH essential package to be offered at all levels of the healthcare system includes: safe motherhood initiative, FP, Post-Abortion Care, STIs, HIV/AIDS, PMTCT of HIV, infertility, cancers of the reproductive organs, gender-based violence and male involvement. On integration, the policy specifically commits to: integrate PMTCT of HIV into maternal and child health (MCH) services at all levels of health care; ensure that HIV positive clients make an informed choice on the method of contraception of their choices; enforce integration of FP into PMTCT services and other relevant Primary Health Care (PHC); ensure integration of STIs and HIV management into SRH services, ensure integration of HIV testing and counselling in all sexual and reproductive health services, and promote access to free and routine HIV testing and counselling for all couples/partners. The policy commits to develop monitoring and evaluation indicators for coverage, utilisation, quality, resources as well as for measuring output and impact but this is not yet developed.

A *strategy* to guide the implementation of the policy is currently in draft form and unpacks the strategies it will employ to, among others, strengthen an integrated approach for provision of SRH services and other related services such as STI, HIV/AIDS, including:

- Assess the level of integration of SRH, STI, HIV/AIDS services
- Implement the recommendations of the assessment in the already existing SRH services
- Review/update and distribute integrated guidelines and tools based on the assessment findings
- Sensitize and train health workers on the integrated guidelines approach on SRH
- Sensitize other stakeholders (development partners, programme managers, etc.) on integrated services

The document does not guide on the SRH and HIV services that can be integrated at the different levels of the healthcare system. Except for PMTCT guidelines, which are already available, it may be the case that the guidelines the strategy commits to develop above are yet to be developed given the fact that the strategy itself is still in draft form.

PMTCT policy and guidelines were developed in 2007 and published in 2008 (Southern Africa Development Community and African Development Bank 2009). Textbox III provides a summary of the progress and challenges in PMTCT in Lesotho.

Textbox III: PMTCT in Lesotho

A national scale-up plan¹ was approved in 2007 and implemented from 2008 onwards. By 2009, 71% of HIV positive women were receiving ART to reduce mother to child infection. PMTCT programme expanded from 180 health facilities providing PMTCT in 2008 to 186 by 2009. This was mainly the results of expanded training and decentralisation of PMTCT interventions to health centres. PMTCT services are largely provided by nurses, who have been trained in Integrated Management of Adult and Adolescent Illnesses (IMAI) and are able to assess pregnant mothers and initiate prophylaxis regimens and Highly Active Anti-Retroviral Therapy (HAART) if indicated. The national PMTCT guidelines were revised and updated in 2007² to incorporate changes in best-practice, in particular those in relation to the care and support of HIV-exposed infants. Although the guidelines state that 'PMTCT services at all levels are integrated into ANC and MCH settings' but participants in a 2009 study (SADC and ADB 2009) indicated that a family centred and comprehensive model where PMTCT and counselling and testing are fully integrated is still needed. The new guidelines also support the PMTCT+ approach which encourages greater male involvement in all stages of the reproductive cycle and the use of PMTCT as an entry point to address HIV within the context of the whole family. Different partners are assisting the MOHSW in the PMTCT programme, including ICAP, EGPAF, BIPAI, CHAI, Mothers-2-Mothers and the Global Fund.

The 2009 study identified PMTCT policy and implementation gaps in Lesotho to include:

- Retesting for HIV negative pregnant women.
- Procedures not clear as to what the health care provider should do at maternity room.
- Inefficient drug and test kits supply chain and inadequate human resources.

The study recommended the following for minimum standards:

- Combined and more efficacious regimen, i.e. AZT – prophylaxis based
- Minimum package for mother and infant
- Family centred approach
- Task shifting to other cadres of staff
- Integration of PMTCT into maternal and child health services
- Human resource strengthening in all health facilities
- Quality assurance for PMTCT
- Clear monitoring and evaluation indicators for PMTCT.

¹. GOL (2007). PMTCT Scale-up Plan. Maseru, Lesotho: MOHSW.

². GOL (2007). *Guidelines for the prevention of mother to child transmission of HIV (PMTCT)*. July 2007. Maseru: MOHSW.

Source:

National AIDS Commission (NAC) [Lesotho] (2011). HIV Epidemiology and National Response Situation Analysis Report for the National Strategic Planning Process. Final Draft.

Southern Africa Development Community and Africa Development Bank (2009). The development of harmonized minimum standards for guidance on HIV testing and counselling and prevention of mother-to-child transmission of HIV the SADC region: PMTCT country report, Lesotho.

Tuoane (2004 in Warren 2008) noted that Lesotho did not have explicit FP guidelines for service providers to follow, a situation that resulted in some providers creating their own rules and restrictions. See Appendix 2 for further details of the policies and strategies discussed above.

Although integration is highlighted in some of the HIV and SRH policies and strategies as seen above, many of the study respondents felt that the government was not doing enough to provide leadership on SRH and HIV integration in the country. For instance, some respondents explained that the lack of an integration policy or strategy to guide their activities demonstrated the government's poor leadership on the issue. Indeed, as we have seen, integration messages are fragmented in different policy and strategy documents and there is no universal HIV and SRH integration policy, an implementation strategy, and guidelines. It

could also be the case that government has not extensively disseminated the existing policies and strategies on integration and advocated for integration.

2.3.2 Lesotho's Legislative Framework and SRH and HIV Linkages and Integration

Effective operationalization of the SRH and HIV linkages and integration requires a supportive legislative framework that protects the human rights of all people. Lesotho's overall constitutional framework provides for the protection of the human rights of all individuals. Although there are no specific laws in the country that prohibit same-sex relationships or sex work, the study found that cultural norms and beliefs of the Basotho people do not support these practices and may, to some extent, hamper the recognition and provision of services to these groups, which are already recognised in government policies as vulnerable. Provision of abortion services is prohibited by law except in cases where the mother's life is in danger.

Lesotho has not put in place special laws to protect PLHIV against stigma and discrimination, except the requirement by government of all employers (those employing more than 10 people) to put in place HIV workplace policies that protect the rights of PLHIV. The Sexual Offences Act of 2003 was noted to be playing an effective role in responding to gender-based violence, which is a rampant problem in the country. It was noted that the Act has been extensively popularised countrywide, and police have been trained on its enforcement. Following the enactment of the Act, the police department established a Child and Gender Protection Unit (CGPU) to specifically focus on investigating gender-based violence. Although the CGPU operates countrywide, its offices are based at the district level, a situation that was highlighted as a barrier to reaching communities at the grassroots.

In 2006, Lesotho enacted the Legal Capacity of Married Persons Act which gives women an equal legal right as their husbands. Some participants felt that the law had not been effectively popularised and was therefore not known by many people. This was said to be hampering its implementation.

Interviewees noted that there were a number of legal requirements that were either confusing or hindering service delivery. For instance, for women to receive tubal ligation services, they were required to provide consent from their husbands. The legal ages for marriage in Lesotho (16 years for girls and 18 years for boys), for voting (18 years), for receiving HIV testing and counselling (12 years), and for providing consent to undergo medical procedures (21 years), were noted by interviewees as either confusing and/or hindering young people's access to services.

'Young girls [younger than 16] get married and cannot receive services [for fear of prosecution]. Also, this low legal marriage age [16 years] allows very young girls to get married and then they face challenges during childbirth.' Government Respondent.

'Young people are not allowed to sign forms to receive medical procedures until they are 21, yet they can vote at age 18.' Government Respondent.

2.4 Status of Linkages and Integration at Systems Level

The system level refers to structures put in place to support or ensure successful implementation of stated policy actions. The RH policy, which explicitly commits to SRH and HIV integration, commits to establish two national committees (national steering committee and national technical committee) and two district-level committees (district SRH committee and district technical committee) to oversee its implementation. It also commits to

develop an M&E framework and strengthen data collection systems. The HIV/AIDS implementation strategy, which does not explicitly commit to integration, identifies the activities and outputs and the resources required to implement the different aspects of the policy. It also allocates responsibilities to various government and non-government stakeholders, including MOHSW which is responsible for the integration components of STI and PMTCT. The HIV policy also has an M&E framework.

In this section, we present the assessment findings on the status of existing supportive structures that are needed to bring about effective and beneficial SRH and HIV linkages. These include funding and budgetary support; partnerships; planning, management (including supervision) and administration; staffing, human resources and capacity development; logistics and supplies; laboratory support as well as monitoring and evaluation.

2.4.1 Funding and Budgetary Support for SRH and HIV Integration

The role of funders in population, health and development issues cannot be over emphasized. These three issues are increasingly becoming a single item on the table of funders and development partners alike. Funding partners continuously dictate and influences the planning, coordination and implementation of various population, health and development issues including SRH and HIV activities. It is therefore important to examine their current and future agenda in relation to SRH and HIV integration as this will play a pivotal role in whether or not the effort comes to bear.

In Lesotho, the main funders of SRH programming are UNFPA and the government. Others include Irish Aid, Global Fund (condoms), WHO, PSI (condoms) and UNICEF. In addition, some support is given by partners who implement or are interested in SRH activities such as IPPF (through LPPA), EGPAF, PEPFAR, PIH, ICAP, MSF, Baylor College of Medicine, Millennium Challenge Account (MCA) and Solidermet (a Swedish Christian Organisation through CHAL). Wright et al (2007) noted that funding for RH commodities in Lesotho varied, depending on the use. Generally, most common ANC, EmOC, and STI medicines are funded and procured by the government and provided by NDSO (ibid.). However, contraceptives, condoms, and PMTCT supplies are generally funded and mostly procured by development partners including: IPPF (LPPA), KfW, Global Fund, and USAID (PSI) (ibid.). HIV commodities (PMTCT and other HIV prevention, treatment, and care programmes) are mainly funded by the Global Fund, the World Bank, USAID-PEPFAR, Irish Aid, and the Clinton Foundation (ibid).

For HIV programming, main funders include the government (main funder), Global Fund (treatment), PEPFAR/USAID (treatment), CDC, GIZ and German Development Bank (support local governments activities), World Bank, Africa Development Bank (for lay counselling on HIV), PAI, Irish Aid (first aid kits), PACT, DFID (left the country in March 2011), EU, MCA, MCC, and UN bodies [UNESCO (Lifeskills curriculum), UNICEF (PMTCT), UNFPA, UNAIDS (technical assistance)]. There are a host of other minor funders including local and international/foreign organisations. Evidently, there are more funders and development partners for HIV than for SRH, which corroborates the feeling among SRH stakeholders that SRH activities are not given the deserved attention and funding compared to the spending that goes into HIV/AIDS programming.

UNFPA, being the driver of the integration initiative, sponsors planning meetings on integration and procures the bulk of all FP commodities, including condoms for both SRH and HIV. UNFPA has also set money aside for policy review to incorporate integration with the expectation that this assessment will bring out issues that might generate dialogue on integration. Another effort in this line is the UNDAF Plan developed jointly by UN bodies to

respond to development issues in Lesotho. The UNDAF plan commits to ensuring women, men, children, young persons and vulnerable groups are able to access and use comprehensive, quality health care and sexual and reproductive health information and services. It also commits to ensuring women and girls living with HIV/AIDS have access to sexual and reproductive health rights and services, to support the capacity of government to review Reproductive Health Guidelines including FP to integrate HIV/AIDS issues.

In addition, several funders and development partners were found to be active in the two areas although, mostly in a vertical manner. Given this scenario, integration of funds or funding integration activities on SRH and HIV should not be much of a problem when the initiative takes off. In addition, despite the low TFR in the country, UNFPA sees FP as a priority and is of the opinion that the government will continue to fund FP as it is not seen as a population control tool, but rather one for enhancing quality of life.

It was noted that many bodies involved in SRH and HIV programming (including training institutions) complained about inadequate funding for their activities. For example, NAC felt that funding is not adequate for all its programmes:

'Often partners expect that since NAC is the one coordinating HIV activities, it should also provide funding for these, but sometimes we don't have the funds' NAC Respondent.

Even then, FP was pointed out as an area where there were no funding concerns given UNFPA's and government's commitment to this. It is however important to note that Wright et al (2007) found that there was insufficient funding from the government for RH commodities, including contraceptives, condoms, and PMTCT supplies, which created insecurity when development partners do not provide funds or commodities consistently.

It was noted by a number of interviewees that the government's absorption and management capacity for funds is low. This could be as a result of, among others, disbursement challenges as noted by some interviewees.

'...it would be better if MOHSW is left to implement and donors pay for programmes directly because once the funds get to MOHSW, it stagnates and nothing moves.' Government Respondent.

While the assessment shows that some funders are strict and put restrictions on the use of their money on other activities except those to which they are intended, others are more flexible about use of funds. Still, some providers including government agencies, find ways to incorporate other programmes into funded activities. The downside of this is that the practice is likely to elicit complaints from some programme managers who may feel that funds obtained for their activities are allocated for others as expressed in the quote below.

'...there is a challenge when it comes to disbursement of funds from management. Some funding was obtained to conduct peer education, but it was allocated to another activity.' Government Respondent.

2.4.2 Partnerships

From the interviews, there are a number of partnerships between and within the government and non-public stakeholders in the areas of SRH and HIV individual programming. Areas of partnerships include capacity building for health workers, advocacy, prevention, treatment, care and support in both areas.

(i) Partnerships within government agencies and between government agencies and development partners

The study did not capture any clear partnerships between NAC and MOHSW, between the HIV/AIDS unit and the Family Health Division within the MOHSW, and between NAC and the HIV/AIDS unit and/or Family Health Division except participation in each other's meetings and TWGs, which is discussed in the next sub-section on planning, management and administration. Instead, comments obtained from interviewees suggest that NAC and MOHSW, agencies expected to drive the SRH and HIV programming in Lesotho, are not working as closely as could be expected. This view is corroborated by the players themselves:

'When developing HIV and SRH policies, the two departments (Family Health Division and the AIDS Directorate) work collaboratively. Some challenges exist though since HIV gets lots of money whereas SRH doesn't get much money' Government Respondent.

'There is no joint planning mechanism between HIV and SRH programmes, however we involve SRH stakeholders from MoH in our annual planning meetings for them to provide input' Government Respondent.

It was noted that other line Ministries implementing HIV programmes also struggle to coordinate HIV activities within same ministries. This results in parallel programmes/activities by government agencies.

Even then, the study found that the Ministry of Local Government and Chieftainship has partnered with NAC, GIZ and World Bank in the implementation of its Essential Services Packages (ESP), a standardized programme which utilizes the decentralized government structure (the Gateway approach) to deliver HIV interventions and to a lesser extent SRH interventions tailored to the address the priority needs of the target communities. Community Councils are empowered to lead implementation activities including prioritization of community needs. NAC, World Bank and GIZ provided funding for this programme mainly focusing on building the capacity of the Community Councils through recruitment and training of human resource and their remuneration.

Some interviewees observed that the UN Agencies, as much as they have developed a plan to facilitate a unified response to global priority issues, which include SRH and HIV, are seen to be largely parallel in the way they work.

(ii) Partnerships between government and NGOs

There are some specific partnerships between the government and NGOs that the study found to be moving forward the SRH and HIV integration agenda, and from which learning on integration could be drawn. The government is in partnership with PIH, an international NGO, which was running 7 health facilities in four rural districts offering comprehensive PHC services (integrating SRH and HIV services). Also, the government is in partnership with the LPPA where it provides LPPA with free ARVs and FP services. LPPA also provides integrated SRH and HIV services to the public at a minimal cost. It is also partnering with EGPAF in the provision of PMTCT services across the country, and with the Lesotho Red Cross Society in the provision of HIV services, MCH and OVC support with limited SRH integration through information dissemination at health centres and by trained Peer Educators. The Clinton Health Access Initiative provides technical assistance to the MOHSW to obtain more affordable drugs for HIV also with limited SRH integration. ALAFA, an NGO that lobbies textile factories to establish private clinics within the factories to enable workers

to access health services within the factories, partners with private practitioners, EGPAF, ICAP, Baylor College of Medicine, UN agencies, PACT and the MOHSW. ALAFA has however experienced some challenges with consistent provision of FP services. While many of these partnerships present with challenges to integration of SRH and HIV services, there is an opportunity to address the bottlenecks to facilitate better and intensified HIV and SRH integration.

These are some current partnerships that the government could draw lessons from as it moves forward the integration agenda.

2.4.3 Planning, Management and Administration

There is no specific multi-sectoral group championing HIV and SRH linkages and integration in Lesotho. The assessment revealed that although there are some joint meetings involving SRH and HIV stakeholders, much more needs to be done in terms of championing integration and coordinating stakeholder activities. Joint planning is many times just limited to attendance of meetings of which the effectiveness is questionable. The joint meetings include technical working group (TWG) meetings and annual strategic planning meetings. For instance, within the MOHSW, the Family Health Division and the HIV/AIDS Directorate (now STI/HIV/AIDS under Disease Control Directorate) reportedly work collaboratively through the SRH technical working group which includes stakeholders from STI/HIV and AIDS. In addition, two committees responsible for FP and condom planning were recently merged to form the National RHCS and Condom Programming Coordinating Committee, which is responsible for addressing RH commodity issues for both SRH and HIV services, signifying positive efforts in moving towards integration. However, RH, FH and PMTCT have separate TWGs in which they involve each other. MOHSW also participates in various thematic groups under NAC as well as during development of the national strategy.

The effectiveness of these meetings is not clear. For one, issues with the imbalance of funding to Family Health Division versus the STI/HIV/AIDS Directorate many times stalls any efforts to translate integration plans made in the boardroom to the ground. Respondents complained that they are invited to planning meetings by partners but their contributions are never reflected or acknowledged. This was corroborated by both government and non-government players as it relates to SRH and HIV planning within and between government agencies and participation of other SRH and HIV stakeholders outside of government.

‘Work in the country does not support linkages, MoHSW does their own thing based on their own guidelines’ NGO Respondent.

Respondents noted the multiplicity of the TWGs referring to both internal and external meetings. They felt that streamlining the TWGs to minimize duplication of efforts and to leave room for attending to other priorities is important. Having too many of such meetings has led to low attendance of collaborative meetings. The challenges of closely spaced meetings and giving short notices to attend meetings were also mentioned. Respondents noted that overall the ministry’s coordination of activities of other stakeholders was poor and needed to be strengthened. This sentiment was corroborated by many services providers interviewed.

One of the four specific responsibilities of NAC on the national response to HIV and AIDS is management, coordination and leadership of efforts. However, even within HIV programming, most units and agencies conduct their strategic planning without involving

other partners. Some stakeholders felt that NAC needs to strengthen this responsibility and follow-up by utilizing more effective communication techniques.

'Someway, somehow, NAC is strategically placed to coordinate activities and partners on integration because of where it is housed. However, the structure of NAC is seemingly weak ... How do we take advantage of this strategic positioning of NAC in the integration effort?' Government Respondent.

Who plays the leadership role is also an area of contention as captured in the following excerpt:

'Leadership-level politics between NAC and MoH, often affects the work of the technical departments. The technical support in NAC and MoH work closely and are always open to collaboration, but at the top the need for collaboration between NAC and MoH is not prioritized and often there are conflicts on who reports to who, who informs who about what, and which is the overall body responsible for addressing HIV and AIDS, etc. There is therefore the need to clearly define the relationships between the NAC and MoH – define the coordination role of NAC more clearly for all to have a common understanding; define clear communications and reporting channels between NAC and MoH' Government Respondent.

2.4.4 Staffing, Human Resources and Capacity Development to facilitate Linkages

The success of integration is heavily depended on an empowered and equipped human resource base that is adequate both in numbers and skill-base to provide integrated SRH and HIV services. Wright et al. (2007) found that throughout the Lesotho healthcare system, there was an extreme shortage of skilled health care workers, including doctors, nurses, laboratory technicians, and pharmacists. This shortage had resulted in staffing patterns that often left health care delivery in the hands of overworked providers whose training and qualifications were not sufficient for ensuring the quality of the services they provide. As a consequence, quality of care in most government health facilities was poor. All stakeholders that we interviewed attested to the challenges being experienced in staffing, which include human resource shortages, lack of skills to facilitate integration, retention, frequent transfer of healthcare workers and motivation.

'Due to rotational procedure within hospitals and geographical places, workers are taken from what they know and how to do things to something else and by the time they learn about the new environment, they are rotated again. This has affected the quality of work delivered both at the preventive and curative levels. While the need to rotate staff, especially those in difficult terrains, is necessary, it is equally important to staff health centres with more than one staff in each role category such that when one is transferred, the other continues the service and even assist the newly posted staff to learn the procedure at the centre' NGO Respondent.

In addition, some respondents believe that introduction of integration to the already strained workforce will result in poor quality of care:

'There are genuine concerns that integration may result in poor quality services due to the already strained healthcare human resource capacity and the heavy workload' Donor Agency Respondent.

(i) Staffing: Numbers, Knowledge and Skills, and Attitudes

Although there is a prescribed service pattern of one nurse or clinician, two registered nurses and two nursing assistants at each health centre, this is hardly the case in reality. It was also noted that most staff may not have the skills to integrate SRH and HIV services. The

healthcare worker may be skilled in the provision of SRH services but not in the provision of HIV services and vice versa. It was further noted that, in many cases, health workers are demotivated by low salaries and poor employment benefits particularly for those working in remote areas.

‘Most clinics, especially in the remote areas are grossly understaffed, with some clinics having as few as one qualified nurse, who is expected to do all the work – curative, HIV/AIDS issues (VCT, drug dispensary, MCH, FP etc. This compromises the quality of work they offer’ NGO Respondent.

From the interviews, the same staffing trends emerged in SRH and HIV programmes being implemented by other line ministries such as the National Curriculum Development Centre (NCDC), which is mandated to develop the Lifeskills Education curriculum for primary and secondary schools in Lesotho among other curricula. Teachers feel that they do not have the capacity to teach life skills. They also feel overwhelmed to add life skills as an additional subject to teach. They are also not so committed because it is not an examinable subject.

‘Teachers feel that they do not have the capacity to teach lifeskills. They also feel overwhelmed to add as an additional subject to teach. They also are not committed because it is not an examinable subject’ Government Respondent.

‘...there should be efforts to build capacity of teachers to teach Life skills. There has been no national training. Workshops are held but they are not sufficient, they last 3 days’ Government Respondent.

Attitudes of health workers are also important to facilitate utilisation of health services by community members. The MOHSW study on community perceptions of SRH services (MOHSW 2009) found that while in general community members appreciated the good work of nurse clinicians and CHWs, some members of the community felt that professionals in health facilities have poor customer care skills and customer-focused attitudes.

Another major weakness is in monitoring and evaluation. HMIS data collected in health facilities is often incomplete and unreliable. Health workers also lack the capacity to use data for decision making. The MOHSW study found that majority of health centres and hospitals lacked knowledge of population based indicators such as catchment population and catchment area size and were thus unable to assess the coverage of services provided given the need in the areas.

‘Another issue is that staff don’t know and even those who know do not use data for decision making at the facility level’ Government Respondent.

Health workers lack skills to manage commodity stocks. For example,

‘some facilities report less usage of the FP commodities but order for more...’ Government Respondent.

The lack of guidelines on integration of SRH and HIV services was raised by many respondents as a challenge. Interviews revealed a mixed level of knowledge on the existence of guidelines for the integration of SRH and HIV services that various policies and strategies sporadically highlight. Lesotho has PMTCT guidelines, although some interviewees were not clear where these guidelines were available or not. Many interviewees noted the need for integration guidelines at the service delivery level.

‘At the facility level there is need for integration guidelines’ NGO Respondent.

‘Developing a policy on HIV and SRH integration will guide how we change our programmes, but this will need to be accompanied by proper service delivery guidelines’ NGO Respondent.

‘There is need for guidelines and training on integration at different levels’
Government Respondent.

‘It is not easy for service providers to provide other services due to lack of infrastructure and training manuals and guidelines are in draft for far too long’
Government Respondent.

Although this concern was raised with respect to integration activities that are already defined and being implemented, the concerns appear to highlight a general weakness of the health system’s capacity to provide the necessary tools for effective operationalization of policies and guidelines at service delivery level. This concern will need to be addressed if the government decides to develop a specific policy or strategy for integration.

(ii) Pre-service and In-service Training

The University of Lesotho’s Department of Nursing offers a range of pre-service training courses that cover HIV/AIDS and SRH. However, there is no module on integration of SRH and HIV services. Elements of relationships between SRH and HIV are addressed in the coursework. For example, in the HIV courses, PMTCT is covered while the SRH courses cover contraception – including condom as a dual protection method for both STIs (including HIV) and unwanted pregnancy as well as multiple and concurrent sexual partners – as the key drivers in the transmission of HIV. The Department is also involved in the development of various service guidelines (e.g. PMTCT, EmOC, etc.) under leadership of the Family Health Division of the MOHSW.

There have been attempts to address the human capacity challenges through in-service training, but more needs to be done. For instance, training workshops organized by MOHSW are not sufficient to address the knowledge and skill gaps of healthcare workers. The approach for in service training utilized by the MOHSW, which takes the form of workshops lasting a few days is not sufficient to build the skills base needed, in this case integrate SRH and HIV services. The mentorship model borrowed from the MOHSW’s MCH programme which involves mentorship of new staff is a concept that was endorsed a number of times in the interviews. In addition, the MOHSW study on facility assessment (MOHSW 2011b) recommended the need to empower staff with management and leadership skills and deploy health workers as per accreditation standards in hospitals and health centres.

‘The focus of this (in-service training) is on workshops, yet I don’t think workshops are the best ways for this training. What we need is mentorship rather than, say, one-week workshops’ NGO Respondent.

‘There is need for focal persons in the health centres to be mentors for new nurses’
Government Respondent.

Some NGOs also provide in-service trainings in SRH and HIV. For instance, PIH has trained the CHWs in a range of health issues including STI screening, TB screening, FB needs and ANC. They use the mentorship model to train. LPPA also provides in-service training in SRH and HIV using the same mentorship model.

‘In-service training at the ministerial level does address the SRH problem but to a small extend. It is only now that they are trying to copy [name of organization]. Contraceptive technology is updated every year, but not on the government side. There

is need for post training on SRH and FP and implementation needs have to be addressed as well' NGO Respondent

(iii) Information Programmes for Young People

Several initiatives are on-going to educate youth on SRH and HIV. NCDC has developed a Lifeskills curriculum for both primary and secondary schools. It covers a wide range of topics including identity, gender, sexual and reproductive health (focusing on abstinence and peer pressure; causes, effects and prevention of teenage pregnancy; and support services for sexual abuse and teenage parents in form A through C), human rights and responsibility, interpersonal relationships, coping with stress and anxiety, drug and substance abuse, dealing with violence, safety and security, dealing with HIV/AIDS, dealing with poverty, population growth, and caring for the environment.

The Ministry of Education's HIV/AIDS Coordination Unit also provides services to the education sector employees, pupils, students and stakeholders with the aim of responding to the epidemic. The activities carried out include training teachers in lay counselling to provide psychosocial support to learners and vulnerable children in schools; facilitating care and support for orphans and vulnerable children; procurement and distribution of first aid kits to schools; and conducting voluntary HIV counselling and testing.

In addition to this, Kick 4 Life (K4L), an NGO focusing on stemming the spread of HIV among adolescents and youth aged 10-18 years in Lesotho, has a HIV Lifeskills curriculum which they are trying to get the government to adopt. The difference between the K4L and the government's curriculum is in the method of delivery. K4L uses fun activities, participatory and interactive methods, while the government delivers its curriculum in the classroom. K4L is also able to reach youth who are out of school.

It is important to note that the government of Lesotho does not allow information on safe sex, condom use and other contraception in schools. Thus, Lifeskills Education and other awareness campaigns in schools focus on abstinence and being faithful (AB) messages. This affects the level of information and services that in-school youth can receive through the programmes above. For instance, K4L noted that it has not been allowed to distribute condoms in schools. There is, therefore, need to think through how to effectively integrate SRH and HIV services at this level. The Ministry of Education and Training is doing this by linking students to the established adolescent corners in hospitals where they can access additional SRH and HIV information and services.

2.4.5 Logistics and Supply of Commodities

National Drug Services Organization (NDSO) is a parastatal company that procures, stores, and distributes essential medicines, health supplies, and equipment to pharmacy stores at the 19 Health Service Areas (HSAs) in Lesotho. These in turn deliver supplies to the health centres based on a pull system of requisition orders. HSAs generally pull supplies from the NDSO, with the exception of contraceptives, condoms, and antiretroviral (ARV) drugs, which are pushed based on guidance from programme offices at the MOHSW. An MOHSW official noted that this reliance on programme staff to place orders for FP commodities is tasking given the understaffing in this division. NDSO officials interviewed noted that distribution of ARV drugs is through the NDSO delivery schedule and that there is a planned roll out of a similar tool for RH commodities to address the occasional RH stock-outs experienced at the facility level.

Wright et al. (2007) found that stock-outs were frequent with many types of commodities but were primarily due to deficiencies with staff capacity rather than shortages at NDSO. The study found that there existed reasonably effective logistics management information systems (LMIS), relatively efficient (albeit inadequate) storage facilities, and adequate transport for supply deliveries from the central to HSA level and from most HSAs to health centres (Wright et al. 2007). It noted that the real problem was in the effective use of these systems. Data collected in the LMIS were not always reliable due to poor record keeping and late reporting (ibid.). These data were not used effectively for forecasting (especially for condoms and contraceptives), monitoring and supervision, or for decision-making about procurement resupply, or inventory control (ibid.). Further, staff were not sufficiently trained and motivated at the various levels to use the LMIS for decision making in order to prevent stock-outs (ibid.).

NDSO officials interviewed had slightly different views about stocks-outs. They felt that commodity stock-outs happen, but that they are not a major problem. However, they agreed that stock-outs, for the most part, are mainly as a result of logistical issues such as delay in placing orders, limited storage facilities, and delay in supply due to the transport schedule as opposed to lack of stocks at NDSO. It was noted that the limited storage facilities at the hospital level and in lower level health facilities is being addressed by the Millennium Challenge Account (MCA).

Still, some service providers complained about stock-outs and over-stocking:

'Some clinics are under stocked and some are over stocked, so the committee has a job harmonizing the whole thing' NGO Respondent.

There also seems to be low priority placed on stocking of SRH commodities resulting in shortages as noted below:

'There is a list of 10 essential drugs used in maternity procedures in hospitals – these should never be out of stock, but often they are. If RH Commodities are out of stock, this is not treated as an emergency that requires urgent action' Government Respondent.

At the facility level, some non-government private service providers struggle to get SRH commodities from the government and in fact have to reportedly pay for them. They noted that this results in occasional stock-outs at the facility level because sometimes they are unable to buy the SRH commodities. HIV commodities on the other hand, are obtained free of charge from the government.

'[name of organization] pays for the FP commodities since the government has refused to provide free FP commodities as it does with free ARVs ...' NGO Respondent.

Some service providers feel that an MOU with MOHSW will remove this barrier giving an indication that public service providers are given priority over non-public service providers as it relates to commodities particularly SRH commodities.

The health facilities have a challenge in reporting utilized commodities, which results in problems with forecasting and quantification of commodities. Budgeting for FP by health workers was also noted as a problem and PIH indicated that it had had to train health workers in the facilities where it operates on budgeting for FP.

From the MOHSW facility assessment study (MOHSW 2011b), contraceptives were available in government and CHAL owned facilities, but not in Roman Catholic owned facilities for religious reasons. Our interviews as well as MOHSW study (MOHSW 2011b)

found that the Roman Catholic facilities counselled and referred clients to other facilities for contraceptives. This issue can limit FP use and integration, especially in areas where people depend on these health facilities and non-Catholic health providers are not easily accessible.

2.4.6 Infrastructure and Laboratory Support

Service providers highlighted that there are challenges with equipment and infrastructure necessary to facilitate integration particularly in remote areas. These include lack of accessible laboratory services, lack of storage facilities, substandard examination and delivery rooms, poor lighting, and rundown facilities.

‘There are infrastructural challenges e.g. pregnant women need to be examined under warm conditions while vaccination for children is to be kept in the cold boxes. How do you integrate such services if the recommended conditions are not met?’ NGO Respondent.

The MOHSW facility assessment study (MOHSW 2011b) found that the reproductive health facilities and services are not equally distributed across the country and lack adequate equipment. Delivery rooms were available in majority of the health centres though deliveries were not conducted frequently because of few and incomplete delivery packs. Basic equipment for all levels was available in most health centres. Examination rooms were also used as procedure rooms and few health centres had an area designated as a sluice room. Lying-in-areas for both pre and post natal services were not available in the majority of health centres. With regards to waste disposal, incinerators were unavailable in most of the facilities including placental pit and secure pit. All health centres did not have site laboratories, therefore specimens had to be sent to the hospitals. At the hospitals, essential material for transfusion, blood collection and screening tests were not available in most facilities. Transport for transferring emergencies for pregnancies, labour and delivery was not available at health centres. Also mother’s shelters, which were available in most health centres were utilized for other purposes.

Insufficient laboratory facilities particularly at the lower levels of the health system and challenges with storage and transportation of client samples was corroborated by service providers interviewed.

These challenges are seen to inhibit progress on integration at the service delivery level. The MOHSW is working towards addressing many of these issues through construction of new health facilities that will facilitate integration of services in one place (MOHSW 2011b).

2.4.7 Monitoring and Evaluation

Several types of tools are used by health managers to collect information for monitoring and evaluation (M&E) purposes. These include the MOHSW reporting framework, NAC’s Lesotho Output Monitoring System for HIV/AIDS (LOMSHA) tool, routine quality assurance, monthly narrative reports, spot checks, and sit-ins. Some novel tools are also in use by some NGOs such as the GIS by PIH and Sales Force software, ‘Fit for Life’ tool, which assesses skills in older OVC youth and qualitative research to assess impact by K4L. Other M&E strategies used are client-exit surveys to find out clients’ needs, satisfaction and views on services and KAP surveys.

The reporting system at health facilities is principally vertical, and different SRH and HIV tools are used to collect data. There are no clearly defined indicators of integration and the person responsible for collecting and collating these. Because the M&E systems and

indicators have not been integrated, there are too many forms that need to be filled out by providers as noted below:

'There are so many forms to be filled out. We used to have an MCH integrated form. Now each programme has different forms. When new programmes were instituted, management decided to get separate forms' Government Respondent.

From the MOHSW facility assessment study (MOHSW 2011b), the majority of health centres cited the Lesotho Observation Records (LOR) and Delivery Registers as key sources of data needed to get a complete count of women admitted with obstetric complications. Few listed partograms, admission discharge, PMTCT and PNC. On the other hand, hospitals cited maternity register and general admissions as key data sources needed to get a complete count of women admitted with obstetric complications. The registers were completed as events occur in the case of health centres or within 24 hours in the case of hospitals or at times at the end of the shift because of shortage of staff. It was reported that these records were not reviewed regularly in majority of health centres and hospitals.

Follow-up on referral and tracing of patients is quite limited. Agencies such as Kick 4 Life do follow-up to ensure that young people referred to health centres turn up. ALAFA partners with EGPAF and LENASO to facilitate follow-up of workers who leave factories to ensure that they continue accessing services in the government healthcare system. The PIH's CHWs also do not just refer community members to health centres, but they accompany them to the health centres to ensure that they go to receive care.

'We have developed an electronic file for patients. We receive alerts from this file if workers miss appointments. We then follow workers who have missed appointments in the factories where we counsel them, and in most cases, such workers resume their treatment and appointments. We have very few cases of workers we can't trace at all, especially those who leave factories. To trace such workers, we collaborate with EGPAF and government to help us trace sick factory workers' ALAFA Respondent.

'When CHWs visit households, they screen everyone in the household for everything, including immunization, ARVs, STIs, TB, FP needs, ANC, date of delivery, post-natal needs, etc. Upon screening, they identify and accompany people who need services to the health centres for care.' PIH Respondent.

For government health facilities, an MOHSW respondent indicated that patients referred between TB and HIV clinics often get lost in the system as there are no mechanisms for accompanying the referred patients or for follow-up.

The resource burden of some tools was also mentioned as highlighted by one of the programme managers as follows:

'Accurate recording was once advocated and a book called Lesotho Observation Records (LOR) that is supposed to be capturing complete and accurate information of every client was introduced. This book is however not supplied by the government. The management of health facilities are given a copy and expected to print others. Perhaps the expectation is for the cost of the printing to be incorporated in the budget. However, there has always been a budget cut and the LOR does not go into the priority list' NGO Respondent.

Service providers also reported weak monitoring and evaluation of the work that laboratories do.

At the national level, NAC noted that M&E was one of its biggest challenges and that it was in the process of addressing the challenge by retraining its M&E staff and revising its M&E

tools. Other challenges include shortages of M&E personnel and under-reporting by health facility workers.

Overall and as captured in this quote from a UN respondent,

'[t]he system level, as it is, is inadequate in bringing about SRH and HIV integration. It has to be strengthened for this purpose with coordination of the effort owned by MoH and backed by an efficient M&E system'.

2.5 Status of Linkages and Integration at Service Delivery Level

Although the study did not carry out facility assessments and client-exit interviews, the in-depth interviews with service providers provided some useful information on the level of SRH and HIV integration and the challenges at the service delivery level. The findings are presented below.

Over the past two decades, Lesotho, like many other developing countries across the globe, has seen a rapid increase in HIV activities which have been largely disconnected from broader SRH activities. Unsurprisingly therefore, the in-depth interviews revealed that generally SRH and HIV services are still largely provided vertically.

'When we talk about condoms in our gatherings we focus on their role in protecting people on HIV rather than protecting against unwanted pregnancy as there are other methods for family planning, which are administered by Family Health Division and LPPA' Government Respondent.

'We offer HTC through our stationary and mobile clinics countrywide ... we don't integrate SRH messages (even other FP messages) in our services - mainly because our main focus is HIV. Even our condoming messages only focus on HIV prevention; we only talk about unwanted pregnancy when marketing the female condoms' NGO Respondent.

Some service providers believe that while they see the importance of integration, it is difficult for staff at the health facility level to integrate because they have become too used to delivering SRH and HIV prevention, care and treatment programmes in a vertical manner. However, this seems to be more of a challenge for providers of HIV services than it is for SRH service providers.

'HIV issue was introduced as a vertical issue right from the start. Integration of SRH/HIV will require attitudinal and behavioural change on the part of the policy, system and service providers' players' NGO Respondent.

'...reluctance to embrace changes ... There is need to imbed integration in the culture of an organisation' NGO Respondent.

In addition, some service providers feel that the MOHSW has not advocated enough for integration and that if MOHSW had a policy and guidelines, they would implement it since they align their work to the government policy framework.

'We implement government policy and if the government had a policy on integration and guidelines, then we would be keen to implement the policy - thus we would integrate SRH into our HTC and condoming' NGO Service Provider Respondent.

While some non-government health facilities offer both SRH and HIV services, usually different services are provided on different days of the week.

'The two services used to be vertically delivered. Now...we are positively moving towards integration from planning to implementation. However, services are still given by days of the week...' NGO Service Provider Respondent.

'CHAL offers services on separate days.' Government Respondent.

'Integrated service at the health facility level is by default as only one nurse is ordinarily available at the facilities to give all the services. However, services may also be seen as not integrated as they are compartmentalized by days of the week whereby a specific service is offered on a specific day of the week' Development Partner.

Still, with some providers it was not clear whether true integration is really occurring.

'If you go for HIV testing, information on HIV is provided, there is a talk and also on the walls. Information also addresses pregnancy and STIs' NGO Service Provider Respondent

'Our focus is mainly on HIV, but all our facilities have adolescent corners that offer access to SRH information as well. The health centres have specific days for specific information and services. Focus on primary prevention has been weak' NGO Service Provider Respondent.

Even then, the in-depth interviews revealed that there is some level of integration occurring in the country. For example, EGPAF reported that it is partnering with the MOHSW to implement PMTCT+ throughout the MOHSW's and CHAL's health facilities.

'We are the main partner of MoH in implementing PMTCT. We have an MoU with the MoH... Services integrated include PMTCT, FP, VCT, STI, ANC, PNC, ART' EGPAF Respondent.

Furthermore, some non-government service providers such as LPPA, PIH and the ALAFA reported that they are providing integrated services as well, citing the 'one-stop shop' or 'supermarket approach' where the client receives all services at one point to maximize uptake.

'For a long time our main focus was on family planning, but in 1999 we expanded services to include all HIV issues and SRH services in an integrated manner... LPPA is currently trying to upscale integration of services, but there are challenges of infrastructure and human resources...When people come to LPPA for family planning services, they can also get HIV testing, receive information, and go through cancer screening...' LPPA Respondent.

'I participate in some technical working groups and in one of these recently we were talking about the need to expand the existing PMTCT and TB in HIV services and ARVs, and I told them that at the private clinics in factories, we have already integrated all services since workers receive HIV and SRH services at one place.' ALAFA Respondent.

'PIH programme in Lesotho provides access to comprehensive health services, integrating primary care with treatment for HIV and TB, maternal and child health and social programs that address root causes of poverty and disease' PIH Respondent.

One service provider offering both SRH and HIV services highlighted a challenge they have with universal access to integrated SRH and HIV services. During testing, individuals who test positive are put on HIV treatment and care as well as provided free SRH services. However, individuals who test negative are charged a service fee for SRH services. Many

times provision of integrated services to this group is missed because they opt out of paying for the services.

'...often the services are under-utilised because HIV negative people have to pay for the services they receive. For instance, if they need FP or STI services, they have to pay for these. So we need to expand free health services beyond HIV positive people to reach more people who also need services.' NGO Respondent.

Several stakeholders highlighted the importance of programmes targeting men. At the moment, only LPPA is doing this. It was noted by several respondents that men are the main decision makers in SRH matters, yet their involvement in reproductive health matters is very limited. Some women were reported to hide when going for FP services. For those women who do not risk going for FP services, this cultural norm inhibits their access to integrated SRH and HIV services.

In addition, there are several cultural practices that could hinder effective provision of integrated SRH and HIV services. There is a known practice among some communities that do not allow women who have given birth to leave the home until after 3 months. This inhibits utilization of important post-natal services including an entry point for FP services. According to the MOHSW study on community perspectives on SRH services (MOHSW 2009), some members of the public continue to trust in traditional health practices and services. For instance, they are comfortable to deliver their babies at home in the absence of health personnel. There is a lot to be done to educate communities on the importance of delivering at health facilities and with the assistance of a trained professional. Close to 40% of births are not delivered in health facilities, missing the opportunity for key SRH and HIV services such as PMTCT, ART and FP.

3. Discussion

The study set out to assess the status of SRH and HIV bi-directional linkages at policy, system and service delivery in Lesotho in order to identify gaps and opportunities for strengthening the linkages. The study team reviewed various policies and strategies related to SRH and HIV, as well as general literature on integration. The team also interviewed policy makers, development partners, program managers, and other stakeholders in HIV and SRH to get insights on the status, gaps and opportunities for SRH and HIV bi-directional linkages.

3.1 Lesotho's International Commitments to Integration

The Government of Lesotho has been party to numerous international meetings, protocols, and commitments that have underscored the importance of integrating HIV and SRH, including the 1994 ICPD Programme of Action, and the Maputo Programme of Action (MOHSW 2008). The international agenda for linking SRH and HIV was set by the 1994 ICDP Programme of Action (UNFPA 2004), which listed STIs and HIV as a component of reproductive health and rights. The ICPD called on governments to ensure universal access to basic healthcare by integrating various reproductive health services (including maternal and child health and family planning services) on one hand, and programmes for prevention and treatment of sexually transmitted infection including HIV, on the other. The central place of maternal and child health and HIV and AIDS in improving the wellbeing of people in developing countries were reinforced in the 2000 MDGs declaration, and the subsequent inclusion of reproductive health under the maternal health overall goal in 2007.

3.2 Localizing International Commitments

Despite these international commitments, integration of HIV and SRH programmes has not been systematically championed and operationalized in Lesotho. Emphasis of integration of HIV and SRH services has been increasing in Health, SRH, and HIV policies over the past decade or so. However, these references have mostly been one-directional in the sense that the SRH and HIV policies and strategies have mostly underscored integration from the perspective of their core mandate, and not necessarily from the perspective of the broader needs of the population. Until the expansion of the HIV treatment programmes, emphasis of integration was very much one sided, with the SRH side pushing for incorporation of HIV services into the well-established SRH infrastructure. Nevertheless, the relatively well-resourced HIV sector, which was then mostly focusing on prevention, went on to set up its own infrastructure and implemented its programmes predominantly in a vertical manner. The rapid expansion of the HIV treatment programme and the resulting increase in the numbers of people getting tested for HIV compelled the HIV side to start paying particular attention to the SRH needs of PLHIV. Furthermore, the expansion of PMTCT to take care of the SRH needs of mothers in postpartum period also helped to expand the interest of the HIV sector in integrating its services with the SRH one. PMTCT is the only integration activity with a policy and guidelines and has been scaled-up countrywide.

Currently, as confirmed by the current study, there seems to be strong agreement between the two sectors and other stakeholders across the board on the need to strengthen integration of HIV and SRH programmes and services. All the Health, SRH and HIV policies and strategies developed in the country over the past five years, including the 2011 National Health and Social Welfare Policy, the 2006 HIV and AIDS Policies and Guidelines, the National HIV Prevention Strategy for a multi-sectoral Approach to the HIV Epidemic, and the 2010 Health Sector Policy on Comprehensive HIV Prevention are quite emphatic about integration between SRH and HIV.

3.3 Addressing Leadership and Coordination Hurdles

Although this growing consensus moves the integration agenda in the desired direction, it is a major concern that messages about integration are fragmented over numerous policies, which still largely highlight integration from a one-directional perspective. The primary focus of efforts to enhance synergies between SRH and HIV has been on integration of services, rather than ensuring that there are also strong linkages between the two issues at policy and system levels. Indeed, the Government of Lesotho does not have a universal national policy or strategy on SRH and HIV integration that would place the broader needs and interests of the population at the centre of the integration efforts and focus on enhancing the effectiveness of the health system in meeting those broad needs.

Almost all people that we talked with during the study called for stronger leadership on and coordination of integration efforts in the country. The lack of a universal national integration strategy and strong voices championing the issue was widely presented as a symptom of weak leadership on integration on the part of the MOHSW. While specific SRH and HIV policies emphasize different aspects of integration, there is no designated person in the Family Health Division or the STI/HIV and AIDS unit to coordinate integration activities within and across the two entities. There is also no multi-sectoral technical group working on linkages issues.

Although people from the STI/HIV Unit and Family Health Division get involved in each other's policy and strategy developing meetings, there was sense from some participants that this collaboration is not deep-rooted. In particular, SRH stakeholders who get involved in HIV meetings felt that the involvement is mostly at symbolic level and their input is hardly incorporated in the final outcomes. For the most part, there is no joint planning, budgeting, supervision, or monitoring of activities. The lack of universal guidelines defining what components of SRH and HIV can be integrated and at what levels of the healthcare system and who is responsible for what is particularly a critical barrier to integration among non-public providers, who often need a bit of convincing on why they should integrate their services. Consequently, HIV and SRH healthcare services in Lesotho are still largely being offered vertically or parallel to each other, even if under the same roof.

3.4 Learning from and strengthening on-going Integration Activities in Lesotho

Despite these concerns about the lack of a universal strategy and guidelines to streamline linkages and integration, there is also strong consensus that some integration work is taking place in both public and non-public facilities in the country, and that efforts should be made to strengthen these efforts and learn from their experience. The range of integration possibilities in Table 1 are being implemented in various health facility settings in Lesotho, but not in a well-coordinated manner. Our interviews with government and non-governmental programme managers (including PIH and LPPA) provided a wealth of experience in integration that is critical in informing the country's scale-up efforts. PMTCT+ is typically placed under the HIV sector in most countries, and placing it under the Family Health Division in Lesotho enhances its stature as a truly integrated programme. PMCTC+ is the most entrenched integrated service that routinely includes provision of FP, condoms and BCC. HCT has also been commonly integrated with STI screening and treatment, condom distribution, and BCC in many facilities and for many years. Provision of FP, condoms, and BCC to people on ART treatment is increasingly becoming the norm. Post-abortion services also typically include HCT, BCC, FP, and STI services.

The full extent to which these varied forms of integration are taking place in the country is unknown because there has been no study to investigate this, and the current assessment did not conduct facility assessments and client-exit interviews in order to understand the extent of integration at facility level due to limited resources. Furthermore, there has not been a systematic study of the challenges that these integration exercises are facing. According to MOHSW estimates, 86% of facilities providing antenatal care were also providing HTC and ART for PMTCT in 2009 (UNICEF 2010). It would be valuable to know, beyond this impressive figure, the extent to which clients who are seen/attended to for other SRH services like FP are actually offered HCT and vice versa in such clinics.

3.5 Barriers and Challenges of Integration in Lesotho

Based on integration experiences around the country, nevertheless, respondents reported many policy, system, and operational barriers and challenges that integration is facing and need to be addressed, especially if various integration models get scaled up. These include staff shortages and inadequate skills, poor infrastructure, weak referral systems, logistical challenges in ensuring consistent availability of SRH and HIV commodities, and weak M&E systems overlaid with numerous parallel tools to be filled out. These challenges are in line with challenges identified by a recent situational analysis on Lesotho's HIV/AIDS response (NAC 2011) noted in Textbox I.

The weak leadership and coordination of partners appears to be compounded by the weak inter-relationships between NAC and MOHSW on the one hand, and also between the Family Health Division and STI/HIV/AIDS Unit, on the other. As observed by stakeholders within and outside government and also noted by a recent study by NAC (NAC 2011), this problem weakens the country's response to HIV/AIDS and is likely to hinder effective HIV and SRH integration. But this problem is not unique to Lesotho as poor working relationships between AIDS commissions and ministries of health has been noted in many other African countries (Putzel 2004). Getting the HIV and SRH camps work together and provide leadership in developing an integration strategy would go along way in bridging them and enabling them assume a common purpose on integration. The funding imbalance between SRH and HIV is also a common problem and complaint from the SRH side on why the two camps do not have a smooth bi-directional partnership. With enhanced coordination, joint planning, budgeting, and supervision of integrated services, these funding imbalances will cease being a big matter.

Some participants in this study also highlighted the concern that effective integration will not materialize if donors and development partners do not embrace and champion integration and provide their support through integrated systems and programmes. For instance, it was noted that there is considerable overlap in the support that various UN agencies provide to the Government on SRH and HIV, and that the UN should lead by example by doing better coordination among various UN agencies and integrating their efforts and interface with the government.

The sizable coverage gaps that exist in various areas where intensive programme efforts have been deployed demonstrate the enormous potential for improvement that can accrue from a properly streamlined, coordinated, marketed, and implemented integration program. For instance, as shown in Table 3, the majority of men (63%) and 35% of women have never been tested for HIV; only half of pregnant women are tested for HIV; 64% of HIV-positive women receive ARTs for PMTCT; 33% of HIV-exposed infants received prophylactic ARVs for PMTCT; and only half of HIV positive adults and children eligible for ARTs are on treatment. Generally, maternal and child health services, which are relatively widely available and accessible in Lesotho offer a unique opportunity to reach women and children with HIV prevention, treatment and care interventions. However, there is also considerable undercoverage in this area, with more than half of married and other sexually active women not using modern contraception.

Textbox IV: Barriers and Challenges to Integration

1. Lack of national strategy and guidelines on integration to define what should be integrated at various levels of care
2. Weak coordination of integration activities and partners within and across HIV and SRH sectors and lack of joint planning, budgeting, and supervision of integration activities
3. Weak M&E systems and indicators for monitoring progress of service integration (each sector does its own monitoring and uses indicators focused on their core services, and paper health records for ATR not accessible in SRH settings)
4. Shortage of health workers, burn-out, and frequent rotation of health workers who may be trained in integration, due to tough physical terrain in rural areas, makes it difficult to maintain the services
5. Weak grounding of integration issues in pre-service training, and time and follow-up constraints relating to in-service training
6. Uncertainty about long-term funding and commodity security, commodity stock-outs (due to weak stock management at service delivery points), and imbalanced funding of HIV and SRH commodities, especially in cases where some fee is paid for SRH commodities but HIV ones are free
7. Limited physical space in many facilities compromises audio and visual confidentiality
8. Lack of laboratory capacity at facilities below hospitals precludes integration of services that require lab tests at those levels
9. Weak support and integration of SRH services other than condoms in HIV prevention programmes such as HCT and BCC. As a result, most integration driven by the HIV sector only targets PLHIV
10. Confidentiality issues surrounding HIV and stigma and discrimination by some SRH service providers against positive women when they seek SRH services
11. Lack of champions and public advocacy campaigns for integration (to educate the population on the benefits of integration)
12. Cultural beliefs and traditions that limit use of health services and propagate disempowerment of women (e.g. low use of health facilities for delivery not only aggravates the high level of maternal mortality, but also limits coverage of PMTCT)
13. Weak involvement of men on reproductive health issues, particularly their limited contact with the health care system on MCH and SRH issues in general limits their access to integrated services, and in many cases, women's access to services as well.
14. Tense working relationship between NAC and MOHSW on the one hand, and also between FAMILY HEALTH DIVISION and HIV/STI and STI/HIV and AIDS Unit
15. Weak skills and capacities of community health workers on integration (most are delayed by NGOs that tend to focus on vertical serviced they are interested in)
16. Funding agencies and development partners who support HIV and SRH not embracing and promoting integrated approaches in their funding, in the way they deal with each other, and they way they partner with the government

3.6 The Challenges are not Unique to Lesotho

Most of the challenges discussed in this report are not unique to Lesotho and have been reported in other countries where integration of SRH and HIV has been implemented (Das et al, 2007; Gichuhi et al, 2004; Kaba and Alem 2006; Maharaj 2004; Maharaj and Cleland 2005; Marchal et al, 2005; Republic of Kenya 2009; Scholl and Cothran 2010). Therefore, apart from lessons from integration experiences within the country, Lesotho can also learn from other countries which have a rich reservoir of feasibility studies, practical lessons in program implementation and strategy development on integration. For example, Kenya's 2009 integration strategy development process and strategy itself (Republic of Kenya 2009; Scholl and Cothran 2010) could serve as a useful model to Lesotho as the Government and other stakeholders ponder the way forward on how to streamline and strengthen SRH and HIV linkages.

3.7 Caution: Integration is not the Answer to all SRH and HIV Problems

As we conclude, it is important to note that integration can have positive as well as negative impacts on the health system, health workers, as well as clients if it is not well designed and in line with local realities and needs. As noted by some of the participants in this study and in other countries as well, integration should not be seen as a solution to every SRH and HIV care challenge. The concerns about integration slowing delivery of care, increasing workloads for healthcare workers, and undermining quality of care should not be simply dismissed because integration sounds like a sensible thing to do.

Indeed, despite conventional thinking that paints integration as a win-win initiative for all, there is limited research evidence that quantifies the benefits and costs of integration to the healthcare system and to clients. For example, a recent systematic review of scientific publications on current evidence and practice on integration of maternal, neonatal, and child health and nutrition, FP, and HIV in low and middle income countries found key worrying evidence deficits on areas where good evidence is needed to guide programmes (Lindgren et al. 2011). For instance, the study did not find strong evidence on the impact of integration on existing services, that most studies did not have sufficient follow-up to measure long-term effects of interventions, and that none of the published studies reported on cost or cost-effectiveness of the programmes and impact on stigma. The fact that there is no concrete evidence on some aspects of impact of integration should be taken as a caution for planners and designers to pay attention to evidence on integration when deciding which components of care to integrate and at what levels of the healthcare system.

4. Recommendations

There are two sets of recommendations from this study. The first set addresses the need to rally relevant government units and key stakeholders to work together towards improving coordination and leadership on integration in Lesotho. The ultimate outcome of this process should be the development of an integration policy and/or strategy, which many participants felt would help streamline and guide integration activities in the country. The second set of recommendations highlights the key system and operational challenges that need to be addressed to improve integration activities in the country. The Integration Strategy needs to provide guidance on how the country will address these challenges.

4.1 Improve Leadership, Guidance and Coordination of SRH and HIV Linkages

- (i) Hold a Consultative Workshop co-led by the Family Health Division and the HIV/AIDS and STI Unit to build consensus, reflect and deliberate on the findings of this study and chart the way forward for integration in Lesotho.**

The workshop should be co-led by the Family Health Division and the HIV/AIDS and STI Unit in order to start instilling a sense of common purpose and leadership and integration from the outside. Participants should include a broad range of SRH and HIV stakeholders, including senior public and non-public health facility managers. The workshop should formalize the formation, publicise and determine the composition and functions of the technical working group discussed in #2 below.

- (ii) Form a multi-sectoral Technical Working Group on integration co-chaired by Family Health Division and the HIV/AIDS and STI Unit to oversee the formulation of policies, strategies, and coordinating mechanisms for integration.**

The Group should include NAC, UNFPA, UNAIDS, UNICEF, other relevant government departments, and a broader range of training, research, and service delivery stakeholders. This working group would enhance buy in and support of integration activities, and ensure continued input and perspectives of representatives of all key sectors in initiatives aimed at streamlining and strengthening integration at policy, system, and service delivery levels. Initially, a smaller technical working group could be formed to help translate the findings of this study to inform the direction of the integration agenda in Lesotho. In order to enhance communication, coordination, and partnership within and across the three critical government bodies managing SRH and HIV issues, the MOHSW should consider designating integration desks or officers at the Family Health Division, the HIV/AIDS and STI Unit, and at NAC.

- (iii) Develop a national strategy and operational service and supervision guidelines on integration to provide strategic and operational guidance on SRH and HIV linkages.**

Although Lesotho's HIV and RH policies support linkages and integration at various levels, there is need for a national SRH and HIV integration strategy to provide guidance on bi-directional linkages. The development process should be co-led and the strategy and guidelines co-owned by the Family Health Division and the HIV/AIDS and STI Unit.

The strategy should include a detailed action plan, provide guidance on feasible integration packages at various levels of care, an M&E framework, modalities for strengthening partnerships and coordination mechanisms, clear definition of who plays what roles among key stakeholders, and how joint planning, budgeting and supervision would be done, etc. The strategy should also be quickly unpacked into service and supervision guidelines to guide and stimulate action at various service delivery levels. The strategy should also have cost estimates in order to serve as a useful tool for resource mobilization for integrated programmes and services. Some participants expressed concern on the recent restructuring in the MOHSW that resulted in the HIV Directorate being dissolved and placement of HIV/AIDS and STI functions under the Disease Control Directorate. There was a feeling that this would diminish the central importance of HIV/AIDS in the health system. The extent to which this may actually affect HIV and AIDS programmes in general and integration with SRH, and how this challenge can be addressed should be examined in the strategy development process.

(iv) Consider options for long-term institutionalisation of the integration coordinating mechanism in order to have sustained leadership and coordination of integration efforts.

While the multi-sectoral working group will be vital for steering the development of the integration strategy, and guidelines, it is unlikely to maintain the momentum that is needed to ensure well-coordinated integration activities over the long term. Therefore, there will be need to think about how to institutionalise this role in order to have sustained leadership and coordination of integration efforts. Various models could be considered for this, including having an independent coordination unit within the MOHSW; Joint leadership by the Family Health Division the HIV/AIDS and STI Unit; and placing the coordinating role at NAC. The multi-sectoral Technical Working Group could be maintained with a reduced role aimed at providing a networking platform for various stakeholders to give feedback and share experiences.

4.2 Address Key System and Operational Challenges for Integration

(v) Enhance publicity and dissemination of integration policies and guidelines and advocacy for integration at all levels of care, including communities to galvanise broad-based support and action on SRH and HIV integration.

The strategy and guidelines should be disseminated to all service delivery points and to all stakeholders, including training institutions. The dissemination efforts should also include sub-national workshops to publicise integration. In order to have sustained interest on and commitment to integration, the MOHSW and NAC will need to actively champion and promote SRH and HIV integration in the country. There should also be efforts to identify and empower integration champions among political leaders and civil society organizations. Advocacy for integration should also extend to communities to sensitise people on available SRH and HIV services. Having an informed populace would help increase demand for integrated services and address some of the rumours, myths, and misconceptions that undermine use of various SRH and HIV services. The advocacy and educational campaigns could also help reduce stigma and discrimination of vulnerable population groups including youth, PLHIV, MSMs, and prisoners. Also, community level engagement should prioritise men to ensure that they become central and proactive partners in improving SRH and HIV outcomes.

(vi) Strengthen the Human Resource Base through training and effective supervision aimed at improving the capacity of all cadres of healthcare personnel in planning for and offering integrated services, improve customer care skills, forecasting of supplies, and data capturing.

Most of the healthcare workforce challenges relating to shortage and retention of staff are not specific to SRH and HIV integration issues, but to the entire health sector. Hence, the resolution of these cross-cutting challenges goes beyond the the remit of the integration course. However, the integration strategy should outline plans and strategies for strengthening and streamlining in-service and pre-service training on integration for all cadres of staff, including nurses, clinical officers, lab technicians, medical doctors, and health managers. Proper training would enhance the capacity of health workers in offering integrated services, improve their customer care skills, forecasting of supplies, and data capturing. All pre-service training programmes should compliment their SRH and HIV curricula with integration modules. Innovative strategies for in-service training,

such as on-site training, need to be explored in order to accommodate the varying circumstances of health workers in public and non-public service delivery facilities.

- (vii) Strengthen M&E Systems in order to effectively monitor and evaluate integration programmes and facilitate joint follow-up of patients, reduce excessive paperwork and time that healthcare workers take to fill the paper forms, and help improve data quality.**

The MOHSW needs to strengthen its referral and M&E systems to ensure smooth movement of patient and their records along the treatment line. Automated or joint information systems would facilitate provision of integrated SRH and HIV services and follow-up of patients. It is difficult to measure the level of integration in settings where data capture and reporting systems are compartmentalized according to diseases or sections of facilities where patients are seen. An automated data capturing system could also reduce the excessive paperwork and time that healthcare workers take to fill the paper forms, and help improve data quality. Finally, even in the current manual data capturing system, M&E processes for SRH and HIV should include indicators for integrated services rather than simply their side's core indicators. The Strategy should also include plans for instilling principles of evidence-based programming and define mechanisms for ensuring continued assessment and reflection of how the integration agenda is going. This could include conducting evaluative studies or applying results from similar settings in order to make evidence-based adjustments to guidelines.

- (viii) Improve commodity security and address supply chain hurdles to prevent commodity stockouts and enhance funding for both programmes to ensure long-term commodity security.**

Frequent commodity stockouts and weak commodity security are major hindrances to SRH and HIV integration. This becomes an even bigger problem if one side has commodity security while the other has perpetual shortages. While SRH commodity stockouts were mentioned by a number of respondents, the problem seems to be due to poor management of supplies and weaknesses in forecasting supply needs at facility level, rather than lack of funding at the central level. UNFPA and the MOHSW seem to be working quite well in ensuring that adequate contraceptives are available and funding gaps are addressed quickly. The procurement and distribution of HIV prevention and treatment commodities also appears to be going reasonably well. In particular, there is reasonable government commitment to supplement donor funding for SRH and HIV programmes from its own budgetary resources. This lays a good basis for building self-sufficiency in these important health issues in the long run. However, it is a concern that determination of stock quantities for family planning is based on use statistics rather than a careful assessment of demand at community level. Proper assessment of demand for services at community levels would be vital for galvanizing efforts to reinforce ways of reaching hard-to-reach populations and expand demand creation interventions. The merging of the national RHCS and Condom Programming Coordinating Committee is a positive move that will help integrate planning, budgeting and procurement of SRH and HIV commodities.

5. Appendices

Appendix 1: International Statements Supporting SRH and HIV/AIDS Linkages

Report or policy	Statement
International Conference on Population and Development Programme of Action (UN, 1994) http://www.un.org/popin/icpd2.htm	Names prevention and treatment of HIV an essential component of comprehensive reproductive health care.
Glion Consultation on Strengthening the Linkages between Reproductive Health and HIV/AIDS: Family Planning and HIV/AIDS in Women and Children (WHO, UNFPA, 2004) http://www.who.int/reproductive-health/stis/docs/glion_consultationsummary.pdf	Recommends a course of action for governments, United Nations agencies, donors, nongovernmental organisations, and others to strengthen linkages between family planning and prevention of mother-to-child transmission of HIV (PMTCT) policies and programmes.
Reproductive Health Strategy to Accelerate Progress towards the Attainment of International Development Goals and Targets (WHO, 2004) http://www.who.int/reproductivehealth/publications/general/RHR_04_8/en/index.html	Cites combating HIV as one of five priority aspects of sexual and reproductive health.
New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health (UNFPA, UNAIDS, FCI, 2004) http://www.unfpa.org/upload/lib_pub_file/321_filename_New%20York%20Call%20to%20Commitment.pdf	Calls for an urgent effort to strengthen links between corresponding sexual and reproductive health and HIV policies, programs, and services.
2005 G8 Gleneagles Commitment (UNAIDS, 2005) http://data.unaids.org/Topics/UniversalAccess/PostG8_Gleneagles_Africa_en.pdf	Describes integration with sexual and reproductive health as important in achieving the G8 commitment to reach universal access to HIV prevention, care, and treatment.
Intensifying HIV Prevention (UNAIDS, 2005) http://data.unaids.org/publications/irc-pub06/jc11165_intensif_hiv-newstyle_en.pdf	Names integration an essential policy action or HIV prevention.
Declaration of Commitment to HIV/AIDS (UNGASS, 2006) http://data.unaids.org/publications/irc-pub03/aidsdeclaration_en.pdf	Challenges the global health community to forge closer linkages between sexual and reproductive health and HIV through better policy and program coordination. ²
Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights: 2007–2010 (African Union, 2006) http://www.africanunion.org/root/au/Conferences/Past/2006/September/SA/Maputo/doc/en/Working_en/SRHR_%20Plan_of_Action_2007_Final.pdf	Challenges the global health community to forge closer linkages between sexual and reproductive health and HIV through better policy and program coordination.
Guidance on Global Scale-Up of the Prevention of Mother-to-Child Transmission of HIV (IATT on PMTCT, 2007) http://www.who.int/hiv/mtct/PMTCT_enWEBNov26.pdf	States linkages between PMTCT and sexual and reproductive health services are a key strategic approach to realising comprehensive PMTCT services

Source: FHI 2010. *Policy Support for Strengthening Family Planning and HIV/AIDS Linkage, Family Health International FP/HIV-10-02E*

Appendix 2: Summary of Policies and Strategies Reviewed

Policy/Strategy	Elements of Linkages and Integration
<i>Lesotho National Health and Social Welfare Policy 2011</i>	The policy provides the national framework for addressing health issues. The policy identifies HIV, STI and TB; and SRHR/FP as some of the priority areas to be addressed. The policy emphasizes Lesotho's multi-sectoral approach to managing HIV and AIDS and calls upon all agencies implementing the HIV and AIDS policy to articulate areas for mutual potentiation and synergizing to attain maximum impact on HIV and AIDS prevention and impact mitigation goals. While the policy does not mention HIV and AIDS and SRH linkages and integration, it identifies key areas of focus in the response to HIV and AIDS to include changing risky attitudes and behaviour and PMTCT of HIV, among others. On SRHR, the policy commits to ensuring the PMTCT of HIV, and to providing adolescent SRH information and services including prevention of HIV and STIs.
<i>Lesotho National Adolescent Health Policy 2006</i>	The policy, developed by MOHSW, aims to protect the health, development and rights of all adolescents in Lesotho. The policy does not talk about SRH and HIV linkages and integration, but commits to, among others: promote responsible behaviour among adolescents regarding contraception, safe sex and prevention of STIs, HIV and AIDS.
<i>Gender and Development Policy 2003</i>	The policy, developed by ministry of Gender, Youth, Sports and Recreation, seeks to ensure equality of all opportunities between women, men, girls and boys so that development efforts have an equal impact on all gender. The policy commits the government of Lesotho to ensuring the provision of accessible and affordable SRH care, including FP information and services, maternal and obstetric care and prevention of STIs/HIV and AIDS, and addressing gender-based violence.
<i>National HIV and AIDS Policy 2006</i>	<p>Developed by the NAC, the policy is Lesotho's national framework that spells out the country's response to the epidemic. The policy adopts a multi-sectoral approach in its response to HIV and AIDS in which it commits to establishing order in the planning, coordination and management of HIV and AIDS interventions to avoid the inefficiency of fragmented programmes. The policy commits to ensuring the mainstreaming of HIV and AIDS into all relevant policies, plans, budgets, activities and programmes.</p> <p>The policy does not explicitly mention HIV and SRH linkages and integration rather it commits to various aspects of the SRH and HIV linkages approach, including:</p> <ul style="list-style-type: none"> • PMTCT of HIV but says nothing on responding to the family planning needs of HIV+ women; • Management of STIs by ensuring the routine testing for HIV on STI and antenatal clinic patients; • The protection and fulfilment of the rights of all vulnerable populations, including women and girls and PLHIV, people involved homosexual relationships, and sex workers to prevent the further spread of HIV, and ensure equal access to prevention, treatment, care and support, and impact mitigation services including legal support; • Reducing the vulnerability of women and girls by empowering them with appropriate education to enable them to make informed decisions on their sexual wellbeing and exercise their full human rights. Also, protecting women and girls against gender-based violence;

	<ul style="list-style-type: none"> • Establishing guidelines for management of sexual abuse at healthcare delivery and law enforcement offices; • Ensuring the provision of condoms and proper usage. It also acknowledges that condoms also prevent the transmission of STIs and are used for FP purposes. This is the only place the policy mentions FP; • Providing guidelines for the establishment of special services for sex workers to have access to confidential and user-friendly health services, sexual and reproductive information, free condoms, and free treatment of STIs and care of those living with HIV and AIDS; • Developing guidelines for the establishment of youth-friendly sexual and reproductive health services, including HIV/AIDS and STI information. It further commits to developing guidelines for incorporation of life skills including reproductive and sexual health education into the school curricula to assist children and young people to make informed choices about their sexuality; and • Ensuring that PLWHAs are not discriminated against in access to healthcare and related services, and that respect for privacy and confidentiality is upheld.
<p><i>National HIV and AIDS Strategic Plan 2006-2011 (revised April 2009)</i></p>	<p>Developed by NAC, the strategy sets out the implementation plan for the HIV and AIDS policy. It unpacks the country’s strategies in achieving the commitments pledged in the policy and the strategies that touch on linkages and integration include:</p> <p><i>PMTCT</i> – scale up provision of ART for PMTCT and for PEP. Also integrate neonatal male circumcision (MC) into PMTCT and train technical staff on safe neonatal MC. The guidelines do not address the FP needs of HIV+ mothers.</p> <p><i>STIs</i> – Prioritises the prevention, diagnosis and treatment of STIs. It will also integrate routine HIV testing as part of STI diagnosis. Men who have sex with men (MSM) are recognised as one of its priority vulnerable populations to be targeted with information and services.</p> <p><i>Addressing human rights and gender mainstreaming</i> - Commits to carry out advocacy, public policy and legislation on, among others, issues of human rights and gender mainstreaming. These are key SRH issues as well.</p> <p>Acknowledging that survivors of rape, domestic and other gender-based violence do not report to the authorities due to high stigma, the Strategy commits to ensure that survivors of rape have access to PEP, and educate communities and authorities on PEP, and the need to control infection in cases of rape. The Strategy commits to ensure increased access to condoms, and use and proper use for HIV prevention; it does not commit to promoting condom for their dual purpose in the prevention of both STIs and unwanted pregnancy.</p>
<p><i>National HIV Prevention Strategy for a Multi-Sectoral Response to the HIV Epidemic in Lesotho (Sept 2010 version)</i></p>	<p>It was developed by the NAC. It emphasizes a multi-sectoral approach to HIV prevention that promotes integrated, comprehensive services as the cornerstone of the response. It reinforces the integration of HIV prevention services into the existing healthcare system such as specialty clinics (e.g. STI, Maternal and Child Health clinics), community health services, and both acute and primary health care facilities, so that every encounter with the health system is optimally utilised for preventing HIV infections. The SRH and HIV integration related outcomes spelled out in the Strategy’s results framework include, among others, reduction of HIV transmission resulting from sexual and gender-based violence (SGBV); reduction in behaviours that cause STI infections; and increased number of infants receiving medical circumcision.</p> <p>Strategy also sets out activities to reach most at-risk groups including sex workers, and men having sex with men, among others, including: increased number of districts providing comprehensive prevention services for sex workers; percentage increase of sex workers accessing comprehensive</p>

	prevention services; increased number of districts providing comprehensive prevention services for MSM; percentage increase of MSM accessing comprehensive prevention services; and increased number of districts providing comprehensive prevention services for prisoners.
<i>Health Sector Policy on Comprehensive HIV Prevention 2010</i>	<p>Developed by the MOHSW, the policy aims to integrate HIV prevention activities into all activities of the Lesotho health sector. The policy commits the health ministry to take a leadership role in the prevention of HIV infection, and integration of HIV into SRH and other health sector services. It calls for the linking and integration of HIV and AIDS with poverty reduction strategies including a broader focus on sexual and reproductive health, comprehensive and appropriate sexual education for young people, life skills, school-based education and linkages with existing programmes in all sectors.</p> <p>The policy commits to integrate HIV prevention into sexual and reproductive health services both for adolescents and adults. It outlines a comprehensive HIV prevention package including HTC, PMTCT, safe blood supply, PEP, STIs transmission management, ART, sexual behaviour change communication, male circumcision, and comprehensive condom programming.</p>
<i>Operational Guidelines for Comprehensive HIV Prevention Interventions within the Health Sector</i>	<p>Developed by the MOHSW, provide guidelines on integration and coordination of HIV prevention interventions at various levels of the healthcare system in Lesotho. The document acknowledges that TB, STI and MCH programmes have integrated HTC but fails to include HIV prevention support. The HIV prevention package proposed for integration into healthcare services varies at the different levels of the health system as different levels offer different services. Specifically, the document:</p> <ul style="list-style-type: none"> • Requires the integration of safe sex counselling for prevention of HIV into SRH services as well as adolescent and youth services; • Ironically fails to talk about condoms for prevention of unwanted pregnancy and other STIs; it only talks about condoms for HIV prevention; • Requires SRH facilities to have up to date policies and procedures for managing and assisting survivors of rape to prevent HIV infection; • Under PMTCT, requires the promotion of the integration of PMTCT of HIV with maternal, newborn and child healthcare, ART, FP, RH, and STI services to ensure the delivery of a package of essential services for quality maternal, newborn and child health care; • Commits to expand the provision of good quality STI care into primary healthcare, SRH services and HIV services – the only time the document mentions integrating an SRH issue (STI) into HIV services; • Commits to ensure HIV testing in all settings providing STI care; • On training, fails to talk about the need for training in medical colleges and universities; • Commits to foster working relationships and referral mechanisms with other agencies to support HIV prevention, including domestic violence shelters, among others; • States that the health sector will integrate the already existing services into the comprehensive HIV prevention services.
<i>National HIV and AIDS M&E Plan 2006-2011</i>	Developed by NAC, it's the M&E tool for the national HIV and AIDS policy of 2006. The tool only monitors two SRH-HIV linkage/integration related indicators i.e. the percentage of ANC facilities offering PMTCT; and the percentage of designated facilities surveyed with drugs for STIs in stock and no stock-outs of less than week in the last 12 months.

<p><i>Minimum Package for HIV Prevention among adolescents</i></p>	<p>Developed by the Ministry of Gender, Youth, Sports and Recreation, addresses HIV and AIDS challenges among adolescents and young people in Lesotho. SRH is one of the areas where the package commits to provide information and services.</p>
<p><i>National Reproductive Health Policy 2008</i></p>	<p>The goal of the National Reproductive Health Policy of 2008 is to reduce maternal mortality related to sexual and reproductive health conditions by three quarters by 2015. The policy highlights its commitment to ensuring the integration of HIV and AIDS into SRH. Indeed, it has HIV and AIDS and PMTCT as part of the SRH package that the country has committed to offer at all levels of the healthcare system. For instance, it commits to:</p> <ul style="list-style-type: none"> • Integrate PMTCT of HIV into maternal and child health services at all levels of health care; • Ensure provision of family planning services to all clients with emphasis on protection against unintended pregnancies and the use of condoms for prevention of sexually transmitted infections including HIV; • Ensure that HIV positive clients make an informed choice on the method of contraception of their choices; • Enforce integration of family planning into PMTCT of HIV services and other relevant Primary Health Care; and • Ensure integration of STIs and HIV management into SRH services.
<p><i>Reproductive Health Policy Implementation Strategic Framework (Draft 2010)</i></p>	<p>Integration components of the strategy include:</p> <ul style="list-style-type: none"> • Strengthen an integrated approach for provision of SRH services and other related services such as STI, HIV and AIDS. <ul style="list-style-type: none"> ○ Assess the level of integration of SRH, STI, HIV and AIDS services ○ Implement the recommendations of the assessment in the already existing SRH services ○ Review/ update and distribute integrated guidelines and tools based on the assessment findings ○ Sensitize and train health workers on the integrated guidelines approach on SRH ○ Sensitize other stakeholders (development partners, program managers etc.) on integrated services • Establish/strengthen sexual and reproductive health programmes at the workplace; <ul style="list-style-type: none"> ○ Create awareness campaigns for the employees to utilize integrated SRH work place services ○ Provide supervision and support to the integrated SRH services at work place • Strengthen community mobilisation on PMTCT; Strengthen access to PMTCT services at all levels • Ensure availability of services for gender-based violence survivors; Advocate for the establishment of facilities for protection of survivors of sexual violence and abuse • Increase male involvement in SRH

	<ul style="list-style-type: none">• Integrate SRH services into other existing health care services for both males and females no of facilities providing SRH• Integrate SRH services into the existing HIV and AIDS mobile clinics• Establish new SRH mobile clinics into which other services will be integrated• Integrate SRH issues into existing MOHSW BCC strategies• Provide family planning services to all clients with emphasis on dual protection and method.• Integrate family planning into ART services and other relevant Primary Health Care Services• Integrate sexually transmitted infections and HIV management into SRH services• Promote the use of guidelines for Prevention of Mother to Child Transmission• Monitor implementation of free services for Prevention of Mother to Child Transmission of HIV at all levels of care including private practice• Integrate HIV testing and counselling in all sexual and reproductive health services and all other existing health services• Respect the right to SRH services to all individuals, families, couples including People Living with HIV and AIDS (PLWHAs)
--	---

References

- African Union Commission (2006). *Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010*.
- Askew, Ian (2007). "Achieving synergies in prevention through linking sexual and reproductive health and HIV services". Paper presented at International Conference on Actions to Strengthen Linkages between Sexual and Reproductive Health and HIV/AIDS.
- Das, Rumeli, Kaushik Biswas, Pradeep Panda, M.E. Khan, and Rick Homan (2007). "Strengthening financial sustainability through integration of voluntary counselling and testing services with other reproductive health services (India)." *FRONTIERS Final Report*. Washington, DC: Population Council.
- Gichuhi, Wanjiru, Sarah Bradley, and Karen Hardee (2004). "Provision and use of family planning in the context of HIV/AIDS in Kenya: Perspectives of providers, family planning and antenatal care clients, and HIV-positive women." Washington, DC: Futures Group International/POLICY Project. Kaba and Alem 2006.
- Government of Lesotho (2009). *Lesotho HIV Prevention Response and Modes of Transmission Analysis*. Maseru, Lesotho: GOL.
- Government of Lesotho (2007). *Guidelines for the prevention of mother to child transmission of HIV (PMTCT)*. July 2007 Draft version. Maseru: GOL.
- Government of Lesotho (1993). *The Constitution of Lesotho*. April 2, 1993. Maseru, Lesotho: GOL.
- IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives (2009). *Rapid Assessment Tool for Sexual & Reproductive Health and HIV Linkages: A Generic Guide*.
- Kaba, Mirgissa and Assefa Alem (2006). "Integrating youth friendly VCT to youth reproductive health service provision: Experience from Family Guidance Association of Ethiopia (FGAE) youth centres." Paper presented at conference on Linking Reproductive Health, Family Planning, and HIV/AIDS in Africa, Addis Ababa, 9–10 October.
- Lindgren, Mary Lou and the Cochrane HIV/AIDS Group University of California (San Francisco) (2011). "Cochrane Review of the Evidence: Integration between Maternal, Neonatal, and Child Health and Nutrition and HIV/AIDS". Paper presented at the Meeting on Integration of FP/HIV/MNCH Programs organized by USAID and CDC, Washington DC. March 28-29, 2011.
- Maharaj, Pranitha. 2004. "Integrated reproductive health services: The perspectives of providers." *Curationis* 27(1): 23–30.
- Maharaj, Pranitha and John Cleland (2005). "Integration of sexual and reproductive health services in KwaZulu-Natal, South Africa." *Health Policy and Planning* 20(5): 310–318.
- Marchal, Bruno, Vincent De Brouwere, and Guy Kegels (2005). "Viewpoint: HIV/AIDS and the health workforce crisis: What are the next steps?" *Tropical Medicine & International Health* 10(4): 300–304.

- Ministry of Health and Social Welfare (MOHSW) [Lesotho] (2006). *National Adolescent Health Policy*. Maseru, Lesotho: GOL and MOHSW.
- Ministry of Health and Social Welfare (MOHSW) [Lesotho] (2011a). *National Health and Social Welfare Policy*. Final Version. Maseru, Lesotho: MOHSW.
- Ministry of Health and Social Welfare (MOHSW) [Lesotho] (2011b). *Health Facility Assessment in four districts of Berea, Mokhotlong, Qacha's Nek and Thaba-Tseka* (May 2011 Draft Report).
- Ministry of Health and Social Welfare (MOHSW) [Lesotho], UNFPA, UNICEF (2008). *Report of Situational Analysis and Needs Assessment of youth in Three Districts - Maseru, Leirbe and Butha-Buthe*. Maseru, Lesotho: MOHSW, UNFPA, UNICEF.
- Ministry of Health and Social Welfare (MOHSW) [Lesotho] (2010). *Health Sector Policy on Comprehensive HIV Prevention*. Maseru, Lesotho: MOHSW.
- Ministry of Health and Social Welfare (MOHSW) [Lesotho] (2008). *Reproductive Health Policy 2008*.
- Ministry of Health and Social Welfare (MOHSW) [Lesotho] (2009). *Assessment of Community Knowledge on Reproductive Health including their perceptions on the quality of reproductive health service delivery: A report based on Focus Group Discussions*.
- Ministry of Health and Social Welfare (MOHSW) [Lesotho] and ICF Macro. 2010. *Lesotho Demographic and Health Survey 2009*. Maseru, Lesotho: MOHSW and ICF Macro.
- Ministry of Health and Social Welfare (MOHSW) [Lesotho] and UNFPA (2007). *Situation Analysis of Reproductive Health Commodity Security in Lesotho*. Maseru, Lesotho: MOHSW and UNFPA.
- Ministry of Health and Social Welfare (MOHSW) [Lesotho] (2010 draft). *Reproductive Health Policy Implementation Strategic Framework*. Maseru, Lesotho: MOHSW.
- National AIDS Commission (NAC) [Lesotho] (2006). *National HIV and AIDS Policy*. Maseru, Lesotho: NAC.
- National AIDS Commission (NAC) [Lesotho] (2009). *Annual Report on the National Response to HIV/AIDS – Jan-Dec 2009*. Maseru, Lesotho: NAC.
- National AIDS Commission (NAC) [Lesotho] (2010). *National HIV and AIDS Strategic Plan 2006-2011 (revised April 2009)* Draft version. Maseru, Lesotho: NAC.
- National AIDS Commission (NAC) [Lesotho] (2011). *HIV Epidemiology and National Response Situation Analysis Report for the National Strategic Planning Process*. Final Draft. Maseru, Lesotho: NAC.
- Population Action international (undated). *What is SRH/HIV Integration?*
http://www.populationaction.org/Issues/SRH-HIV_Integration/Index.shtml
- Putzel, James (2004). "Governance and AIDS in Africa: Assessing the International Community's 'Multisectoral Approach'". Paper delivered at the 2004 Annual Meeting of the American Political, Science Association, September 2 - 5, 2004.
- Scholl, Edward and Daniel Cothran (2010). "Integrating Family Planning and HIV services: programmes in Kenya and Ethiopia Lead the Way". *AIDSTAR-One Case Study Series*.

Arlington, VA: UAIS's AIDS Support and Technical Assistance Resources, AIDSTAR-One Task order 1.

Southern Africa Development Community and African Development Bank (2009). The Development of harmonised minimum standards for guidance on HIV testing and counselling and prevention of mother-to-child transmission of HIV in the SADC region. PMTCT Country report: Lesotho.

UNAIDS (2010). *Global Report: UNAIDS Report on the Global AIDS Epidemic 2010*.

UNICEF (2010). *Lesotho: PMTCT Factsheet*. Available at:
http://www.unicef.org/aids/files/Lesotho_PMTCTFactsheet_2010.pdf

UNFPA (1995). *International Conference on Population and Development - ICPD - Programme of Action. Report of the International Conference on Population and Development, Cairo, Egypt from 5-13 September 1994*. Available at:
<http://www.unfpa.org/public/home/publications/pid/1973>

Warren, C., S. Phafoli, B. Majara, and T. Tsukulu (2008). "Extending Prevention of Mother-to-Child Transmission through Postpartum Family Planning in Lesotho". *Frontiers in Reproductive Health*.

Wright, Christopher, Lawrence Anyanwu, Uzo Ebenebe (2007). *Situation Analysis of Reproductive Health Commodity Security in Lesotho*. Arlington, VA: John Snow, Inc./Logistics Services for the United Nations' Population Fund (UNFPA).

WHO, UNFPA, UNAIDS, IPPF, UCSF (2009). *Sexual and Reproductive Health Linkages: Evidence Review and Recommendations*.

WHO and UNFPA (2007). "Integration of HIV/AIDS, SRH and STI services towards the MDGs in Maternal, Newborn and Child Health: Implementation Framework". (unpublished document).