PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: AB4723

Project Name	Lesotho HIV and AIDS Technical Assistance Project
Region	AFRICA
Sector	Health (60%); Other social services (23%); Sub-national government administration (10%); Central government administration (7%)
Project ID	P107375
Borrower(s)	KINGDOM OF LESOTHO
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Implementing Agency	
Environment Category	[ ] A [X] B [ ] C [ ] FI [ ] TBD (to be determined)
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1. Country and Sector Background

Lesotho has the third highest HIV adult prevalence rate in the world at 23.2[1] percent. For a small country with a population of 1.8 million, completely surrounded by South Africa, HIV presents an unprecedented challenge. There are an estimated 62 new infections and 50 deaths due to AIDS each day (implying that epidemic threshold has not yet been reached and that the pool of HIV positive persons – who need care and treatment, and who can infect others – keeps

[1] Data presented in the PAD, unless otherwise identified, is taken from the Lesotho UNGASS Country Report of Jan. 2006 – Dec. 2007, as finalized and presented in June 2008.

growing). At the end of 2007, there were an estimated 270,000 people living with HIV (PLWHA), of whom 11,801 are children. Life expectancy at birth has dropped to 36.8 years. The total number of orphans was estimated to be around 108,700 in 2007.

The impact of the HIV epidemic is devastating on all aspects of society. The demographic structure of the country is changing as large numbers of people die in their productive years, thus creating a rising and high dependency ratio. Economically, the epidemic disrupts capital optimization by striking at a quarter of adult Basotho and diminishing labor inputs. Critical skill shortages are being felt in government services as well as in business. The social fabric is fraying due to the large burden of orphans and vulnerable children (OVCs) and others living with HIV/AIDS. Households are being reduced to asset stripping, if not outright penury. The inter-generational spillovers are substantial, as the OVCs are often deprived of access to education, good nutrition and health care and will be ill-equipped to deal with the future.

Lesotho has the fifth highest Tuberculosis (TB) incidence in the world with 635 cases per 100,000 people. TB deaths have tripled since 1990 and it is now the leading cause of death for those with HIV and AIDS. With 80 percent of HIV positive patients co-infected with TB, the HIV epidemic has dramatically increased the threat of TB. Multi-Drug resistant (MDR) and Extremely Drug Resistant (XDR) are on the rise, threatening both Lesotho and the Southern Africa Region as a whole. This “two disease, one patient” issue needs to be addressed in a carefully coordinated way.

The country regards HIV as the one of its most important development issues, declaring it as a national emergency in 2000. Since then, several major policies have been adopted by the Government, including the National HIV and AIDS Policy, National Orphan and Vulnerable Children Policy, HIV Testing and Counseling Policy, and Blood Transfusion Policy. The Labour Code Act was amended to prohibit discrimination against PLWHAs, and a Legal Capacity of Married Person’s Act was passed to empower women to fight HIV and AIDS. The National AIDS Commission (NAC) was established in 2005, to replace the Lesotho AIDS Programme Coordination Authority (LAPCA) and strengthen coordination of the national response. A National HIV and AIDS Strategic Plan (2006-2011) (NSP) and a corresponding HIV and AIDS Monitoring and Evaluation Framework (2006-2011) were approved in December 2006. In particular, the NSP identified the main drivers of the epidemic – multiple and concurrent sexual partnerships (MCP) and cultural factors including gender inequality and women’s disempowerment. The NSP focuses on achieving four main strategic objectives: (a) strengthening management and coordination mechanisms; (b) preventing transmission of HIV; (c) treatment and care; and (d) mitigating the impact of the epidemic in the population.

The strong political commitment and increasing social mobilization plus increasing internal and external funding have contributed to improvement in several key HIV and AIDS related interventions in recent years. The coverage of Prevention of Mother to Child Transmission (PMTCT) increased fivefold from 5 percent in 2005 to 31 percent in 2007. The roll out of Antiretroviral Therapy (ART) made significant progress, with 21,710 patients receiving treatment in 2007. The “Know Your Status” (KYS) campaign resulted in a total of 229,092 people being tested for HIV by December 2007, representing 12 percent of the population and about three times the number tested in 2005. Lesotho has maintained a TB case detection rate above 80% for the past 3 years, and currently has a treatment success rate of 73%.

These improvements in HIV service delivery have not necessarily yielded sufficient changes in HIV incidence, although it has recently shown signs of stabilizing (especially amongst young women). Lesotho is at a crossroads in the fight against HIV and AIDS. The country and its partners have a rare opportunity to make a difference now. First, although there is no significant decline in the adult HIV prevalence rate (which could partly be the result of the roll out of the ART program), adult HIV incidence rate decreased from 2.9% in 2005 to 2.3% in 2007 and new infections dropped from 26,000 to 21,558 in the same period. This is the first time the HIV epidemic has shown signs of declining. Second, following several major analytical studies (sponsored by the Government, Bank and UNAIDS), we have a better understanding of the drivers of the epidemic, which include multiple concurrent partners, unsafe sexual behaviors, low condom use, limited male circumcision as well as social-economic factors. This provides the intellectual underpinning for tackling the epidemic effectively. Third, we have increasing knowledge on what works on the ground. For example, the UNGASS 2008 report listed the PMTCT and the KYS campaigns as best practices. Fourth, increasing resources for HIV programs, both internal and external, are available. If used effectively and efficiently, there is a real possibility of making a dent in the epidemic.

The country has moved towards but not yet reached its Universal Access Targets to HIV prevention, care and support. Reaching these targets is a Government commitment and will be a sign of the HIV response maturing and being implemented to scale in Lesotho.

Despite this progress, the national response significantly falls behind in terms of the optimal coverage of key interventions required to address the epidemic effectively. The implementation of the National Strategic Plan (2006-2011) has been slow. The major challenge to expediting and expanding the response to the epidemic remains due to weak implementing systems at both the national and local levels, which urgently require support on capacity building, organizational strengthening, and the creation of an enabling environment at all levels.

Lesotho enjoys increasing support from development partners. The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), Irish Aid, US Government (PEPFAR), DFID, GTZ, European Union, UN Family (ILO, UNAIDS, UNDP, UNFPA, UNICEF, WHO, and the World Food Programme), and the Bank are committed to the implementation of the “three ones principles” and are providing funding to support the national response. About 57 percent of HIV/AIDS spending for the period 2005/06 and 2006/07 was sourced from international partners while 43 percent came from Government. GFATM is by far the largest external financer in the HIV area, with a cumulative amount of US$ 114 million for HIV and TB programs (of which, more than US$102 million is earmarked for HIV). Two issues were identified in the UNGASS 2007 report and the National AIDS Spending Account (NASA): (i) despite the increasing funding from both the Government and partners, significant financial gaps remain. For the fiscal year 2006/07 alone, the funds shortage is estimated to be Maloti 477 million (US$ 48 million); and (ii) based on the data from NASA for the three-year period 2005/06 to 2007/08, more than 76 percent of resources was budgeted for direct programs (prevention; treatment, care and support; and impact mitigation). No significant support was given to strengthen the implementing system, which largely explains why with larger amounts of money pumped into the system, the allocated resources for HIV programs were absorbed relatively slowly due to the limited capacity. The National Strategic Plan (2006-2011) calls for greater attention to system strengthening and capacity building– whilst improving the efficiency of coordination efforts.

2. Objectives

The project aims at building capacity of government agencies and civil society organizations at both the national and local level to address the identified key gaps in implementing the National HIV and AIDS Strategic Plan in an effort to contain and reverse the epidemic.

The following key gaps were jointly identified during project preparation for the IDA project to focus on: (i) weak coordinating capacity for multi-sector response; (ii) obsolete research capacity to organize and use scientific evidence to guide implementation; (iii) fragmented national HIV M&E systems; (iv) weak implementation capacity to scale up those effective interventions that address the key drivers of the epidemic; and (v) uncoordinated local response with low capacity to monitor the implementation of HIV services, and use the monitoring information to improve program planning and service delivery.

As this project is a gap-filling technical assistance project, the success of the project will be measured by (i) client satisfaction with HIV coordination; (ii) the extent to which the national response is informed and guided by research and scientific evidence; and (iii) the extent to which the district level monitoring and evaluation system is functional.

3. Rationale for Bank Involvement

The Bank has a comparative advantage to help address these key gaps. As a grant-giving agency, GFATM mainly focuses on financing major intervention programs instead of addressing gaps in the implementation systems. In addition, GFATM has no local presence and therefore cannot provide hand-on technical support. Similarly, EC's implementation and technical capacity on the ground is very limited and relies on partners to help implement its programs. For example, the design and implementation of its OVC program was contracted out to UNICEF. PEPFAR, financed by the US Government, normally implements its programs using separate implementation arrangements from the Government system. UN agencies mainly provide technical support and normally do not provide significant financing. The Bank, with its financing and technical capacity, is in a unique position to help address the key gaps in implementing the NSP. During project preparation, joint missions with development partners (e.g., GFATM, UNAIDS, etc.) and wide consultations were conducted, and both the Government and partners regard the Bank's support to addressing the key gaps crucial to the country's fight against HIV and AIDS. This project is also expected to be a building block for the future SWAp type of coordination for the national HIV and AIDS program.

4. Description

The three project components are structured to address the key gaps mentioned earlier. Component 1 has a focus on strengthening capacity for the national level institutions to coordinate the multi-sectoral response and improving the research and M&E capacity to guide policy-making and implementation. Component 2 supports the health sector to scale up high-impact interventions targeting the epidemic drivers. Component 3 provides urgently needed support to the district level and local communities to strengthen the local response which has suffered from a lack of resources and attention.

Component 1: Improved institutional capacity to implement the multi-sectoral response ($1.8 million).

Lesotho has made progress in its national HIV response, but gaps remain in implementation due to lack of capacity and coordination, and lack of information (evidence) with which to improve the effectiveness of the response (by implementing those interventions that will work most effectively at reducing the number of new infections). This component builds on the previous HCTA project and complements existing programs, notably the GFATM. It is intended to support capacity building of national level institutions, both public and private, in support of Lesotho's HIV and AIDS multi-sectoral response. These national level institutions include: National AIDS Commission; selected line ministries (Labor and Employment, Education and Training, Youth, Gender, Sports and Recreation, and Works and Transport) to mainstream HIV and AIDS implementation; the Global Fund Coordination Unit (GFCU) in the Ministry of Finance and Development Planning; Umbrella Civil Society Organizations; Business and Labor Coalitions; and the Lesotho Council of NGOs selected under Round 8 as the second GFATM principal recipient. Specifically, the component will: (i) strengthen the NAC's capacity to coordinate the national multi-sectoral response; (ii) strengthen the country's HIV and AIDS research capacity to generate timely and accurate evidence to guide a more effective national response; (iii) contribute towards the implementation of a national HIV monitoring and evaluation system; and (iv) strengthen the NAC capacity to monitor resources for a better functioning of the HIV national strategic plan. The component will also provide financial and technical support for mainstreaming HIV and AIDS activities in selected key ministries and relevant institutions in the private and civil society sectors.

Component 2: *Improved capacity to scale up the health sector response ($1.9 million).*

This component will mainly support Ministry of Health and Social Welfare units to build capacity for delivering essential and effective HIV services and to mitigate the impact of the epidemic. Specifically, it will fill gaps in existing programs to support: (i) integration of effective HIV services with other health services such as TB and sexual reproductive health; (ii) mitigate the impact of the epidemic on Orphans and Vulnerable Children (OVC); and (iii) strengthen institutional capacity for evidence-based planning, monitoring and evaluation. This component will build on support by the HCTA and complement support provided by other development partners such as the GFATM, European Commission and the Millennium Challenge Corporation (MCC). Support in this component will improve implementers' ability to: (a) facilitate implementation of HIV prevention interventions, including BCC and male circumcision; (b) strengthen integration of the TB and Sexual and Reproductive Health (SRH) services; (c) manage pediatric HIV cases, including PMTCT; (d) expand and manage the OVC program; (f) manage and analyze health information at the district level for program improvement purposes; (g) facilitate evidence-based planning through operational research into what works best in HIV service delivery and integration; (h) provide a more adequate legal framework for the health sector; and (i) manage procurement of essential HIV commodities.

Component 3: Capacity Support to the decentralized local response ($1.3 million).

This component will build capacity through provision of technical assistance to government and civil society implementers at district and community levels to plan, coordinate, implement and monitor a range of defined essential HIV and TB services that need to be in every community for an effective, expanded HIV response to scale (and to ensure Universal Access). This

component will build upon and supplement the successful experience of the earlier HCTA project which provided capacity building support to larger NGOs but nothing directly to the district level and below. Support in this component will improve implementers' ability to provide activities that fall within the defined package of essential services, known as "the Essential HIV and AIDS Services Package (ESP)", which provides a menu of activities that may be provided at the sub-district/community level. It covers five areas – changes in sexual behavior, prevention of mother-to-child transmission, access to HIV services, OVCs, and support for HIV positive people.

Specifically, this component will (i) support Community Councils to coordinate the implementation and monitoring of provision of the ESP; (ii) develop and strengthen the operational and management capacities of the District AIDS Committee and the proposed Community AIDS Committee to harmonize HIV and TB activities at the community level, and (iii) strengthen the skills and operational capacity of the community-based organizations to provide, monitor, evaluate and report on HIV and TB services at the community.

5. Financing

Source:	($m.)
BORROWER/RECIPIENT	0
IDA Grant	5
Total	5

6. Implementation

This multi-sectoral project is intended to support the implementation of the National HIV Strategic Plan. Its implementation arrangements therefore reflect the implementation requirements of the national strategic plan, involving several key players which include the MOFDP, MOHSW, MOLGC, NAC, and LCN (representing the CSOs). Component 1 of the project will be mainly implemented by NAC, the MOFDP, and LCN. The MOHSW will be responsible for implementing Component 2. The implementation of Component 3 will be led by the MOLGC and LCN. To ensure coordination among the implementing agencies, a Steering Committee, comprising senior officials of the implementing agencies, is being established to provide overall policy and implementation guidance. The multi-sectoral Technical Working Group, which comprises technical staff of the implementing agencies and has played an active and effective role in project preparation, will be retained during the implementation period to address technical and implementation issues within the project.

The project will maximize the use of existing systems and capacity created by the HCTA. First, all the implementing agencies, except the MOLGC, participated in the HCTA and are therefore familiar with the implementation of an IDA project. Second, the project will support and use the existing HCTA fiduciary arrangements—the PAU and PU of the MOHSW will continue to take on financial management and procurement responsibilities respectively.

The following adjustments are also made to reflect the changes in design of this project in comparison to the HCTA. First, the leading implementing agency of the HCTA was the principle recipient of the GFATM—the GFATM Coordination Office of the MOFDP. For this proposed project, with its focus on the national strategic plan, the NAC will be responsible for

coordinating the implementation of the project. Second, the HCTA focused on capacity building at the national level, while this project extends its support to the local level in response to the urgent need for local response support identified during project preparation,. Therefore, the MOLGC will take the lead in implementing the support to the local response. Implementation responsibilities within each agency have been clearly defined.

7. Sustainability

The project will help build institutional and implementation capacity required for implementing the national strategic plan. In particular, the project will help build capacity for research, M&E, planning, public expenditure and financial management, procurement, private sector engagement, etc. The skills and procedures built by the project are expected to benefit the public sector particularly. The project also focuses on engaging civil society and builds capacity for NGOs, both national and local, to contribute to the national response to the HIV epidemic. This will help sustain collaboration between the public and private sector.

8. Lessons Learned from Past Operations in the Country/Sector

Lessons from the previous Bank operations and analytical work both in Lesotho and nearby countries, the recent Country Portfolio Performance Review (CPPR), CAS Completion Report, and partners' programs include:

- Given the weak management capacity and technical capacity in Lesotho, project design and implementation needs to be backed up to ensure implementing capacity. It is important for the Government and the Bank to: (i) avoid unrealistic and ambitious project design; (ii) ensure practical institutional arrangements; and (iii) consider specific activities or components for capacity building and technical assistance.
- As more resources are becoming available to finance HIV programs, it is the Bank's comparative advantage to focus on system strengthening. The Bank's hands-on implementation support is much needed given that the GFATM as a grant-providing agency can only provide limited implementation support.
- Sustained government commitment and coordination among government agencies are keys to the success of the national response.
- M&E systems are vital to guide the national and district level responses, and strengthening the country systems should be given attention from the onset.
- The limited impact of the HIV program on prevalence is understandable given that multiple factors, not all under the control of the projects, can influence outcomes. The government and Bank should pay greater attention to investigate the determinants of prevalence, probably jointly with other development partners.
- The Bank and other development partners acknowledge that the National HIV/AIDS Strategic Plan (NSP) has been a major step forward, but that it has yet to bear full fruit depending on the significant upgrade of implementation capacity.
- The use and strengthening of existing systems is preferred over creating separate fiduciary and other systems.

Additional lessons from the Implementation Completion Report (ICR) of the HCTA have been incorporated into the project design. Specific lessons include: (i) ensuring that implementation capacity remains after provision of technical assistance has ended by supporting capacity

building of existing local staff (through external training or on-the-job training) as well as including specific skills transfers in the expected results for proposed technical assistance contracts. (ii) HCTA implementation showed that some procurement delays were caused by lack of clarity between user departments on the functions to be performed by various technical assistance consultants. This has been addressed by ensuring that the needs for technical assistance were discussed by the project preparation team and clearly defined in the terms of reference with functions and results that have been shared. (iii) Weak logistics management of drugs and supplies was also highlighted and will be supported under Component 2 to improve the logistics management of drugs by the National Drug Supply (NDSO) to avoid stock-outs.

9. Safeguard Policies (including public consultation)

Safeguard Policies Triggered	Yes	No	TBD
Environmental Assessment (OP/BP 4.01)	X		
Natural Habitats (OP/BP 4.04)		X	
Pest Management (OP 4.09)		X	
Forests (OP/BP 4.36)		X	
Physical Cultural Resources (OP/BP 4.11)		X	
Indigenous Peoples (OP/BP 4.10)		X	
Involuntary Resettlement (OP/BP 4.12)		X	
Safety of Dams (OP/BP 4.37)		X	
Projects in Disputed Areas (OP/BP 7.60)		X	
Projects on International Waterways (OP/BP 7.50)		X	
Safety of Dams (OP/BP 4.37)		X	
Projects on International Waterways (OP/BP 7.50)		X	
Projects in Disputed Areas (OP/BP 7.60)		X	

10. List of Factual Technical Documents

Sharing Growth by Reducing Inequality and Vulnerability: A Poverty, Gender, and Social Assessment, Report No. 46297-L, World Bank PREM, December 2008.

HIV and AIDS Capacity Building and Technical Assistance Project (HCTA) (Gr. H113-LSO) Project Appraisal Document, Aide-Memoires, and Implementation Completion and Results Report

Dupas P., “Relative Risks and the market for sex: Teenagers, Sugar Daddies and HIV in Kenya,” 2006

Global Fund HIV and AIDS Bi-Annual Progress Report, Round 2 Phase 11, Jan.-Jun. 2007, Bi-Annual Progress Report for Round 5 Global Fund Support in Lesotho, Reporting Period Nov. 2006-Apr. 2007

Government of Lesotho, “Guidelines to prevent Mother to Child Transmission of HIV,” June 2004

Lesotho: New Plan to Reduce HIV Infections in Children” (April 2007)

Sustaining Treatment for AIDS in Lesotho, Presentation by Dr Ramatlapeng, Minister of Health and Social Welfare, Lesotho, 2007

Male Circumcision for HIV Prevention in Young Men in Kisumu, Kenya: A Randomized Controlled Trial. The Lancet. Vol. 369. Feb. 24, 2007

Cost of Male Circumcision and Implications for Cost-Effectiveness of Circumcision as an HIV Intervention. PowerPoint Slide Presentation. Health Policy Initiative. USAID. June 2007

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