



Lesotho Planned Parenthood Association (LPPA) Strategic Plan

2010-2014

STRATEGIC PLAN DOCUMENT

i. FOREWORD

The Lesotho Planned Parenthood Association (LPPA) developed its first strategic plan (1999-2003) in 1999, and the second one (2005-2009) in 2004. It represents a roadmap that the association intends to follow over the next five years in the process of providing quality Sexual and Reproductive Health (SRH). The development of the 2005-2009 Strategic Plan benefited from the processes leading to both the National Vision 2020 and the now defunct Poverty Reduction Strategy (PRS). On the contrary, the 2010-2014 one was developed during a period when the country's planning and budgeting processes was being guided by a broad Interim National Development Framework (INDF). Government has since decided to revert back to the concept of Five Year Development Plans (5YDP) with the next scheduled to cover the period 2011/12 to 2015/16.

Review of implementation of plans informs the development process of successive ones. Whatever challenges, successes and lessons learned during implementation become a basis and stepping stones for future plans. In this way the Association is able to improve on its successes and come up with alternative strategies to address whatever challenges it has experienced.

The specific objectives of the strategy process of the LPPA are to provide a framework within which annual operational plans are derived; create a common platform for managing emerging SRH challenges; and spearhead a national vision of the future of SRH in collaboration with all Stakeholders. In view of these objectives, a concerted effort was made to ensure a buy-in by all key stakeholders in and outside government.

It can be anticipated that implementation of this plan will face daunting challenges. Key among these can be included the continuing scourge of HIV and AIDS; environmental degradation due to global warming; increasing poverty and unemployment. All these challenges have been compounded by the recent global economic crunch that has had negative economic ripple effects that have affected southern Africa, including Lesotho.

The significance of the above challenges is that 2014, the end of this Strategic Plan, will almost coincide with the end of implementation of both the Millennium Development Goals (MDGs) in 2015, and the next 5YDP in 2016. If recent reports on Africa's performance on the MDGs are anything to go by, life will not get any better, but mostly depressing and hard in the Mountain Kingdom.

Dr. Phiny Hanson

LPPA President

ii. Acknowledgements

I am deeply grateful to those individuals who made time and effort to actively participate in the development of the 3rd five-year Strategic Plan of the Lesotho Planned Parenthood Association. Without their commitment and support, this document that spells out the direction of the Association in the next five years would not exist.

Countless other individuals contributed to this through their counsel and suggestions and through assistance in arranging interviews with communities. Not forgetting those whose wit and laughter cannot be put down on printed page. It is also fitting to pay tribute to all those taking interest in promoting sexual and reproductive health and rights (SRHR) throughout the country. In particular the following individuals are mentioned for their outstanding active involvement:-

Mrs. Agnes Lepphoto, Christian Health Association of Lesotho (CHAL); Mrs. Mantsane Monaheng, Ministry of Finance and Development Planning; Ms. Mangose Sithole, Ministry of Health and Social Welfare - Family Health Division; Ms. 'Matšitso Mohoanyane, Ministry of Health and Social Welfare; Dr. Thabelo Ramatlapeng, UNFPA; Mr. Makhetha Moshabesha, UNICEF; Mr. Thabo Lebaka, National Aids Commission (NAC); Mr. Rapelang Raliengoane, People's Choice (PC) FM and Mr. Sebotsa Lesoli, Paballong Centre.

Special thanks to LPPA Senior Volunteers; Dr. Phiny Hanson, the President of LPPA; Ms. 'Malinotsi Rafutho, the Vice President of LPPA; Ms. 'Marealeboha Raphael, Finance and Administration Committee (FAC) Chairperson; Ms. Mamotšeliseli Monaheng, National Programmes Committee (NPC) Chairperson; Ms. 'Mamoalosi Lepamo, Branch Chairperson, North; Mr. Machefo Thobileng, Northern Branch Representative to the NEC; Mr. Refiloe Lefatle, YAM Chairperson; Ms. Nkomile Mpoosa, Youth Representative and Mr. Lerato Lebeisa Youth Representative, North.

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Last but not least, the LPPA Staff, from branch to headquarters level, whose invaluable contribution and support have been central in putting together this document from beginning to the end, are indeed applauded.

I salute you all.

Dan Mofokeng Makhetha

Chief Executive

iii. LIST OF ACRONYMS

AGM	-	Annual General Meeting
AIDS	-	Acquired Immuno Deficiency Syndrome
ARH	-	Adolescent Reproductive Health
ARVs	-	Anti-Retrovirals
BCC	-	Behaviour Change Communication
BEC	-	Branch Executive Committee
CBDs	-	Community Based Distributors
CHAL	-	Christian Health Association of Lesotho
CPR	-	Contraceptive Prevalence Rate
CYP	-	Couple Year Protection
eIMS	-	electronic Integrated Management System
FP	-	Family Planning
GOL	-	Government of Lesotho
HIV	-	Human Immuno Virus
ICPD	-	International Conference on Population and Development
IEC	-	Information, Education and Communication
IPPF/ARO	-	International Planned Parenthood Federation – Africa Regional Office
LPPA	-	Lesotho Planned Parenthood Association
MA	-	Member Association
MCH	-	Mother and Child Health
MIS	-	Management Information System
MOHSW-	-	Ministry of Health and Social Welfare
MOU	-	Memorandum of Understanding
NEC	-	National Executive Committee
NGOs	-	Non-Governmental Organisations
PAC	-	Post Abortion Care
PLWHAs-	-	People Living with AIDS
PMTCT-	-	Prevention of Mother To Child Transmission
PRB	-	Population Reference Bureau
PASCAAL –	-	Private Sector Coalition Against AIDS in Lesotho
PRSP	-	Poverty Reduction Strategy Paper
SDPs	-	Service Delivery Points
SP	-	Service Provider
SRH	-	Sexual and Reproductive Health
SRHR	-	Sexual and Reproductive Health and Rights
STIs	-	Sexually Transmitted Infections
UNAIDS-	-	Joint United Nations Programme on HIV and AIDS
UNICEF-	-	United Nations Children Fund
UN	-	United Nations
HTC	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation
YRC	-	Youth Resource Centre

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2. HISTORY OF LESOTHO PLANNED PARENTHOOD ASSOCIATION

The founding of the Lesotho Planned Parenthood Association (LPPA), herein after interchangeably referred to as the Association or Member Association (MA) of the International Planned Parenthood Federation (IPPF), was co-founded in 1967 by two volunteers, Mrs. P.D. Robinson and Mrs. ‘Mamakoa’ Taoana, under the name Lesotho Family Planning Association (LFPA) and legally registered in 1968.

At the time of its founding, there was no population growth pressure on Lesotho. The major factors that necessitated family planning included wide prevalence of malnutrition and the deterioration in the health of mothers and their children. These challenges, mainly attributed to too frequent childbearing; improper spacing of children; and malnutrition; culminated into high infant, child and maternal mortality.

Consequently, the MA’s campaign slogan at the time was “*too early, too many, too soon, too late*”, which was a strategy to discourage early pregnancy, promote child spacing and advice against the risk of conceiving at old age.

Early activities of the Association mainly included family planning and nutrition education by LFPA nurses. Prescription of contraceptives was offered by two private practicing doctors from Scott Hospital.

In 1970 a state of emergency was declared and activities of the Association were banned. Mrs. Robinson was also deported to her country, the UK. The ban was lifted in 1971 and through advocacy, the MA gained support of the Government, religious leaders, chiefs, politicians and the public. More volunteers were recruited and family planning campaigns were intensified.

In 1973 Mr. Ben Pekeche was employed as the first Executive Secretary and Mr. P.S. Maqache as the first Information and Education Officer. Dr. F.N. Rathabaneng was engaged as the first Association’s doctor in 1974. In the same year, the LPPA became an affiliate of the IPPF, and has since then received both financial and technical support from there.

The first office of the Association was at Fraser’s Memorial African Library. The first committee elected in 1967, included Mr. B.M. Mokoteli as the first Chairperson and Dr. R.N. Ntšekhe as his Vice. The Association was registered in 1968 and it had 305 family planning acceptors by the end of that year.

The MA has contributed significantly towards raising family planning awareness and acceptance in Lesotho. A 1977 study, at the time when all the family planning (FP) services were provided by MA, indicated a contraceptive prevalence rate (CPR) of 7%. In the 1980’s, it had increased to 11%, while in the new millennium it is estimated to have shot from 37% to over 41% to date.

Following the 1994 International Conference on Population and Development (ICPD), the MA transformed its mandate from a linear role of family planning services to an integrated SRH programme aimed not only at women in child-bearing age, but at all women, men, young people of both sexes, children and disadvantaged groups. It has also joined forces with other stakeholders to fight the AIDS pandemic.

The MA continues to play a significant role in all family planning services in the country, and through its static clinics, has a physical presence in eight out of the ten districts.

As a pioneer in SRH services, the MA continues to enjoy Government financial and material support. It has actively participated in advocacy efforts for, and contributed in development of conducive SRH-related policy and legislative framework.

Among policy instruments that have since been successfully passed, in whose development the Association participated, include the 1994 National Population Policy; the National Gender and Development Policy; the National Reproductive Health Policy; the 2006 National Adolescent Health Policy; HIV and AIDS Policy; Health and Social Welfare Policy; the 2005 National Policy on Orphans and Vulnerable Children; the Blood Transfusion Policy; the HIV Counselling and Testing Policy; Sexual Offences Act (2003); and the National AIDS Commission Act (2005).

There are also sector specific AIDS policies inclusive of the Education Sector HIV and AIDS Policy; and the Communication and Advocacy Policy for the National AIDS Commission (NAC).

On the legal front, there is the Labour Code (Amended) to ensure non-discrimination; the Sexual Offences Act (2003); the National AIDS Commission Act (2005) and many others. Due for enactment include the Draft Children's Protection and Welfare Bill (2004) and the National HIV and AIDS Bill.

3. Introduction/Situation Analysis

Country Context and Demographic Features:

The Mountain Kingdom of Lesotho is a small country of about 30, 000 square kilometers in area, surrounded by the Republic of South Africa. Its demographic features are such that although the 2006 census reflected it had a population of 1.8 million (51% of whom were females) the 1966 census reflected a higher total population of 1.96 million. With an estimated annual growth rate of 2.1%, it had been projected that in 2006 it would have been around 2.2 million. The 1966 population had been focused to double in 33 years.

While the fertility rate might have remained the same over the years, the corresponding twin effects of high HIV and AIDS prevalence and the outward migration are believed to have played significant roles in having moderated further the population growth rate. At any rate, experts maintain that even the declining population growth to near 2% is still very high. This is based on a conviction that in order to maintain (or improve) existing standards of living, the economy must grow at rates equal to the growth rates of the population. Even so, although a lower population growth rate is desirable, an even more desirable option is that the decrease should be due to a decline in fertility rather than an increase in mortality.

Given the limited arable land as well as the declining environmental quality, even a moderate 2.2 million at a growth rate of 2.1% would have most put a lot of pressure on the natural resource base. This would have most certainly been the case considering the traditional agricultural land use practices where mountain slopes are seriously underutilised.

The population is predominantly rural, with only 17% living in urban areas. Lesotho has one of the highest HIV and AIDS prevalence rates globally at 23.2%. This has had significant impact on the population structure and life expectancy. The current average life expectancy has dropped from 60 years in 1996 to 45 years for males and 54.2 years for females in 2008. This is a slight increase from the initially estimated 34.5 years estimated by UNICEF in 2005 (UNICEF 2005).

Lesotho's economic mainstay constitutes of agriculture, livestock production, textile manufacturing, quarrying and diamond mining. The latter's contribution to GDP is expected to increase from 7 to 9 percent during 2010/2011. The economy is inextricably linked to that of South Africa. Not only is the latter the main trading partner, but she also employs over 50,000 Basotho in its mines and industries, excluding those in services and other tertiary sectors whose exact numbers are unknown. This is exacerbated by those students who instead of returning to Lesotho after study, eventually get employed in the South Africa after graduating. It is estimated that close to 40% of the male population seeks employment in South Africa, resulting in a large proportion of female headed households.

Although the average per capita income (Gross National Income at Purchasing Power Parity) was \$2,980 in 2003, severe income inequalities exist, and 43% of the country still lives on less than \$1 per day¹

a) Adolescents/Young People

Lesotho's young people aged 10-24 made up 34.3% of the total population in 2003.² Premarital sex is common and the age of first sexual debut is low at 12 years for males and 14 years for females.³ In 2002, 34.9% of 12-19 year old males and 28.2% females reported being sexually active.⁴ It is also noteworthy that research shows a significant proportion of around 17% of Young People of both sexes (aged below 20) that are married.⁵ Even though there is a high sexual activity among youth, contraceptive prevalence among young People of both sexes for any method is 16.3%.

Condom use during first sexual encounter is 10% among adolescent males and 6% for adolescent females with only 11% of adolescent girls reporting currently using condoms.⁶ Consequently, low rates of contraceptive and condom use have resulted in high rate of pregnancy among young people. The magnitude of teenage pregnancy estimated at 23% (Mohai et al; 2002),¹³ while rape is also a serious issue for young women making up 31% of all reported cases in urban areas and 50% in rural areas.⁷

These behaviour patterns are associated with challenges including early and unwanted pregnancy, unsafe abortion, STIs and HIV infection. In 2002, the Ministry of Health and Social Welfare (MOHSW) survey found that more than a third of sexually active young people of both sexes and more than half of young pregnant mothers were diagnosed with STIs (MOHSW 2002).⁸ Records indicate that 12% of the new AIDS cases reported in 2000 were young people aged 10-24 years (UNAIDS/WHO 2002). According to the above, girls accounted for 10% while boys were only 2%, suggesting patterns of intergenerational sex.⁹

The number of children orphaned or made vulnerable by HIV and AIDS increases yearly. It is now estimated that there are over 185,000 OVCs in Lesotho. The plight of these children has become the most visible evidence of the impact of the HIV epidemic on Lesotho.

¹ All information in this paragraph is from UNFPA (2003), Country Profiles for Population and Reproductive Health: Policy Developments and Indicators 2003

² Lesotho Demographic Data 2003

³ NAHP 2003

⁴ LRHS 2002

⁵

⁶ LRHS 2002 13. Mohai et al "Factors Associated with teenage pregnancy in Lesotho" 2002

⁷ LRHS 2002

⁸ MOHSW Disease Control 2002

⁹ UNAIDS/WHO Epidemiological Fact Sheet 2002

The sentinel HIV and syphilis survey showed that prevalence of HIV among STI patients was high at 56.2% (52.6%- 59.7%). Among young people aged 15-19 and 20-24, HIV prevalence among STI clients was around 20% and 40% respectively compared to the prevalence among young people surveyed in 2004 LDHS which was at 7.72%. The adjusted HIV prevalence among young women aged 15-24 was 14.9% compared to 5.9% among young men in the same age.

While there is a range of organizations working on youth SRH in Lesotho, LPPA is one of the few going beyond information provision/peer education to provide a wide range of SRH services. LPPA estimates that around 18% of the current client load is young people of 24 and under and this proportion is increasing. The establishment of the Youth Resource Centre in Maseru has provided a potential model for the provision of SRH information and services to young people. LPPA has also shown commitment at programme and governance level to facilitate the participation of young people within the organization.

MOHSW has sought to address youth friendly services through the establishment of Adolescent Health Corners within Government hospitals. However, success in attracting young people to services appears to have been limited. LPPA therefore has a leading role to play in youth SRH in Lesotho through its experience of the Youth Resource Centre, both in using this to expand its own youth service provision but also to share lessons with the Government and other agencies.

b. HIV AND AIDS

Records from both the country's Global Fund Coordinating Unit (GFCU), and the National AIDS Commission (NAC),[^] indicate that Lesotho is in the midst of a massive effort to scale-up a comprehensive national response to the HIV epidemic. These efforts however, have met with both successes and challenges. While the country's estimated adult HIV prevalence rate remains at 23.2%, the third highest globally, other indicators are steadily improving. Between 2007 and 2008, the estimated incident rate dropped from 2.9% to 2.7%.

ART coverage has increased from 26% in 2007 to 40% in 2008. ART is now provided through decentralized approaches at local health centers across the county. The MOHSW, in collaboration with development partners, has recently launched new prevention initiatives.

Despite these gains, some disturbing trends remain. Each day there are an estimated 62 new infections and about 80 deaths due to AIDS. In 2007 there were approximately 270,273 people living with HIV and AIDS (PLHIV). The prevalence of HIV among sexually transmitted infection (STI) patients, with the bulk of new infections in 2008 occurring in those reporting a single partner is reported to be as high as 62% and those with multiple partners going up as high as 59%. Seventy six percent of patients infected with tuberculosis (TB) were found to also be HIV positive, supporting the need for better integration of HIV and TB services.

Life expectancy has declined drastically from 60 years in 1996 to 50 years in 2001¹⁰. In addition, the pandemic has altered the structure of the population to one where the very young, middle aged and older people are dominating the population structure, creating very high age-dependency ratios. HIV AND AIDS continues to drive, and be driven by poverty and is hindering the country's overall economic development.

The most common mode of HIV transmission in Lesotho is heterosexual contact. Youth and women have been disproportionately affected by HIV and AIDS, with 75% of all reported HIV and AIDS cases being young people aged between 15-29 years, and 55% of all reported HIV and AIDS cases being women¹¹. Sentinel surveillance records from the early 1990s indicate a steady increase in HIV prevalence among women attending antenatal clinics. In addition, it is reported that 68% of children admitted at the country's main public hospital (Queen Elizabeth II Hospital in Maseru) were HIV positive. In 2001, the country was estimated to have 73,000 AIDS orphans¹², who live with no formal systems for ensuring their social security.

There are significant behavioural challenges to comprehensively addressing HIV and AIDS. Despite a contraceptive prevalence rate of 41% and almost universal knowledge of the factors that lead to HIV infection, condom use remains low and infection rates and prevalence continue to rise. Systems for care and support for the HIV infected and affected are stretched and stigma exists because of social and cultural values.

The Government of Lesotho has demonstrated strong political and financial support towards addressing HIV and AIDS. In response to the crisis, the government has declared HIV and AIDS national crisis and has launched a number of responses at the national level to provide prevention, care and treatment services. These include the provision of free national HTC services, provision of free ARVs and PMTCT drugs, and the development of guidelines for scaling up the response to HIV and AIDS to the national level.

LPPA has developed a number of strategies to address the growing concern of HIV and AIDS, such as the promotion of abstinence to delay sexual debut, promotion of correct and consistent condom use, IEC, BCC, nutrition care, and most recently, is integrating the provision of HTC services at four selected Service Delivery Points. It is well positioned to expand the range of services offered to include care and support for people living with HIV and AIDS. The Association has identified the need to strengthen its staffing and clinical capacity to provide these expanded services in the future. Of particular importance is the need for LPPA to expand its counseling and support capacity in relation to HTC. The Ministry of Health and Social Welfare has capacitated LPPA with ART drugs and training of service providers. LPPA will soon provide ARVs from its Maseru based clinic before the end of 2010 while expansion to other clinics will also be followed up during the strategic plan period.

¹⁰ LPDS 2001

¹¹ Government of Lesotho, Ministry of Health and Social Welfare (2000), Disease Control

¹² UNAIDS/WHO Epidemiological Fact Sheet, 2002 Update

Now, more than ever before, numerous strategic and collaborative partnership opportunities exist for LPPA to continue to address HIV and AIDS. There are District AIDS Task Forces; Community Councils; a joint UNAIDS programme; and the MOHSW PMTCT programme. There also are increased number of NGOs inclusive of CARE; World Vision; Population Services International (PSI); Christian Health Association of Lesotho (CHAL); PACT-USA-PEPFAR; International Centre for AIDS Care and Treatment Programme (ICAP); Partners in Health International (PIH) and several others who are providing components of the range of interventions required to address HIV and AIDS. Due to its historical involvement in family planning, LPPA is well positioned to effectively integrate these services into its own service delivery points or partner with others to do so.

c. Abortion

Information on induced abortion is scarce in Lesotho due to the stigma around abortion and its current legal position. In 2002, less than 1% of men and women surveyed admitted that they had either induced abortion or encouraged a partner to have one.¹³ Abortion in Lesotho is currently governed under common law and is legal only to save the life of the mother. This notwithstanding, there now is a decided court case where a woman was granted to abort for reasons other than medical.

There also is wide access to safe abortion in a more liberal environment for those who can afford and are able to cross the border to South Africa. In SA abortion is legal on demand up to 12 weeks.

Abortion is a sensitive subject at community level and among other SRH information and service provision organizations. Lesotho is a Christian country with a large Catholic majority, however there is no specific group that could be described as promoting an anti-choice agenda.

Despite the availability of legal and safe abortion in South Africa and the lack of data, it is clear that unsafe abortion in Lesotho is high. For example, the 1994 Queen II Hospital gynaecology ward report revealed that 54.6% of females below 24 years old admitted to the ward were cases of incomplete abortion.¹⁴ High incidences of induced abortions among adolescents in particular have been observed. According to MOHSW reports, 16.8% of all hospital deaths for females aged 14 years were due to abortion complications and the Nzoika study indicated that 13% of all abortion cases attended were among adolescents. Post Abortion Care is currently available in Government hospitals and some, but not all, church hospitals. Beyond the issue of PAC, there are no other NGOs addressing the issue of abortion in Lesotho.

d. Access

¹³ Lesotho Reproductive Health Survey

¹⁴ Makatjane 2002

The government of Lesotho is the key provider of health services, including reproductive health and family planning in the country. Its efforts are supplemented by the private sector and NGOs who also provide hospital and clinic based services. There is generally fair access to general health services with a reported 86% of the population living within five kilometers from a health facility¹⁵.

However, rural areas often face shortages of family planning commodities, which during the next five years will be tackled through increased partnership with other stakeholders. One strategy of ensuring a steady supply of contraceptives will be through expansion of community based distribution services, as well as utilization of the newly introduced extensive outreach infrastructure of Community Council offices and the Gateway Approach. Before the introduction of local governance in 2005, expanding access to services at the national level, and in line with the National Population Policy and the principles of the ICPD, was difficult due to the limited institutional capacity of the government.¹⁶

Social, economic and cultural barriers pose the greatest challenges to accessing SRH services. Despite a relatively high contraceptive prevalence rate of 41%¹⁷, and the general availability of family planning, STI treatment and MCH services, the relatively poor status of women has adversely impacted the progress of population and reproductive health programmes, particularly with respect to safe motherhood, safe abortion, family planning and contraceptive services. Civil and customary law still regards women as minors and they are therefore often limited in their capacity to fully exercise their rights to accessing services. Challenges also exist in the access of SRH services for males.

It is acknowledged that while additional research is needed to identify male specific SRH needs and to establish the most appropriate means of service provision for males, as reported by LPPA, efforts to provide male specific services have not been very successful. This is of utmost concern given the fact that uneven gender relations and their impact on HIV infection are resulting in disproportionate infection rates among men and women.

Youth friendly services are being provided by the Ministry of Health (through the Adolescent Health Corners), and LPPA and other agencies such as UNICEF, and it appears that communities and families are supportive of these services. However, there is still need to scale up the provision of youth friendly services, ensure more private settings for service provision, and to conduct additional research in order to implement more innovative strategies to attract and

¹⁵ Government of Lesotho, Ministry of Development Planning (2002), Lesotho's Country Report for the Fourth Meeting of the Follow-up Committee on the Implementation of the DND and the ICPD – PA

¹⁶ UNFPA(2004), Country Profiles for Population and Reproductive Health: Policy Development and Indicators 2003

¹⁷ UNFPA(2004), Country Profiles for Population and Reproductive Health: Policy Development and Indicators 2003.

maintain youth clients. In addition, recognizing the heterogeneity of young people, there is need to ensure that age specific and gender sensitive services are provided.

In reference to maternal and child care services, data indicates a slight preference for community based services, particularly in relation to maternal and child care. While at least 87% of pregnant women have at least one prenatal visit, only 59% of births were attended to by a skilled professional¹⁸. Full immunization coverage among infants in 2002 was estimated at 67%; the coverage was estimated at 68% for urban areas and 66% for rural areas¹⁹. Access to baby friendly health facilities is still relatively low, with such services being provided in only 39% of all facilities²⁰.

With the government's national response to HIV and AIDS, access to HTC services, ARV and PMTCT therapy has been greatly expanded, but given the magnitude of the pandemic in the country, there is need for further interventions in this area. In this regard, LPPA's intention to integrate a wide range of HIV and AIDS related services into its SRH packages at its service delivery points would complement existing interventions. There is still limited capacity to provide care for orphans.

Initiatives to expand access to SRH services will need to fully incorporate research to determine demand and type of services, ensuring quality of care, capacity building of providers and facilities, integration of services to avoid stigmatization, innovative marketing approaches to create awareness, community based approaches and the strengthening of effective referral networks.

e. Advocacy

The political environment in Lesotho is currently relatively stable and political will and commitment by GOL is very strong. HIV and AIDS in particular, has generated strong political commitment with the government declaring the epidemic as a national crisis. Political commitment has further been demonstrated by active involvement on a range of SRH issues whose major benchmarks are incorporated in the national Vision 2020; the 2004/2005 – 2006/2007 Poverty Reduction Strategy (PRS); the Millennium Development Goals (MDGs); policy and legislative instruments, inclusive of the Labour Code (Amendment); Lesotho Health Sector Reform Strategic Action Plan 2003-2010; the National Reproductive Health Policy; and the National Gender and Development Policy.

The Vision 2020 document envisages a country which will have a good, accessible and affordable quality of health system where there shall be no new HIV and AIDS infections; and where there will be care and support for those infected and affected and for orphans as well. It incorporates major benchmarks on gender parity and the elimination of HIV and AIDS.

¹⁸ Population Reference Bureau (2002), PRB

¹⁹ Lesotho Population Data Sheet 2001.

²⁰ Population Reference Bureau PRB

The development of the second LPPA's Strategic Plan (2005-2009) coincided with publication of the PRS. The later recognized the need to increase the use of preventive services, including family planning and MCH in order to mitigate the impact of disease on the poor and enable them to engage their energies in income earning activities. Whilst government did not extend the PRS beyond 2007, it has indicated that the priorities and goals contained therein remain valid. The country will instead, revert to the concept of Five Year Development Plans (5YDPs).

To ensure that discrimination against PLWHAs is eliminated, the Government has reviewed and amended the Labour Code to accommodate HIV and AIDS issues. According to the Lesotho Health Sector Reform Strategic Action Plan of 2003 – 2010, disease; sexuality; and reproductive health, are closely linked. Other policies and plans are also relevant for SRH in Lesotho including the National Development Plan, National Reproductive Health Policy and a National Gender and Development Policy.

Government has established co-coordinating bodies; systems for resource allocation; and the piloted of a range of HIV and AIDS related services. However, important areas of advocacy remain around increasing access to these services and protecting the rights of people living with HIV.

Another key advocacy issue underpinning the enjoyment of SRH rights is the unequal gender position of women under the law. On a positive note, GOL has over the years, in partnership with the MA and other Stakeholders, made major strides in formulating policies and enacting laws aimed at providing a conducive environment to health problems of national importance.

Civil and customary laws that regarded women as minors and placed them under the guardianship of male family members are gradually being reviewed with a view of repealing them. Review will make it possible for women to participate in making key decisions regarding property, fertility regulation and inheritance issues. Recent pieces of legislation whose aim is to improve the position of women include as the Married Persons' Equity Act of 2000. However, there is still some work to do towards realization of actual implementation of these acts.

LPPA has developed a strong relationship with the Government, including the Ministry of Finance and Development Planning, MOHSW and Ministry of Gender, Youth, Sports and Recreation. This has ensured their involvement in policy arenas including the development of the Population and the Adolescent Health Policies. LPPA is also identified as a key partner in service provision by the Government and is supported in efforts to deal with sensitive issues such as the introduction of the female condom. Other partnerships have been established with NGOs, UN agencies and the private sector.

The reputation and position of the MA that have consistently prevailed within the current political environment, have continued to give it significant opportunity to positively influence the development and reform of legislation, policy and implementation of services at the national

level. Consequently, it has been in a position to identify and publicize the existence of a range of policies and legislation with SRH implications, and work with the Government to prioritize those aspects that further develop an enabling environment for the provision of SRH information and services.

The MA and its volunteers in particular, will endeavour to intensify and sustain its leadership role towards the development of longer-term networks and partnerships in order to provide a stronger advocacy voice on the key SRH issues facing Lesotho.

f. Internal Organisational Factors

LPPA is guided by the Constitution which is approved by the AGM and adopted by the IPPF. The structure of LPPA which is composed of the Annual General Meeting (AGM), the National Executive Committee (NEC), and the Secretariat enhances transparency and control. The secretariat is headed by the Chief Executive who is assisted by two Directors for program and financial management. The total staff complement is fifty six. .

The existence of good systems and protocols for management and staff as well as for programme implementation makes LPPA to run efficient and effective operations.

LPPA has skilled personnel for programme development, implementation and evaluation.

In response to emerging SRH issues, LPPA's future focus is based on IPPF Strategic Framework, which evolves around 5As which represent five Strategic Focal Areas (Access, Adolescent, HIV and AIDS, Abortion and Advocacy).

LPPA has service delivery points in eight of the ten districts of Lesotho. Even though all the service structures are rented, the MA has invested in two buildings housing the Head Office and the Youth Resource Centre, and a prefabricated structure accommodating a Male Clinic. LPPA has a good corporate image and enjoys a harmonious relationship with Government, stakeholders, partners, donors and the community. These strategic partnerships are going to be enhanced and more stakeholders are going to be engaged during implementation of this strategic plan.

The sustainability and partnership prospects of LPPA are therefore strong. LPPA faces resource mobilization challenges in order to reduce its dependency on donors.

4. VISION STATEMENT

Our vision is a healthy society with a zero infection rate of HIV, where every person can exercise his or her right to dignity. A society where there is universal access to quality sexual and reproductive health information and services free from fear, stigma, discrimination and any other barriers; and where young people grow to enjoy their youth, fully participate in the control of their destiny and are able to make informed decisions.

5. MISSION STATEMENT

Lesotho Planned Parenthood Association is a non-governmental, non-profit sexual and reproductive health organization which strives to become a leading, thriving and driving force through its commitment to:

- the provision of quality sexual and reproductive health information and services to men, women, youth and marginalized groups
- prevention and mitigation of HIV and AIDS
- strategic partnerships with communities and stakeholders
- its role as a catalytic partner in advocating for sexual and reproductive rights
- needs-based and sustainable programmes

6. CORE VALUES STATEMENT

We are guided by the principles and objectives of IPPF. We have committed, honest, accountable, competent, and supportive volunteers and staff who recognise the core values that represent the following basic fabric of our organisational culture:

(a.) Equity

We believe in equity SRH service.

(b.) Respect and Integrity

Those seeking services are invariably treated with respect and integrity

(c.) Quality Standards

We uphold the highest level of quality Sexual and Reproductive Health standards.

(d.) Evidence – based interventions

We believe in interventions that are supported by research and are responsive to the felt needs of the communities.

(e.) Accountability and transparency

As an organization, we believe in being accountable to ourselves, the community, the Government, and donors and we conduct our day to day business in a transparent manner.

(f.) Zero tolerance

We aspire to a society with zero infection of HIV and AIDS, stigma and discrimination free environment and responsible parenthood.

(g.) Universal recognition of rights

We believe in the right to access to SRH services for and by all segments of the population.

7. PROGRAMME STRATEGIC DIRECTIONS

LPPA made a policy decision to adopt the five A's from the Strategic Framework of its mother body, the IPPF. Each of these A's has critical importance for the sexual and reproductive health and rights environment for Lesotho. Therefore, LPPA's Strategic Directions include Advocacy, Abortion, HIV and AIDS, Access, and Adolescents/Young People of both sexes.

8. PROGRAMME GOALS, OBJECTIVES AND STRATEGIES

Strategic Direction One: ADVOCACY

Goal

GOAL: To contribute towards legislative and policy reform and to the removal of social, legal and cultural barriers that infringe upon the rights of men, women and young people of both sexes to access sexual and reproductive health (SRH) information and services; and to reduce stigma and discrimination in partnership with other stakeholders.

OBJECTIVE 1: To strengthen the role of partnerships in influencing advocacy in SRH Rights.

Programme Activities for Objective One;

- Identify SRH stakeholders, partners, and their profiles.
- Organize a stakeholder advocacy forum to identify the prevailing SRH advocacy issues.
- Develop Advocacy guidelines
- Conduct joint stakeholder campaigns to increase awareness on SRH rights exploitation and its impact.

OBJECTIVE 2: To establish evidence based facts on prevailing SRH issues that infringe upon the rights of men, women and children.

Programme Activities for Objective Two: Build relationships with stakeholders and NGOs who have undertaken research in order to share research findings.

- Convene forums for targeted groups (young people of sexes, orphans, domestic workers, and LGBTIs) to share research findings and identify areas of action.

OBJECTIVE 3: To create an enabling legal environment for practical translation of Lesotho laws and policies around abortion procedures.

Programme Activities for Objective Three: LPPA to commission Doctors and nurses to write papers on their clinical experiences regarding present circumstances allowed by law with regard to abortion.

- Hold a forum for policy makers, partners and service providers for dialogue on abortion.
- Compile forum discussions report to inform abortion policy.

OBJECTIVE 4: To reduce the social and cultural barriers at the community level which lead to stigma and discrimination and the under-utilization of SRH services.

Programme Activities for Objective Four:

1. Develop good media relations to increase positive coverage of SRH issues.
2. Work in partnership with influential groups such as community and religious groups such as community and religious leaders, women's groups and groups of young people of both sexes to increase their support in the promotion of positive attitudes towards SRH rights and services.

Strategic Direction Two: ABORTION

Goal

To contribute to the reduction of unsafe abortion-related maternal morbidity and mortality and to initiate and facilitate dialogue among political leaders, religious leaders, policy makers, stakeholders, care providers and communities on the magnitude of unsafe abortion and also on the existing abortion laws.

Objective One

To increase access to abortion-related services as an integral component of sexual and reproductive health.

Programme Strategies for Objective One

1. Expand/establish and integrate the provision of abortion-related services, including:
 - a. Pregnancy testing and counselling on unwanted pregnancy
 - b. Develop networks for effective referral for safe abortion, within the fullest extent of the law
 - c. Treatment for incomplete abortion.
 - d. Post abortion counselling
 - e. Provision of family planning services
2. Develop staff capacity for the provision of abortion-related services through sensitization and training.
3. Increase awareness of the availability of abortion-related services.

Objective Two

To increase awareness among men, women and young people of both sexes on legal and service issues around abortion.

Programme Strategies for Objective Two

1. Identify the legal stipulations and services available on abortion and disseminate tailored information to specific groups, including clients, service providers, community leaders and to the general public.
2. Integrate information on abortion issues into other SRH information channels.

Objective Three

To reduce the incidence of unsafe abortion by creating an enabling legal and policy environment.

Programme Strategies for Objective Three

1. Sensitise staff and volunteers on abortion issues.
2. Establish and document the magnitude of unsafe abortion in the country.
3. Form networks to support awareness raising and advocacy activities around abortion.
4. Initiate and facilitate the process of dialogue on unsafe abortion.
5. Initiate and facilitate the process of dialogue on existing abortion laws.

Strategic Direction Three: HIV and AIDS

Goal

To contribute to the reduction of the HIV transmission rate and HIV prevalence and to reduce the impact of HIV and AIDS through ensuring wide access to a comprehensive package of care and support within a conducive environment of fundamental human rights.

Objective One

To increase HIV and AIDS competency and access to HIV prevention services among the public and specific target groups, including *inter alia* women, men, young people of both sexes, commercial sex workers and miners in high and low prevalence areas.

Programme Strategies for Objective One

1. Using lessons learned from other programmes, implement Behaviour Change Communication (BCC) strategies, involving *inter alia* People Living with AIDS (PLWHAs) and celebrities.
2. Develop messages to address gender and age dynamics and barriers to condom use and to develop HIV and AIDS competency.
3. Provide Voluntary Counselling and Testing (HTC) services.
4. Provide post-exposure prophylaxis.
5. Promote condom use through innovative distribution strategies targeting women, men, young people of both sexes, and rural communities.
6. Develop and implement innovative targeted strategies to increase the levels of male involvement in SRHR issues.
7. Train other service providers/agencies on HIV and AIDS prevention and on the provision of HTC services.

Objective Two

To reduce HIV and AIDS related morbidity and mortality among people who test positive at LPPA HTC centers.

Programme Strategies for Objective Two

1. Build staff and clinical capacity to establish services for the provision and management of ARVs and drugs for treatment of opportunistic infections.
2. Expand access to Anti Retroviral therapy through referral of patients to Government services or direct provision.
3. Expand access to PMTCT services through provision of HTC, counselling, ante-natal care, nutritional advice, effective referral of clients for obstetric services and providing support and information to the family.
4. Develop the capacity of staff to provide a full range of SRH services that are sensitive to the needs of HIV positive people.
5. Train care givers at the community level to provide support to HIV positive people and home based care.

Objective Three

To enhance an environment free from stigma and discrimination for the HIV infected and affected in the community and in the workplace.

Programme Strategies for Objective Three

1. Conduct research on how people living with HIV and AIDS are treated in the community and at workplace.
2. Popularise disclosure of HIV status in the community and workplace within a safe and supportive environment.
3. Sensitise the government, community, employers and employees on the acceptance and support of people infected and affected by HIV and AIDS.
4. Advocate for and disseminate legislation, policies and guidelines that protect the rights of people infected and affected by HIV and AIDS.

Objective Four

To increase the participation of people living with HIV and AIDS at all levels of governance and in all programme stages.

Programme Strategies for Objective Four

1. Develop partnerships with networks of PLWHAs to share knowledge on effective HIV programme approaches.
2. Recruit PLWHAs into the governance structures of the Association.
Develop mechanisms for the involvement of PLWHAs in projects and programmes that

affect them.

Strategic Direction Four: ACCESS

Goal

To increase access to comprehensive, high quality sexual and reproductive health information and services that are gender sensitive and target group specific and to ensure an enabling environment for SRHR using a rights-based approach from 2010 to 2014

Objective One

To increase access to comprehensive quality, sexual and reproductive health information and services for men, women, boys, girls and people with special needs.

Programme Strategies for Objective One

1. Provide comprehensive quality SRH services for men, women, boys, girls and people with special needs
2. Build capacity to provide expanded SRH services through reviewing staffing needs, providing needs-based training for service providers and providing equipment and supplies
3. Expand utilization of modalities covering people with special needs at all levels
4. Ensure adherence to Quality of Care standards and guidelines is service provision
5. Expand a range of family planning methods through introduction of implants and surgical methods in selected SDPs
6. Ensure effective distribution of contraceptives at all levels
7. Produce and disseminate target-group specific IEC/BCC messages and materials
8. Develop and implement strategies to market the expanded services

Objective Two

To increase male participation, involvement and commitment to sexual and reproductive health services

Programme Strategies for Objective Two

1. Conduct a study to investigate patterns of male involvement and utilization of SRH services
2. Improve access to male friendly services based on the results of the study
3. Implement male specific IEC/BCC activities
4. Raise awareness on gender equity and sexual and reproductive rights among men

Objective Three

Increase access to quality sexual and reproductive health information and services at the workplace and in rural areas

Programme Strategies for Objective Three

1. Identify the needs and demand for workplace SRH information and services and provide these as necessary
2. Investigate the potential for provision of other SRH services in workplace settings and provide these as possible
3. Recruit, orient, train and deploy CBDs
4. Provide CBD services in collaboration with MoHSW and CHAL
5. Identify additional mechanisms for the distribution of condoms such as vending machines

Objective Four

To contribute to the reduction of maternal and neo- natal morbidity and mortality through provision of comprehensive sexual and reproductive health services

Programme Strategies for Objective Four

1. Provide comprehensive SRH services including child survival activities (immunization, nutrition and growth monitoring), and referral for PMTCT obstetric care
2. Develop and disseminate IEC materials on child and maternal health
3. Develop strategies for marketing the MCH services

Objective Five

To increase access to services through leveraging comparative advantages of partners, collaborators and communities.

Programme Strategies for Objective Five

1. Establish and sustain partnerships/collaborations with other stakeholders to facilitate sharing resources
2. Facilitate sharing of plans, reports and lesson learned with other stakeholders
3. Develop and implement strategies to collaborate with stakeholders in SRHR programming

Strategic Direction Five: Adolescents/Boys and Girls

Goal

To contribute to the overall empowerment of boys and girls, and promotion of their sexual and reproductive health and rights including provision of information and services and to their increased participation in decision making in all spheres of their lives.

Objective One

To maintain the participation of young people of both sexes at all levels of governance and all programme stages and to strengthen the commitment, motivation and capacity of their volunteers.

Programme Strategies for Objective One

1. Recruit, orient and train volunteers of young people of both sexes in SRH, programmatic and life skills at branch level.
2. Develop strategies for motivating volunteers of young people of both sexes such as sports and recreation at the branch level.

Objective Two

To increase access to integrated youth-friendly, age-specific and gender sensitive sexual and reproductive health and rights information and services.

Programme Strategies for Objective Two

1. Implement BCC strategies including the use of a range of communication mechanisms and training in life skills.
2. Promote abstinence and consistent and correct condom use as part of one of a range of choices to exercise sexual and reproductive rights.
3. Train peer educators to provide SRH information and to distribute non-prescriptive contraceptives.
4. Use the experiences and lessons learned from the Youth Resource Centre to continue to integrate youth-friendly SRH services into LPPA's existing SDPs and in MOHSW's youth corners.
5. Implement marketing strategies to promote youth-friendly services.
6. Maintain and strengthen SRH service provision from the LPPA YRC.

Objective Three

To enhance an enabling environment for the enjoyment of sexual and reproductive health and rights by young people of both sexes.

Programme Strategies for Objective Three

1. Identify opportunities for advocacy within existing legislation, policies and guidelines, including the National Adolescent Health and the National Youth Policies.
2. Generate commitment among government, policy-makers and stakeholders for the formal recognition of SRHR of young people of both sexes.

Address social and cultural barriers to their SRHR through advocacy with communities, religious leaders and parents;

Use existing partnerships to solicit support for simplification and dissemination of legislation and policies.

Strategic Direction Six: ORGANISATIONAL STRATEGY/INSTITUTIONAL CAPACITY BUILDING

Goal:

A sustainable, innovative, accountable Association with effective and efficient governance and management systems.

Objective One:

To increase the sustainability prospects of LPPA and its programmes through diversifying its partners, donors and national resource base.

Programme Strategies for Objective One

1. Identify potential new donors;
2. Develop and market proposals for funding;
3. Lobby for increased financial and political government support;
4. Fundraise locally from the public and private sectors;
5. Map existing and potential partners and areas of partnership;
6. Develop long term partnership agreements and Memoranda of Understanding;
7. Use strategic partnerships to solicit financial support for SRHR programmes from government and private sector;
8. Identify appropriate, cost effective and sustainable facilities for service provision.
9. Implement income generating activities;
10. Develop and implement a sustainability plan.

Objective Two:

To strengthen the effectiveness of staff and volunteers in governance, management and programming.

Programme Strategies for Objective Two

1. Develop master plan, to include training of strategic partners as appropriate;
2. Identify a resource base for the implementation of the training master plan;
3. Provide needs based training for staff and volunteers;
4. Enhance the capacity of volunteers to play a greater role in advocacy and resource mobilization;
5. Develop the capacity of female and young volunteers to effectively participate in governance;
6. Maintain compliance to IPPF guidelines regarding age and gender involvement within Association governance structures;
7. Cultivate a culture of good governance and accountability among staff and volunteers.

Objective Three:

To strengthen programme effectiveness and accountability through evidence-based programming and documentation.

Programme Strategies for Objective Three

1. Review and revise the Management Information System (MIS) to improve information flow for management decision-making;
2. Improve reporting by electronic Integrated Management System (eIMS);
3. Undertake/Sustain research for advocacy, to improve programme design and to determine the impact of programmes;
4. Strengthen monitoring and evaluation systems;
5. Document and disseminate best practices and lessons learned.

Objective Four:

To enhance the conducive working environment for staff at all levels

Programme Strategies for Objective Four

1. Develop capacity in human resource management;
2. Strengthen systems for addressing staff welfare;
3. Review the organizational chart to ensure staffing patterns that address organizational needs.
4. Strengthen the systems for the flow of information between management, staff and volunteers.

Objective Five:

To improve the corporate image of LPPA and increase the number of clients served through innovative marketing approaches

Programme Strategies for Objective Five

1. Develop and implement a strategy to improve LPPA's corporate image and its public relations.
2. Use innovative strategies and media to market the services offered by LPPA.
3. Document and disseminate information on LPPA and its successes.

9. LOGICAL FRAMEWORK

1. ADOLESCENTS/YOUNG PEOPLE OF BOTH SEXES

GOAL :

To contribute to the overall empowerment of young people of both sexes, and promotion of their sexual and reproductive health and rights including provision of information and services and to their increased participation in decision making in all spheres of their lives.

Objectives	Strategies	Verifiable Indicators	Means of Verification	Expected Outcome
<p>Objective One To maintain the participation of young people of both sexes at all levels of governance and all programme stages and to strengthen the commitment, motivation and capacity of youth volunteers.</p>	<ul style="list-style-type: none"> Recruit, orientate and train youth volunteers in SRH programmatic and life skills at branch level. Develop strategies for motivating volunteers of young people of both sexes such as sports and recreation at the branch level. 	<p>1. Number of recruited young people of both sexes.</p> <p>2. Number of branch young volunteers oriented and trained in programmatic and life skills.</p> <p>3. Number and type of activities undertaken to motivate young people.</p>	<p>Youth volunteer reports in the branches.</p> <p>Thakaneng reports.</p> <p>Implementation reports.</p>	<p>Youth volunteers increased in numbers.</p> <p>Young people equipped with lifeskills.</p> <p>Young people retained as volunteers.</p>
<p>Objective Two To increase access to integrated youth-</p>	<p>1. Implement BCC strategies including the use of a range of communication</p>	<p>1. Number of young people who express</p>	<p>Behaviour change study reports</p>	<p>Improved sexual and reproductive</p>

<p>friendly, age-specific and gender sensitive sexual and reproductive health and rights information and services.</p>	<p>mechanisms and training in life skills. 2. Promote abstinence and consistent and correct condom use as part of one of a range of choices to exercise sexual and reproductive rights. 3. Train peer educators to provide SRH information and to distribute non-prescriptive contraceptives. 4. Use the experiences and lessons learned from the Youth Resource Centre to continue to integrate youth-friendly SRH services into LPPA's existing SDPs and in MOHSW's youth corners. 5. Implement marketing strategies to promote youth-friendly services. 6. Maintain and strengthen SRH service provision from the LPPA YRC.</p>	<p>consistent and correct use of condoms. 2. Decreased number of young people contracting STIs/HIV and AIDS. 3. Decreased number of young girls with unintended pregnancies. 4. Number of young people displaying assertive behaviour. 5. Number of young males and young females provided with SRH services by type. 6. Number of SDPs providing youth friendly SRH services.</p>	<p>SDP reports. Thakaneng reports.</p>	<p>health of young people.</p>
<p>Objective Three To enhance an enabling environment for the enjoyment of sexual and reproductive health and rights</p>	<p>1. Identify opportunities for advocacy within existing legislation, policies and guidelines, including the National Adolescent Health and the National Youth Policies.</p>	<p>1. Number and type of policies with enabling statements for advocacy.</p>	<p>Advocacy reports.</p>	<p>Policy makers, religious leaders and parents committed and supportive of youth SRHR</p>

<p>by young people of both sexes.</p>	<p>2. Generate commitment among government, policy-makers and stakeholders for the formal recognition of SRHR of young people of both sexes. 3. Address social and cultural barriers to their SRHR through advocacy with communities, religious leaders and parents. 4. Use existing partnerships to solicit support for simplification and dissemination of legislation and policies.</p>	<p>2. Number of newspaper clippings with official statements for recognition and support of SRHR of young people. 3. Number of public gatherings and type of target group addressed on cultural barriers to youth SRHR. 4. Number of advocacy activities with other partners. 5. Number and names of partners in advocacy for youth SRHR activities.</p>	<p>Documentation center. Youth library. Media houses. Partnership report.</p>	<p>activities.</p>
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2. HIV AND AIDS

GOAL:

To contribute to the reduction of the HIV transmission rate and HIV prevalence and to reduce the impact of HIV and AIDS through ensuring wide access to a comprehensive package of care and support within a conducive environment of fundamental human rights.

Objectives	Strategies	Verifiable Indicators	Means of Verification	Expected Outcome
<p>Objective One To increase HIV and AIDS competency and access to HIV prevention services among the public and specific target groups, including <i>inter alia</i> women, men, young people of sexes, commercial sex workers and miners in high and low prevalence areas.</p>	<p>1. Using lessons learned from other programmes, implement Behaviour Change Communication (BCC) strategies, involving <i>inter alia</i> People Living With HIV and AIDS (PLWHAs) and celebrities.</p> <p>2. Develop messages to address gender and age dynamics and barriers to condom use and to develop HIV and AIDS competency.</p> <p>3. Provide Voluntary Counselling and Testing (HTC) services;</p> <p>4. Provide post-exposure prophylaxis (PEP).</p> <p>5. Promote condom use through innovative distribution strategies targeting women, men, young people of both sexes, and rural communities;</p>	<p>1. Number of celebrities by name and type who have been used for HIV and AIDS BCC activities.</p> <p>2. Type of messages developed.</p> <p>3. Number of people by age and sex who have been addressed with HIV and AIDS messages.</p> <p>4. Number of people by sex and age who have tested for HIV and AIDS.</p> <p>6. Number of condoms distributed.</p> <p>7. Number of clients provided with</p>	<p>Service statistics report.</p> <p>IEC/BCC reports.</p> <p>SDP HTC reports.</p> <p>Male clinic reports.</p> <p>Training reports.</p>	<p>Women, men and young people who consistently and correctly use condoms and know their status. HTC</p> <p>Service Providers and clients are protected against HIV and AIDS.</p> <p>Males seek SRH services.HTC</p>

	<p>6. Develop and implement innovative targeted strategies to increase the levels of male involvement in SRHR issues;</p> <p>7. Train other service providers and agencies on HIV and AIDS prevention. HTC</p>	<p>condoms by sex and age.</p> <p>7. Number of service providers and clients who have been provided with PEP.</p> <p>8. Number of other SPs and agencies who have been trained in HIV and AIDS prevention.</p> <p>9. Number of males who have sought SRHR services from LPPA SDPs. 10. Number of males who received services from the Male Clinic</p>		
<p>Objective Two To reduce HIV AND AIDS related morbidity and mortality among people who test positive at LPPA HTCHTC sites.</p>	<p>1. Build staff and facility capacity to establish services for the provision and management of ARVs and drugs for treatment of opportunistic infections.</p> <p>2. Expand access to Anti</p>	<p>1. Number of service providers trained in ART provision.</p> <p>2. ARV drugs available.</p>	<p>Training reports.</p> <p>Service statistics reports</p> <p>SDP reports.</p>	<p>LPPA staff conversant with ART provision.</p> <p>LPPA clients provided with integrated services.</p>

	<p>Retroviral therapy through referral of patients to Government services or direct provision.</p> <p>3. Initiate and expand access to PMTCT services through provision of HTC, counselling, ante-natal care, and nutritional advice, effective referral of clients for obstetric services and providing support and information to the family.</p> <p>4. Develop the capacity of staff to provide a full range of SRH services that are sensitive to the needs of HIV positive people.</p>	<p>3. Drugs for treatment of opportunistic infections available.</p> <p>4. Number of mothers provided with HTC services, counselling and nutritional advice.</p> <p>5. Number of pregnant mothers provided with ante-natal care in two selected facilities.</p> <p>6. Number of clients who have been referred for obstetric services.</p> <p>7. Number of staff provided with skills.</p> <p>8. Number of staff providing a full range of SRH services.</p> <p>9. Number of SDPs equipped and improved for ART provision.</p>	<p>Stores records cards.</p>	<p>PLWHAs provided with SRH services that are sensitive to their needs..</p>
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<p>Objective Three To enhance an environment free from stigma and discrimination for the HIV infected and affected in the community and in the workplace.</p>	<ol style="list-style-type: none"> 1. Conduct research on how people living with HIV and AIDS are treated in the community and at workplace. 2. Popularise disclosure of HIV status in the community and workplace within a safe and supportive environment. 3. Sensitise the government, community, employers and employees on the acceptance and support of people infected and affected by HIV and AIDS. 4. Advocate for and disseminate legislation, policies and guidelines that protect the rights of people infected and affected by HIV and AIDS. 	<ol style="list-style-type: none"> 1. Study report. 2. Number of community and staff members who disclose their HIV status. 3. Number of employees infected and affected with HIV and AIDS who are supported by other staff members. 4. The number of organisations addressed with information/guidelines that protect the rights of people infected and affected by HIV and AIDS. 	<p>Study report.</p> <p>HIV and AIDS reports</p> <p>Human Resource reports.</p> <p>IEC reports.</p> <p>Stakeholder reports.</p>	<p>People living with HIV and AIDS are accepted and supported in their communities and at workplace.</p>

<p>Objective Four To increase the participation of people living with HIV and AIDS at all levels of governance and in all programme stages.</p>	<p>1. Develop partnerships with networks of PLWHAs to share knowledge on effective HIV programme approaches.</p> <p>2. Recruit PLWHAs into the governance structures of the Association.</p> <p>3. Develop mechanisms for the involvement of PLWHAs in projects and programmes that affect them.</p>	<p>1. Number and names of networks of PLWHAs partnerships established.</p> <p>2. Number of active PLWHAs in LPPA governance structures and programmes.</p>	<p>Partnerships reports.</p> <p>AGM, NEC, NPC, FAC and BEC minutes.</p> <p>Programme reports.</p>	<p>LPPA fully involves PLWHAs in its program and in all levels of governance.</p>
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3. ABORTION

GOAL:

To contribute to the reduction of unsafe abortion-related maternal morbidity and mortality and to initiate and facilitate dialogue among political leaders, religious leaders, policy makers, stakeholders, care providers and communities on the magnitude of unsafe abortion and also on the existing abortion laws.

Objectives	Strategies	Verifiable Indicators	Means of Verification	Expected Outcome
<p>Objective One To increase access to abortion-related services as an integral component of Sexual and Reproductive Health.</p>	<p>1. Establish , Expand and integrate the provision of abortion-related services, including: a) Pregnancy testing and counselling on unplanned pregnancy. b) Develop networks for effective referral for safe abortion within the fullest extent of the law; c) Treatment for incomplete abortion. d) Post abortion counselling e) Provision of family planning services</p> <p>2. Develop staff capacity for the provision of abortion-related services.</p> <p>3. Provide the required equipment for the provision of abortion-related services.</p>	<p>1. Number and type of abortion related activities established within LPPA SDPs.</p> <p>2. Number of service providers provided with abortion related service provision skills.</p> <p>3. Number and type of target group provided with information on the availability of abortion related services.</p>	<p>Service Statistics reports.</p> <p>·</p> <p>Training reports.</p> <p>IEC reports</p>	<p>Increased access to abortion related services..</p> <p>Increased proficiency in providing abortion related services.</p> <p>LPPA clinics equipped for provision of abortion related services.</p> <p>The public aware of availability of abortion related</p>

	4. Increase awareness of the availability of abortion-related services.	4. Number and type of medium through which awareness on abortion related services was provided.		services.
<p>Objective Two To increase awareness among men, women and young people of both sexes on legal and service issues around abortion.</p>	<p>1. Identify the legal stipulations and services available on abortion and disseminate tailored information to specific groups, including clients, service providers, and community leaders and to the general public.</p> <p>2. Integrate information on abortion issues into other SRH information channels.</p>	<p>1. Number and type of IEC materials produced and distributed on legal stipulations surrounding services available on abortion.</p> <p>2. Type and location of target group targeted with information on abortion legal stipulations.</p> <p>3. Number and type of IEC materials produced on abortion and SRH issues.</p>	<p>IEC reports.</p> <p>Program reports.</p>	<p>Women are generally well informed about legal stipulations regarding services available on abortion.</p>
<p>Objective Three To reduce the incidence of unsafe abortion by creating an enabling legal and policy</p>	<p>1. Sensitise staff and volunteers on abortion issues.</p> <p>2. Establish and document the magnitude of unsafe abortion in the</p>	<p>1. Number of staff and volunteers with positive attitude towards abortion</p>	<p>Abortion consensus building reports.</p> <p>Unsafe abortion</p>	<p>LPPA staff and volunteers ready to advocate and provide abortion</p>

<p>environment.</p>	<p>country.</p> <p>3. Form networks to support awareness raising and advocacy activities around abortion.</p> <p>4. Initiate and facilitate the process of dialogue on unsafe abortion.</p>	<p>issues.</p> <p>2. Distribution of women by age, urban/rural dwelling who have ever attempted an unsafe abortion.</p> <p>3. Number and location of networks who raise awareness and create advocacy on abortion.</p> <p>4. Number of politicians and community leaders who issue positive statements regarding abortion and women's rights.</p>	<p>study report.</p> <p>Abortion reports.</p> <p>IEC and Advocacy reports.</p> <p>Service statistics reports</p>	<p>related activities.</p> <p>The government and the public convinced about the need for safe abortion services.</p>
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4. ACCESS

GOAL:

To increase access to comprehensive, high quality sexual and reproductive health information and services that are gender sensitive and target group specific and to ensure an enabling environment for SRHR using a rights-based approach from 2010 to 2014

OBJECTIVES	STRATEGIES	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	EXPECTED OUTCOME
<p>Objective 1</p> <p>To increase access to comprehensive quality, Sexual and Reproductive Health information and services for men, women, young people of both sexes and people with special needs.</p>	<ol style="list-style-type: none"> 1. Provide comprehensive quality SRH services for men, women, young people of both sexes and people with special needs 2. Build capacity to provide expanded SRH services through reviewing staffing needs, providing needs-based training for service providers and providing equipment and supplies 3. Expand utilization of modalities covering people with special needs at all levels 4. Ensure adherence to Quality of Care (QoC) standards and guidelines in service provision 5. Expand a range of family planning methods through introduction of implants and surgical methods in selected SDPs 6. Ensure effective distribution of contraceptives at all levels 	<ol style="list-style-type: none"> 1. Number of SDPs providing comprehensive Sexual and Reproductive Health services 2. Number of clients by age and sex provided with comprehensive and target specific SRH services by type of service 3. Number of SDPs adequately staffed with qualified, skilled and competent SPs 4. Number of facilities adequately equipped to provide quality SRH services 5. Number and type of trainings provided to increase competence of SPs 6. Number of SPs who are trained to communicate with people with special needs 7. Number of SDPs that provide SRH services for people with 	<p>Clinic records.</p> <p>Facility assessment reports.</p> <p>Stock records.</p> <p>Training plans and reports.</p> <p>Promotional activities' reports.</p> <p>Supervisory/Quality assurance reports.</p> <p>Client exit interviews reports.</p>	<ul style="list-style-type: none"> • Increased access to quality SRH services by all target groups • Reduced magnitude of negative SRH indicators

	<p>7. Produce and disseminate target-group specific IEC/BCC messages and materials</p> <p>8. Develop and implement strategies to market the expanded services</p>	<p>special needs</p> <p>8. Number of clients by age and sex with special needs who are provided with SRH services</p> <p>9. Number and type of strategies employed to promote use of and increased access to SRH services by people with special needs</p> <p>10. Number of SDPs who comply with the guidelines and the quality standards in provision of services</p> <p>11. Number of men, women, young people of both sexes and people with special needs who report favourably on the quality of services provided</p> <p>12. Number of FP acceptors by age and sex and type of method</p> <p>13. Number of SDPs which comply with the logistics and stock management guidelines</p> <p>14. Number and type of IEC/BCC activities undertaken among the target groups</p> <p>15. Number of people reached with the IEC/BCC messages.</p> <p>16.</p>	<p>Suggestion boxes.</p> <p>Focus groups discussions.</p> <p>Clinic records.</p> <p>Demographic health survey.</p> <p>IEC/BCC reports.</p> <p>Programme Behavioral surveillance survey.</p> <p>Marketing strategy report .</p>	
<p>Objective 2</p> <p>To increase male</p>	<p>.</p> <p>1. Improve access to male friendly services based on the results of</p>	<p>1. Number of males reached with IEC/BCC messages</p> <p>2. Number of SRHR awareness</p>	<p>IEC/BCC reports.</p>	<p>Increased number of males who are supportive of women</p>

participation, involvement and commitment to Sexual and Reproductive Health services	the study 2. Implement male specific IEC/BCC activities 3. Raise awareness on gender equity and sexual and reproductive rights among men	activities undertaken	Evaluation reports.	exercising their SRH rights Increased number of males demanding and utilizing SRH services
Objective 3 Increase access to quality Sexual and Reproductive Health information and services at the workplace and in rural areas	1. Expand workplace SRH information and services. 2. Investigate the potential for provision of other SRH services in workplace settings. 3. Identify, orientate, train and deploy CBDs 4. Provide CBD services in collaboration with MoHSW and CHAL 5. 5. Identify additional mechanisms for the distribution of condoms.	1. Number of workplace programmes designed and implemented 2. Number of workplace-based facilities providing SRH services 3. Number of CBD agents recruited and trained 4. Quantities of contraceptives by type distributed by CBDs 5. Number of community-based FP acceptors 6. Quantities of contraceptives by type distributed through social marketing 7.	Service statistics reports LPPA periodic reports	Expanded SRH information and services at the workplace and in rural areas
Objective 4 To contribute to the reduction of maternal and	1. Provide comprehensive SRH services including child survival activities (immunization, nutrition and growth monitoring), and referral for PMTCT obstetric care	1. Number of women provided with MCH services 2. Number of children provided with services by type 3. Number of women referred for	service statistics report	7. Improved MCH services.

<p>neo- natal morbidity and mortality through provision of comprehensive Sexual and Reproductive Health services</p>	<p>2. Develop and disseminate IEC materials on child and maternal health 3. Develop strategies for marketing the MCH services 4. Capacitate SPs with skills to provide MCH services</p>	<p>PMTCT and followed up 4. Number of women who found the IEC materials informative and helpful 5. Number of women who are utilizing the MCH services-as the result of the promotional activities. 6. Number of SPs who been refreshed with MCH services.</p>		
<p>Objective 5 To increase access to services through leveraging comparative advantages of partners, collaborators and communities</p>	<p>1. Establish and sustain partnerships/collaborations with other stakeholders to facilitate sharing resources 2. Facilitate sharing of plans, reports and lesson learnt with other stakeholders 3. Develop and implement strategies to collaborate with stakeholders in SRHR programming</p>	<p>1. Number of partners/ collaborators working and sharing plans, reports and lessons with LPPA 2. Number and type of activities implemented jointly with other partners and stakeholders 3. Amounts of funds saved</p>	<p>Documentation centre. LPPA periodic reports. Financial reports.</p>	<p>Increased effective programme implementation</p>

5. ADVOCACY

GOAL : To contribute towards legislative and policy reform and to the removal of social, legal and cultural barriers that infringe upon the rights of men, women and young people of both sexes to access Sexual and Reproductive Health (SRH) information and services; and to reduce stigma and discrimination in partnership with other stakeholders.

Objectives	Strategies	Verifiable Indicators	Means of Verification	Expected Outcome
Objective 1. To strengthen the role of partnerships in influencing advocacy in SRH Rights.	<ol style="list-style-type: none"> 1. Identify SRH stakeholders, partners, and their profiles. 2. Organize a stakeholder advocacy forum to identify the prevailing SRH advocacy issues. 3. Develop Advocacy guidelines 4. Conduct joint stakeholder campaigns to increase awareness on SRH rights exploitation and its impact. 	<ol style="list-style-type: none"> 1. List of partners and stakeholders by name and location. 2. Number of stakeholders participating in LPPA advocacy forum. 3. Number of stakeholder campaigns on SRH rights awareness 4. Advocacy guidelines document 	<p>Partnership and stakeholder reports.</p> <p>Advocacy reports.</p> <p>IEC reports.</p> <p>Advocacy guidelines document.</p>	LPPA partners and stakeholders actively cooperate on advocacy.
Objective 2. To establish evidence based facts on prevailing SRH issues that infringe upon the rights of	<ol style="list-style-type: none"> 1. Build relationships with stakeholders and NGOs who have undertaken research in order to share research findings. 2. Convene forums for targeted groups 	<ol style="list-style-type: none"> 1. List of research areas by stakeholder. 2. Number of 	<p>Copies of research documents.</p> <p>Advocacy forum</p>	Duplication of efforts by stakeholders avoided.

men, women and children.	(young people of both sexes, orphans, domestic workers, and LGBTIs) to share research findings and identify areas of action.	participants by type and age who participated in forums to share research findings. 3. Action plans developed.	report.	Implementation of complementary activities from stakeholders and partners enhanced
Objective 3. To create an enabling legal environment for practical translation of Lesotho laws and policies around abortion procedures.	<ol style="list-style-type: none"> 1. LPPA to commission Doctors and nurses to write papers on their clinical experiences regarding present circumstances allowed by law with regard to abortion. 2. Hold a forum for policy makers, partners and service providers for dialogue on abortion. 3. Compile forum discussions report to inform abortion policy. 	<ol style="list-style-type: none"> 1. Number of doctors and nurses who have publicized papers on abortion. 2. Number of articles by topic publicized 3. Number of policy makers, partners and service providers who participated in dialogue on abortion. 	Articles/papers on abortion. Forum report.	The right environment for abortion dialogue is created.
Objective 4. To reduce the social and cultural barriers at the community level which lead to stigma and discrimination and the under-	<ol style="list-style-type: none"> 1. Develop good media relations to increase positive coverage of SRH issues. 2. Work in partnership with influential community groups including those of religious, women's and young leaders to 	1. List of media that have covered issues of SRH in print and on air.	IEC reports. Newspaper clips.	People will access SRH services free from stigma and discrimination.

utilization of SRH services.	increase their support in the promotion of positive attitudes towards SRH rights and services.	2. List of community groups, religious groups, women's groups and young leaders who promote positive attitudes towards SRH rights and services.		
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6. INSTITUTIONAL CAPACITY BUILDING *(Pls complete this section)*

GOAL :

A sustainable, innovative, accountable Association with effective and efficient governance and management systems.

Objectives	Strategies	Verifiable Indicators	Means of Verification	Expected Outcome
<p>Objective 1.</p> <p>To increase the sustainability prospects of LPPA and its programmes through diversifying its partners, donors and national resource base.</p>	<p>1. Identify potential new donors; 2. Develop and market proposals for funding; 3. Lobby for increased financial and political government support; 4.. Fundraise locally from the public and private sectors; 5.. Map existing and potential partners and areas of partnership; 6.. Develop long term partnership agreements and Memoranda of Understanding; 7.. Use strategic partnerships to solicit financial support for SRHR programmes from government and private sector; 8.. Identify appropriate, cost effective and sustainable facilities for service provision. 9. Implement income generating activities; 10.. Revise and implement a</p>	<p>1. Number of new donors. 2. Number of proposals developed. 3. Number of proposals funded 4. Amount of funds raised from government. 5. Amount of funds raised from private sector. 6. Map of existing partners.. 7. A revised</p>	<p>Donor list. Proposal bank. Fundraising report. Map of partners. MOU documents. LOA documents. Partnership reports. Sustainability plan. Sustainability plan operational report.</p>	<p>The LPPA and its program is sustained.</p> <p>LPPA has a broad donor base.</p> <p>4. LPPA has sustainable partnerships.</p>

	sustainability plan.	sustainability plan. 7. Facility structures for SRHR established.		
<p>Objective 2. : To strengthen the effectiveness of staff and volunteers in governance, management and programming.</p>	<p>1. Develop training master plan, to include training of strategic partners as appropriate; 2. Identify a resource base for the implementation of the training master plan; 3. Provide needs based training for staff and volunteers; 4. Enhance the capacity of volunteers to play a greater role in advocacy and resource mobilization; 5. Develop the capacity of female and young volunteers to effectively participate in governance; 6. Maintain compliance to IPPF guidelines regarding age and gender involvement within Association governance structures; 7. Cultivate a culture of good governance and accountability among staff and volunteers.</p>	<p>1. Training master plan developed. 2. A budget developed for the training master plan. 3. Number of LPPA staff trained. 4. Number of volunteers trained in advocacy and resource mobilisation. 5. Number of advocacy activities undertaken by volunteers. 6. Number of resource mobilisation activities undertaken by volunteers.</p>	<p>Master plan document. Budget document for master plan. Training report. Advocacy report. Fundraising /resource mobilisation report. Members register. NEC, BEC, NPC and FAC minutes.</p>	

		7. Number of young people and women within LPPA structures.		
<p>Objective3: To strengthen programme effectiveness and accountability through evidence-based programming and documentation.</p>	<p>1. Review and revise the Management Information System (MIS) to improve information flow for management decision-making; 2. Improve reporting by electronic Integrated Management System (eIMS); 3. Undertake/Sustain research for advocacy, to improve programme design and to determine the impact of programmes; 4. Strengthen monitoring and evaluation systems; 5. Document and disseminate best practices and lessons learned.</p>	<p>1. Number of LPPA staff able to report to IPPF by eIMS. 2. Number and type of program related research studies undertaken. 3. Number and type of program monitoring and evaluation procedures undertaken. 4. List of best practices and lessons learnt.</p>	<p>Study reports. M&E systems. Program implementation reports. Minutes of programme meetings. Best practices report.</p>	<p>LPPA staff able to send reports to IPPF as required. LPPA staff able to share important documents with other MAs. LPPA program is realistic and responds to the needs of target groups.</p>

<p>Objective 4: To enhance the conducive working environment for staff at all levels</p>	<p>1. Develop capacity in human resource management;</p> <p>2. Strengthen systems for addressing staff welfare;</p> <p>3. Review the organizational chart to ensure staffing patterns that address organizational needs.</p> <p>4. Strengthen the systems for the flow of information between management, staff and volunteers.</p>	<p>1. Number of staff trained in human resource management.</p> <p>2. Number and type of staff welfare package.</p> <p>3. Organizational chart developed and implemented.</p> <p>4. Type of communications systems between staff and volunteers established.</p>	<p>HR reports.</p> <p>LPPA organogram.</p> <p>Copies of letters and e-mails to volunteers.</p> <p>Minutes of meetings.</p>	<p>5. Conducive working environment for staff</p>
<p>Objective 5. To improve the corporate image of LPPA and increase the number of clients served through innovative marketing approaches</p>	<p>1. Develop and implement a strategy to improve LPPA's corporate image and its public relations;</p> <p>2. Use innovative strategies and media to market the services offered by LPPA;</p> <p>3. Document and disseminate information on LPPA and its successes.</p>	<p>1. Number of times publications of LPPA and its program are reflected in local newspapers.</p> <p>2. The list of services marketed by LPPA in local newspapers.</p> <p>3. Number of meetings held for dissemination of information on LPPA and its</p>	<p>Newspaper clippings.</p> <p>Minutes of meetings</p>	<p>The corporate image of LPPA is improved.</p>

		successes.		
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MONITORING AND EVALUATION

Activities of the Strategic Plan will be implemented annually through the Work Programme and Budget (WPB), while the Monitoring and Evaluation Plan (M&E-P) will be conducted through existing M&E systems over the five year period leading to 2014.

Baseline studies will be undertaken to measure the initial indicators prior to the implementation of activities. Regular monitoring will be done with programme implementation reports and regular review meetings. The Management Information System (MIS) including M&E system will be improved such that access to accurate and timely information will be facilitated to efficiently undertake the exercise. The Branch Senior Nurses and Programme Officers will be responsible for undertaking the monitoring activities, under the supervision of Monitoring and Service Delivery Coordinator and the Programmes Director.

Mid-term and final evaluation will be conducted at the end of the third and fifth year respectively to measure both the process and impact indicators. External consultants will be engaged to undertake the evaluation.