

COUNTRY CONTEXT

Lesotho has the third highest HIV prevalence rate in the world. The most recent estimates indicate an adult HIV prevalence of 23%, representing about 290,000 people living with HIV (PLHIV) (UNAIDS 2010). The principal mode of transmission of HIV in Lesotho is through multiple concurrent sexual partners (NAC 2009). The prevalence of HIV infection is 27% for women aged 15-49 and 18% for men aged 15-49.

Lesotho established a *National AIDS Commission* (NAC) in 2005 responsible for coordinating the overall HIV response. The Ministry of Health and Social Welfare (MOHSW) is responsible for coordinating the health sector response. The multi-sectoral *National Strategic Plan for HIV and AIDS 2006-2011* focuses on: prevention; treatment, care and support; impact mitigation; and management, coordination and support mechanisms (NAC 2007).

One of the key challenges in Lesotho is pervasive AIDS-related stigma. Stigmatizing beliefs about AIDS and associated fears of discrimination may be a barrier to use HIV-related services such as HIV testing and counseling (HTC). Indeed, while the number of facilities providing HTC has increased and represent the largest share of expenditures on HIV prevention most people in Lesotho do not get tested (Macro International 2008).

STUDY FOCUS

Stigma and discrimination remain among the most poorly understood aspects of the epidemic. *This study aimed to determine the socio-economic determinants of HIV-related stigmatizing attitudes in Lesotho, and whether there is an association between fear of discrimination and use of HIV testing services*

The findings are crucial for designing prevention strategies that can make a difference in fighting the HIV epidemic.

STUDY METHODS

Data of two consecutive rounds of the Lesotho Demographic and Health Survey were analyzed (LDHS 2004 & 2009).

The LDHS is appropriate to study HIV-related discrimination since it includes questions which are good proxies to measure discriminating behavior against PLHIV; it elicits information regarding the HIV testing behavior of the respondent; it includes HIV testing of respondents; and the sample is nationally representative with standardized variables which allows comparisons over time and across countries.

The LDHS were conducted using a representative sample of 14,719 women and 6,114 men of reproductive age (15-49 years) living households in the ten districts of Lesotho (urban and rural). A random sample of 12,178 individuals (6,869 women, 5,309 men) were selected and tested for HIV.

The LDHS included five questions to measure respondents' attitudes towards PLHIV:

1. Would you buy vegetables from an HIV positive vendor?

LESOTHO AT A GLANCE

Region	Southern Africa
Capital	Maseru
Population (millions)	2.07
GDP (US\$ billions)	1.58
Life expectancy at birth (total years)	45
Primary completion rate (total %relevant age group)	70
Number of people living with HIV	290,000 [260,000-310,000]
Adult prevalence rate (age 15-49)	23.6% [22.3%-25.2%]
Adults living with HIV (aged 15 and up)	260,000 [240,000-280,000]
Women living with HIV (age 15 and up)	160,000 [140,000-180,000]
Children living with HIV (age 0-14)	28,000 [17,000 - 37,000]
Deaths due to AIDS	14,000 [10,000-18,000]
Orphans due to AIDS (age 0-17)	130,000 [110,000-160,000]
National Policy: <i>National Strategic Plan 2006-2011</i>	
National Coordinating Body: <i>National AIDS Commission (NAC)</i>	
Source: UNAIDS 2010 & World Bank 2011	

COMMUNITY RESPONSE EVALUATION

'Communities'

can be described as *cultural identity* (members belong to a group that shares common characteristics or interests), or as a *geographic sense of place* (a group in a location or an administrative entity)

'Community response'

The combination of actions and steps taken by communities, including the provision of goods and services, to prevent and/or address a problem to bring about social change

Typologies of Community Response

Community responses can be characterized in six main ways:

1. types of implementing organizations and structures
2. types of implemented activities or services and beneficiaries
3. actors involved in and driving responses
4. contextual factors influencing responses
5. extent of community involvement in the response
6. extent of involvement of wider partnerships/collaboration

Source: Rodriguez-Garcia et al 2011

2. If a male teacher has the HIV virus, should he be allowed to continue teaching in the school?
3. If a female teacher has the HIV virus, should she be allowed to continue teaching in the school?
4. If a member of your family got infected with the virus that causes AIDS, would you want it to remain a secret or not?
5. If a relative of yours became sick with the virus that causes AIDS, would you be willing to care for her/him in your own household?

Data analysis was focused on: the percentages of women and men who express stigmatization attitudes towards PLHIV by background characteristics; and the extent to which specific socio-economic factors contribute to HIV stigmatization in women and men (i.e., age, education, location, wealth, traditional circumcision).

Study Findings

What are the socio-economic characteristics associated with stigmatizing attitudes related to AIDS?

Age: Younger and older respondents are more likely to express discriminating behaviors than respondents 20-39 years old.

Gender: The proportion of respondents expressing stigmatizing attitudes is higher among men.

Education: The proportion of individuals who report stigmatization behaviors decreases with education. For example, the percentage of respondents saying they will not buying vegetables from an HIV positive vendor decreases from 65% for people with no education to 20% for those with secondary or higher education. Also, having some primary education increases the willingness to care for an HIV-infected relative in the household (compared with having no education).

Rural/urban location: Those living in urban areas are less likely to express discriminating behaviors.

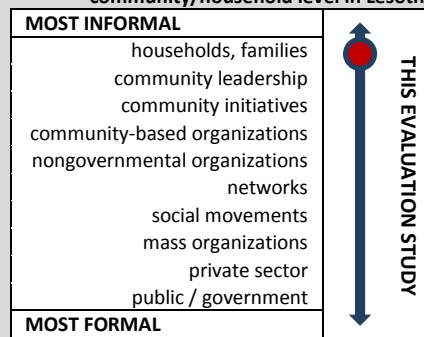
Wealth: The percentage of both women and men who express discriminating behaviors is the highest among respondents in the lowest wealth quintile and the lowest among those in the highest wealth quintile.

Religion: Being Catholic is associated with higher stigmatization for women. For men, not having a religion is associated with higher stigmatization compared to being Protestant.

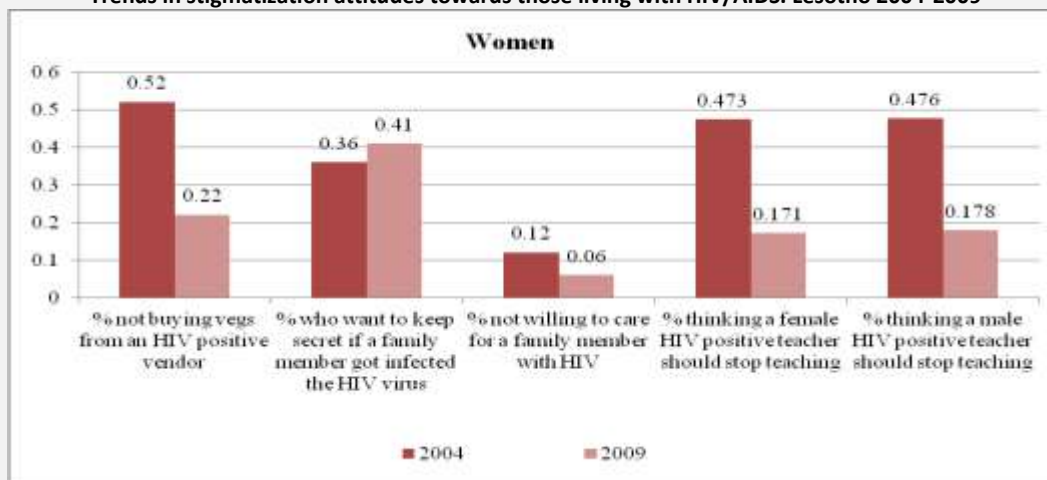
Traditional circumcision: Being circumcised is associated with higher stigmatization in men. (In Basotho culture, many young males are sent by parents to ‘initiation schools’ where they are given information about sexual relations and reproductive health by elders. ‘Traditional circumcision’ of this sort is more a symbolic incision and different from medical circumcision.)

Civil society organization (CSO): is a generic term, inclusive of all community-based initiatives and organizations (e.g. CBOs, NGOs, FBOs, networks, as well as local initiatives).

This evaluation study is focused on stigma at a community/household level in Lesotho



Trends in stigmatization attitudes towards those living with HIV/AIDS. Lesotho 2004-2009

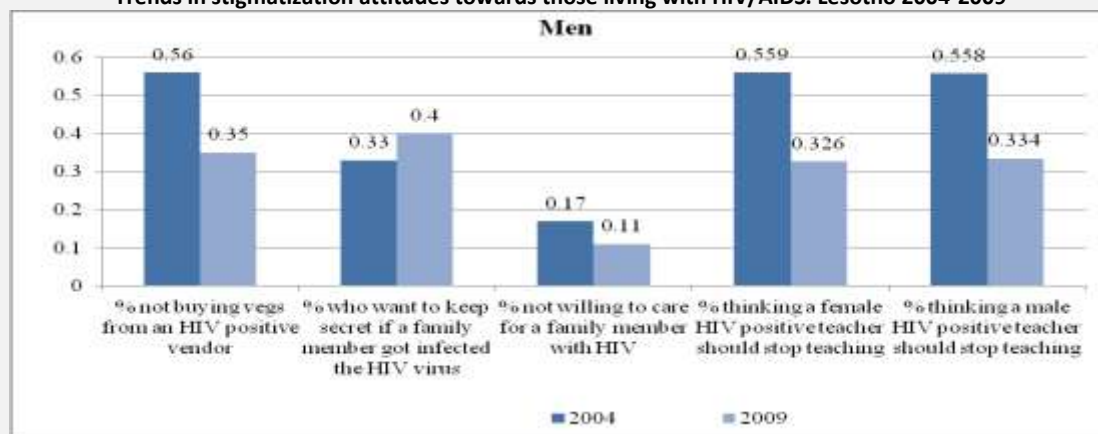


Is there an association between fear of discrimination and use of HIV testing services?

Probability of being tested for HIV test (based on aggregate measure of stigmatization): HIV-related stigma is strongly associated with not using VCT services. Men seem to be more easily deterred by stigma from being tested for HIV.

Probability of receiving HIV test results: The higher the stigmatizing attitudes at the work place and within the household, the less likely that an individual obtains the result of an HIV test. This seems to be particularly important among men. However, it is not known whether decreased stigma *causes* increased uptake of services or if increased access to testing and treatment causes stigma to fall. For women, having some primary education has a positive effect on the likelihood of obtaining HIV test results.

Trends in stigmatization attitudes towards those living with HIV/AIDS. Lesotho 2004-2009



CONCLUSIONS

The findings suggest that educational achievement (especially at primary level), wealth and urban location are associated with less stigmatization. These findings underscore the importance of access to schooling and the need for effective HIV prevention programs in schools.

The Government of Lesotho is expanding access to primary and secondary education. A good example of school-based HIV prevention is the Life Skill Curriculum advanced by the Ministry of Education, which brings HIV/AIDS education into the primary school curriculum.

The finding that traditional male circumcision is associated with higher stigmatization towards PLHIV may be important to better understand the specific practice in Lesotho and to fashion messages that reflect the local realities.

Apart from the necessity to address HIV-related stigma from a human rights point of view, the Lesotho data also show that stigmatizing behaviors represent a barrier for HIV testing and for obtaining the results of the test. However, programs targeting stigmatizing attitudes are still very limited in Lesotho. Effective programs for reducing HIV-related stigma should be implemented at all levels and on a large scale and their impact should be closely monitored. Measures to address stigmatization should include appropriate laws, AIDS education to combat the ignorance that causes people to discriminate, and initiatives that seek to empower PLHIV, for example, in the work place.

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EVALUATION OF THE COMMUNITY RESPONSE TO HIV AND AIDS

The World Bank in collaboration with DFID and the UK Consortium on AIDS and International Development launched an evaluation exercise in 2009 to assess the results achieved by community responses to HIV and AIDS. The primary objective of this effort is to build a more robust pool of evidence on the impact and added value of community-based activities and actions. This brief is part of a series summarizing the findings from studies conducted in Burkina Faso, India, Kenya, Lesotho, Nigeria, Senegal, South Africa and Zimbabwe.

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EVALUATION PARTNERS IN LESOTHO

This evaluation in Lesotho is the result of a joint collaboration between the World Bank Africa Region, the World Bank's Development Impact Initiative (DIME) and the AIDS Team in the Human Development Network (HDNE). The LDHS are conducted by the Lesotho Ministry of Health and Social Welfare in collaboration with the Bureau of Statistics and ORC Macro International.

This brief is based on a more detailed paper entitled "Combating the AIDS Pandemic in Lesotho by Understanding Beliefs and Behaviors: Quantitative analysis of HIV/AIDS discrimination" prepared by Lucia Corno and Damien de Walque.