Analysis of Services for Orphans and Vulnerable Children in Lesotho – A Desktop Review

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Abbreviations and Acronyms

ANC	-	Antenatal Clinic
AIDS	-	Acquired Immune Deficiency Syndrome
ALAFA	-	Apparel Lesotho Alliance to Fight AIDS
BOS	-	Lesotho Bureau of Statistics
CBC	-	Lesotho Catholic Bishops' Conference
CBO	-	Community-based Organisations
CCM	-	Country Coordinating Mechanism
CHAL	-	Christian Health Association of Lesotho
DFID	-	Department for International Development
DMA	-	Disaster Management Authority
DSW	-	Department of Social Welfare
EMICS	-	End Decade Multi-indicator Cluster Survey
EPI	-	Expanded Programme of Immunisation
FAO	-	Food and Agricultural Organization
FBOs	-	Faith-based Organizations
FPE	-	Free Primary Education
GDP	-	Gross Domestic Product
GFATM	-	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOL	-	Government of Lesotho
HSAs	-	Health Service Areas
HBC	-	Home-based Care
HIV	-	Human Immunodeficiency Virus
HSRC	-	Human Sciences Research Council
ILO	-	International Labour Organization
LHDS	-	Lesotho Health and Demographic Surveys
MOET	-	Ministry of Education and Training
MOHSW	-	Ministry of Health and Social Welfare
M&E	-	Monitoring & Evaluation
MVCP	-	Mapoteng Vulnerable Children's Programme
NAC	-	National AIDS Commission
NAS	-	National AIDS Secretariat
NFE	-	Non-formal Education
NPOVC	-	National Policy on Orphans and Vulnerable Children
NGO	-	Non-governmental Organisation
OVC	-	Orphans and other Vulnerable Children
PEPFAR	-	US President's Emergency Plan for AIDS Relief
PLWHA	-	People Living with HIV/AIDS
PRSP	-	Poverty Reduction Strategy Papers
RAAAP	-	Rapid Assessment Analysis and Action Planning
SADC	-	Southern African Development Community
SOA	-	Sexual Offences Act
STI	-	Sexually Transmitted Infection
UN	-	United Nations
UNGASS	-	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	-	United Nations Children's Fund

UNAIDS	-	Joint United Nations Global Programme on HIV and AIDS
USAID	-	United States Agency for International Development
WHO	-	World Health Organisation
WFP	-	World Food Programme

1. Introduction

This background document will provide inputs into the drafting of the Situation Analysis of Services for Orphans and Vulnerable Children (OVC) in Lesotho. It provides a desktop review of the nature and extent of OVC services in Lesotho. The aim of this review is to assess the nature and extent of services provided to OVC in Lesotho, and to identify gaps and challenges. Lessons have also been drawn from regional and international experiences. In the first place, the report provides brief background information on Lesotho. It then highlights the extent of HIV and AIDS and orphan prevalence in Lesotho. Special emphasis is placed on some of the challenges faced by OVC and the response mechanisms of the state and civil society organisations, including non-governmental organisations (NGOs) – international, national and local – as well as faith-based organisations (FBOs), in the third and fourth sections of the report. The policy framework to protect OVC will be analysed in the third section of the report. Section five discusses types of services provided to OVC in Lesotho. This is followed by an analysis of the role of civil society in providing services to OVC in the sixth and final section of the report. As a desktop study, this section of the report is based on the review of existing data obtained through database searches and documents obtained through government and civil society contacts in Lesotho. The search methods used are explained below.

2. Search Methods for Identification of Studies

2.1. Electronic searches for published literature

Published literature was searched via databases such as Academic Search Complete and African Journals Online on Ebsco Host and JSTOR. The search found there to be a distinct lack of peer-reviewed journal articles on the subject of OVC services in Lesotho. The articles that were retrieved were found to be useful for their attention to pertinent topics in Sub-Saharan Africa and Southern Africa generally, as opposed to Lesotho in particular. In deciding on relevant publications, the following key words were used to guide the process: OVC services, orphans, vulnerable children, Lesotho, HIV, AIDS, poverty, NGO. References from published materials can be found under the *Books, articles and reports* in the References list.

In analysing the literature, these reports were approached as raw data to be examined for the types and outcomes of services provided by governmental and non-governmental initiatives. The few peer-reviewed journal publications germane to the study were, meanwhile, mined for possible themes and connections not considered in the initial literature searches. In addition, references cited in these articles that were deemed to be of interest were later obtained.

2.2. Grey literature

Due to the nature of this study, it is perhaps unsurprising that it relies for its data predominantly on reports produced between 2000 and 2010 by international and domestic NGOs. These were accessed by visiting the websites of the following organisations, known to be active in Lesotho: UNICEF Lesotho, World Vision, the World Food Program (WFP), Save the Children, Lesotho Red Cross Society, Letsema, and Sentebale among others. The website of the Government of Lesotho (GoL) was also accessed in order to retrieve official policy documents drawn up by ministries responsible for OVC. These have been listed under*: Government reports and policies* in the list of references.

Google Scholar was another resource used when searching for unpublished reports. Initial searches were conducted between 1 April and 30 June 2010, although the websites were revisited regularly during the analysis of the data to ensure that the latest information was included and examined in the study.

3. Socio-economic and demographic profile of Lesotho

3.1. Demographic profile of Lesotho

Located in southern Africa, Lesotho is a landlocked country with an estimated population of 1.8 million (BOS, 2007). According to the Lesotho Bureau of Statistics (BOS), Lesotho has about 1,876,633 inhabitants, made up of 912,798 males and 963,835 females (Ibid.). The population grew by an estimated 659,818 from 1976 to 2006 (Ibid.). It is worth noting that the population has in general been increasing at a decreasing rate due mainly to the decline in fertility rates. For example, there were 5.3 children per woman in 1976, 4.1 and 3.5 children per woman in 1996 and 2006, respectively (Ibid). The decline in fertility rates is partially attributable to the AIDS epidemic.

Lesotho is a young country by population age. The BOS (Ibid) found that more than half (52%) of its inhabitants were below the age of 18 years. The situation is no different in the Southern African sub-region. Save the Children (2006) found that seven out of ten countries had children under 18 years numbering more than half of the total population.

The 2006 Census found that there were clear disparities in the distribution of population by place of residence, ecological zones and districts in Lesotho (Ibid.). The disparities were most likely due to social, economic, cultural and demographic reasons. The 2006 Census further observed that in as far as place of residence is concerned, disparities occur due to many reasons, such as accessibility, availability and affordability of services (Ibid.). Table 1 lists the population distribution of Lesotho by district. The urban district of Maseru had the highest concentration of people, followed closely by the district of Leribe.

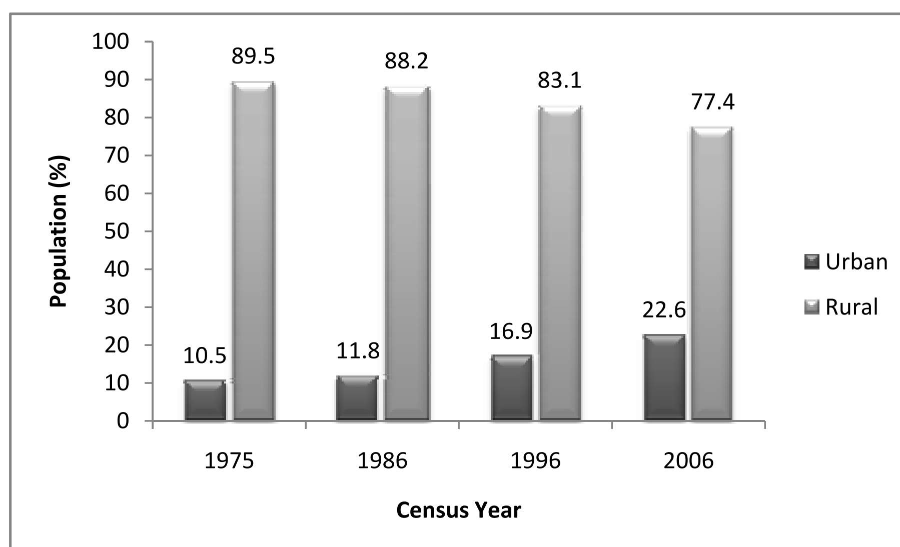
Table 1: Population of Lesotho according to districts, 2006

District	Census Year				
	1966	**1976**	**1986**	**1996**	**2006**
Botha-Bothe	63,179	77,178	106,077	109,192	110,320
Leribe	161,493	206,558	273,678	300,160	293,369
Berea	118,248	146,124	148,794	240,754	250,006
Maseru	201,832	257,809	311,254	385,869	431,998
Mafeteng	119,087	154,339	204,553	211,970	192,621
Mohale's Hoek	109,927	136,311	173,,909	184,034	176,928
Quthing	72,746	88,491	119,766	126,342	124,048
Qacha's Nek	62,955	76,497	68,207	71,665	69,749
Mokhotlong	60,167	73,508	79,671	85,628	97,713
Thaba-Tseka	---------	----------	108,187	126,353	129,881
Total Population	**969,634**	**1,216,815**	**1,595,096**	**1,841,967**	**1,876,633**

Source: BOS (2007)

While the majority of Basotho live in rural areas (76.5%), there is rapid urban migration taking place. Figure 1 illustrates the urbanisation pattern over the last ten years. It shows that people are now migrating to urban areas in search of better living standards. For example, urban population increased by 1.3%, 5.1% and 5.7% during the intercensal periods 1976-1986, 1986-1996, and 1996-2006 respectively (Ibid.). Meanwhile, the rural population decreased by the same percentage points during those periods.

Figure 1: Percentage of population in place of residence, 1976-2006



Source: BOS, 2007 (Figure 2.3, p.21)

Table 2 further indicates that Maseru is the most rapidly growing district in Lesotho for the past four censuses. Along with Berea and Mokhotlong, Maseru had an increased percentage share of the national population during the last decade. Meanwhile, the share of the population in the rest of the districts either decreased or remained stable over the same period.

Table 2: Percentage distribution of de-Jure population by districts 1976 – 2006

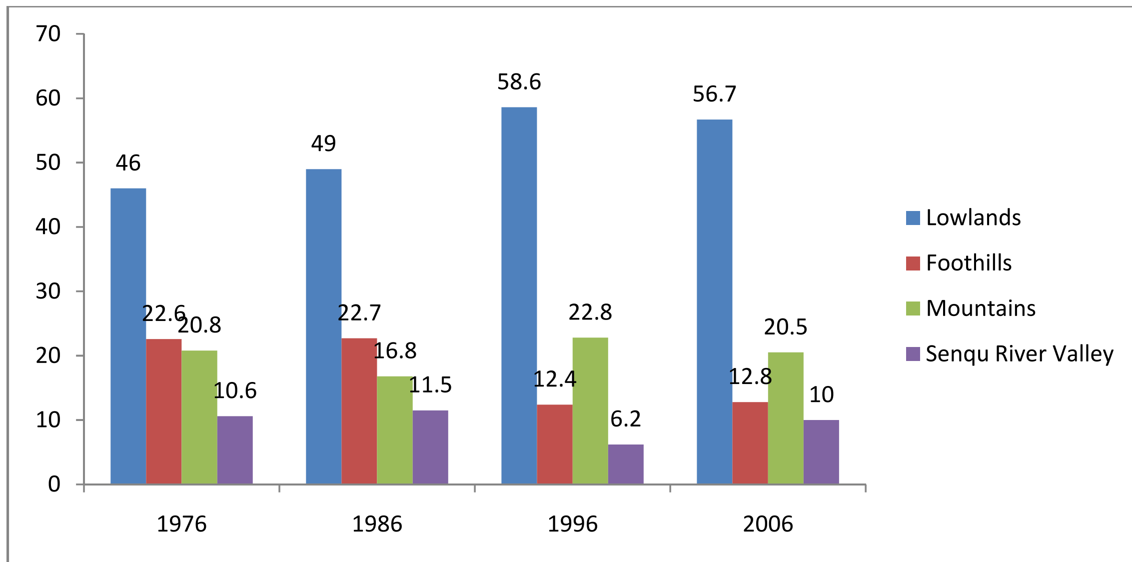
District	1976	1986	1996	2006
Botha-Bothe	6.3	7	6	5.9
Leribe	16.3	17	16	15.7
Berea	12	9	13	13.4
Maseru	18.2	19	21	22.9
Mafeteng	13	13	11	10.3
Mohale's Hoek	11	11	10	9.4
Quthing	7.2	7.2	7	6.6
Qacha's Nek	4	4	4	3.7
Mokhotlong	5	5	5	5.2
Thaba-Tseka	7	7	7	6.9
Total (%)	100	100	100	100
Total Population	1,216,815	1,605,177	1,862,275	1,876,633

Source: BOS, 2007 (p.22)

Services provision in Lesotho is highly dependent on the often dramatic spatial features of the country. The country is divided into four zones: lowlands, foothills, mountains and Senqu River Valley. Glaring patterns emerge with regard to population distribution in geographical zones. As

Figure 2 illustrates, the lowlands have the largest share of the population, while the foothills, mountains and Senqu River valley experienced fluctuating population size during the period 1976 to 2006. While it is evident that the lowlands will have better access to services, it is not known why the populations of the foothills and Senqu River valley kept fluctuating (BOS, 2007: 25).

Figure 2: Percentage distribution of population by ecological zones, 1976-2006



Source: BOS, 2007 (Figure, 2.4, p. 25)

3.2. Socio-economic dynamics of Lesotho

Lesotho has been designated a Least Developed Country with Gross National Product per capita thought to be $740 (2004) (GOL, 2005). About 35% of the labour force is unemployed or under-employed (MOHSW, 2005). A quarter of the population lives under the "food poverty line" (MOHSW, 2005; Lesotho Red Cross, 2006). Lesotho's economy is anchored in agriculture, although its main export has been its labour to gold mines in South Africa. However, with the decline of gold mining, state revenue has taken a sharp knock. At the same time, the backbone of the economy, agriculture, is facing serious decline. In recent years, notably 2006-2008, the country has been plagued by heavy droughts, which has pushed thousands of households into severe poverty (Lesotho Red Cross, 2006). Ironically, the sale of water to South Africa has become the main source of foreign revenue for Lesotho in recent years.

In 2006, Lesotho was one of the six countries in the world that were severely affected by food shortages due to drought (UNICEF, 2006) prompting the WFP intervention to donate food to severely affected communities, especially those living in remote rural villages. Poverty which leads to food insecurity, along with HIV and AIDS, have been identified as the biggest threats to the survival, care, protection and development of children in Lesotho

(Kimane, 2005). Orphans are disproportionately affected. A survey by the National Nutrition and Expanded Programme of Immunisation (EPI) cluster indicates that the underweight prevalence among orphans was higher than non-orphans; that is, 15% of non-orphans were underweight compared to 20%, 21% and 40% for maternal, paternal and double orphans respectively (Government of Lesotho, 2002).

Regarding the provision of bulk services, roughly 64.7% of the population in Lesotho have access to improved drinking water, while only 19% have access to adequate sanitation (BOS, 2007). Registration of births is very low in Lesotho. The End-decade Multi-indicator Cluster Survey (EMICS) (2000) estimates that only 50.6 % of children 0-4 years old have had their births reported and registered. A higher number of children's births were recorded (53%) in rural areas compared to urban areas (40.7%).

4. HIV and AIDS Prevalence in Lesotho

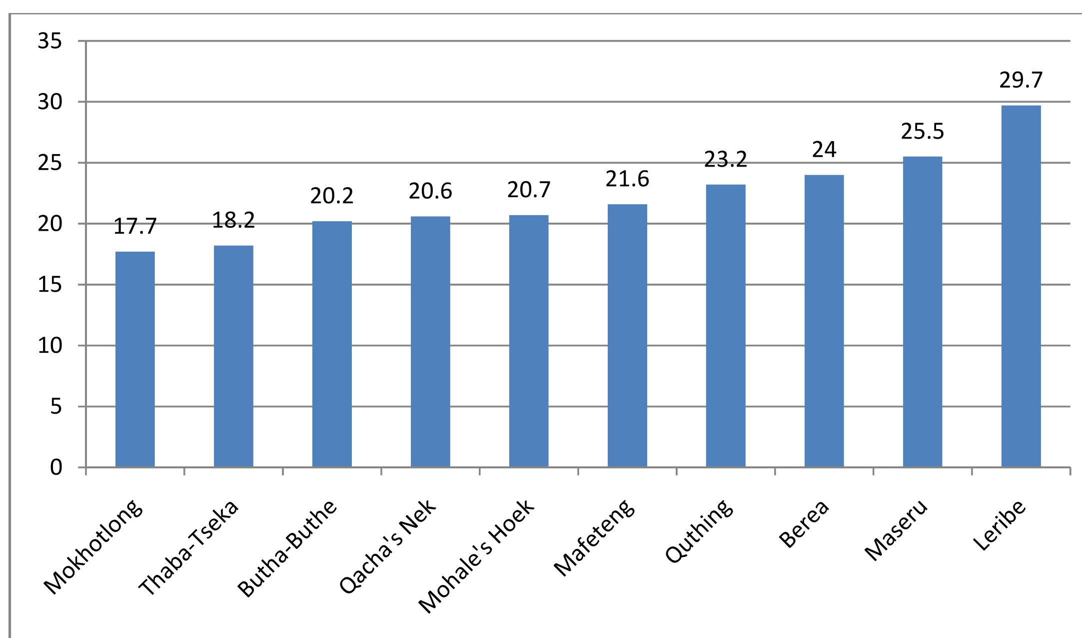
4.1. The HIV and AIDS crisis

Lesotho has the third-highest HIV sero-prevalence rate in the world, after Botswana and Swaziland. It is suspected that the AIDS epidemic in Lesotho began in the late 1970s or early 1980s (GOL, 2003). However, the first case of AIDS was reported in 1986 (Ibid.). Khobotlo *et al*. (2009) note that sentinel surveillance among antenatal clinic (ANC) clients and sexually transmitted infections (STI) clinic attendees was established in Lesotho at five sites in 1991. This has been expanded to ten sites since 2005, covering three geographical zones of Lesotho: the lowlands, foothills and highlands, as well as urban and rural settlements (Ibid). The epidemic has reportedly reached a plateau, albeit at a high level, of 23% prevalence rate (273,798 adults aged 15-49 years) (BOS, 2007).

Women and young people, especially girls, are disproportionately affected by HIV and AIDS. The HIV sero-prevalence rate was 26.4% for females and 19.3% for males in 2006 (BOS, 2007). Khobotlo *et al.* (2009) note that this higher overall HIV prevalence in females is partly due to there being more females in the country (m:f sex ratio 95:100). Moreover, it is widely accepted that females are harder hit by the epidemic, not least because their physiology makes them more vulnerable.

It has been found that there are small differences in HIV prevalence across the four ecological zones, ranging from 21% (mountain zone) to 25% (lowlands) (Khobotlo *et al.,* 2009: 15). The Lesotho Health and Demographic Surveys (LHDS) of 2004 found that female prevalence tends to be lowest in the mountain zone, and male prevalence was lowest in the foothills (Ibid.). Furthermore, the 2004 LHDS found urban prevalence to be significantly higher (29.1%) than rural prevalence (21.9%) ($p<0.001$). Prevalence in urban women was 33.0% compared with 24.3% for rural women. The LHDS found that the district-specific HIV prevalence shows differences in HIV prevalence across districts, ranging from 17.7% in Mokhotlong District to 29.7% in Leribe District (see Figure 3).

Figure 3: District-specific HIV prevalence in Lesotho, 2004



Source: LHDS (2004) (Table 12.4).

While there has been no significant change in national adult prevalence since 2005, as indicated by the sentinel surveillance conducted in 2007 (GOL, 2007), there appears to be a slight downward trend in the HIV prevalence among young people 15-24 years old. The rate of prevalence dropped to 8.9% in 2007 from 11% in 2005 (GOL, 2007).

Poverty is regarded as the root cause of the escalation of the epidemic in Lesotho, as it drives internal and external migration, heightens the disempowerment of women and results in a lack of resources to mount an effective response (MOHSW, 2005; ALAFA, 2006). The crisis of HIV and AIDS has a knock-on effect on other services such as health. The public health sector in Lesotho is reportedly overwhelmed, as more than half of hospital beds are occupied by AIDS patients (Lesotho Red Cross, 2006: 3).

4.2. Responsive measures

In response, the GoL has demonstrated political leadership by declaring the pandemic a national disaster with top political leadership speaking up and supporting HIV and AIDS responses. The Government has embarked on a large-scale campaign to achieve universal access to HIV prevention, treatment, care and support. In addition, the Government has established the Lesotho AIDS Programme Coordinating Authority (LAPCA) and NAC to

coordinate HIV and AIDS activities in the country. Policy measures include the National HIV&AIDS Policy (2000), the Sexual Offences Act (2003), Poverty Reduction Strategy Papers, Lesotho Vision 2020, Youth Policy (1999), Gender Policy (2002), Adolescent Health Policy (2003), and the Social Welfare Policy (2003). Makoae *et al.* (2009) provide an inventory of the HIV and AIDS policy and legislative framework in place in Lesotho since the early 2000s. The Child and Gender Protection Unit has been established within the Police Department to address gender-based violence. Guidelines on clinical management of HIV and AIDS, home-based care and prevention of mother-to-child transmission have also been developed by the Ministry of Health and Social Welfare.

Along with Botswana and South Africa, Lesotho has embarked on a nationwide programme to provide ART to AIDS patients and address the prevention of mother-to-child transmission (PMTCT) of HIV. According to Khobotlo *et al.* (2009), MOHSW records indicate that in December 2007, 22,430 adults were on ART, including 14,915 women (66% of all adults on ART). It is suspected that the higher number of women on ART is mainly due to the HIV care and treatment provided within the PMTCT programme, which leads to an average of 300-400 pregnant women getting started on ART each month (Ibid.).

One of the ironies of the AIDS pandemic is that it is killing the most productive members of society, especially young adults. Also, as noted, the disease affects women disproportionately, many of whom are mothers. The undesirable, yet predictable, social repercussion of the pandemic is the unprecedented increase in orphaned children, with many more becoming vulnerable in the process.

5. The Crisis of Orphanhood and Child Vulnerability

5.1. Orphan prevalence

As a result of the high HIV sero-prevalence rates, Lesotho faces a huge problem of orphanhood. However, the problem of orphan prevalence is compounded by the lack of a uniform method of accounting for its extent. Different agencies use different sources of information and thereby end up providing varying figures. The problems associated with the definitions used for orphanhood are well documented. The UN defined an 'orphan' as a child under the age of 18 who has lost either or both parents, and who lives in difficult conditions, which includes a lack of food and access to services and support (UNAIDS 1999; 2000; 2002; UNICEF; 1999).

This definition has been criticised on a number of fronts. It has been argued that while orphans, and in particular children orphaned by AIDS, do face some unique challenges, many of the areas of vulnerability that they face, such as hunger, being unable to pay school fees and poor access to health care services, are shared by other children living in poverty. Children who are not living with their biological parents even though they are alive may also find themselves in this category of non-orphaned yet vulnerable children (see Wilson *et al*., 2002; Bray, 2003; Croke, 2003; Giese *et al*., 2003; Meintjies *et al*., 2003; Skinner *et al*., 2005; Meintjies & Giese, 2006). Some argue that in the context of many African traditions, the concept of orphanhood, where it exists, is related directly to poverty (Wilson *et al*., 2002; Meintjies *et al*., 2003; Meintjies & Giese, 2006).

Regarding the prevalence of orphans in Lesotho, the 2006 Census of Population and Housing notes that there were 221,403 orphaned children in the country (BOS, 2007). This number indicated a 70% growth in the orphan population, as the 1996 Census estimated that there were 130,245 orphans in the country. It is not know how many of these children were orphaned due to HIV and AIDS. About 110,729 orphans were males while 110,674 were females. The age distribution of orphans reflects a much higher proportion of orphans for the age group 10–14 years. This finding is similar to other findings in the SADC region. Jooste *et al.* (2006) made similar observations in South Africa, as did Tsheko *et al.* (2007) in Botswana. Table 3 provides a breakdown of orphan prevalence by age and gender in Lesotho.

Table 3: Orphan prevalence by age and gender, 2006

Age Group	Male	Female	Total
0-4	13.6	13.9	13.8
5-9	24.7	24.7	24.7
10-14	35.6	35.5	35.5
15-17	26.1	26.0	26.0
TOTAL	110,729	110,674	221,403

Source: BOS, 2007 (Table 5.1, p. 80)

Orphans are categorised into paternal, maternal and double orphans. A maternal orphan is a child who has lost a mother, a paternal orphan is one who has lost a father, while a double orphan is a child who has lost both parents. According to the 2006 Census, paternal orphans accounted for 63.0%, while maternal and double orphans accounted for 16.6% and 20.4% respectively (Ibid.). Again, this pattern is observable across most SADC states (see Jooste *et al.* (2006) for South Africa, Tsheko *et al.* (2007) for Botswana and Mahati *et al.* (2006) for Zimbabwe). As BOS (2007: 82) observes, mortality seems to be affecting more males than females. This is attributable to the fact that males often indulge in risky behaviour such as excessive consumption of alcohol and mostly work in hazardous conditions, which make them prone to accidents and death. Moreover, males often do not seek health care service even when illness suggests they should.

Lesotho's immediate neighbour, South Africa, is equally grappling with the challenges posed by the AIDS pandemic. Between five and seven million people are thought to be living with HIV in South Africa (Shisana *et al.*, 2005; Department of Health, 2008). This represents about 11% of the total population (Shisana & Simbayi, 2002; Shisana *et al*., 2005; Shisana *et al*., 2009). As a result, there is an unprecedented increase in the number of orphaned children in the country. In 2002, the Human Sciences Research Council (HSRC) survey found that 8% of children aged 0-15 years had lost both biological parents (Shisana & Simbayi, 2002). This figure had risen to 11% in 2005 (Shisana *et al*., 2005), and 17% in 2008 (Shisana *et al*., 2008). In its 2003 report, UNICEF (2003) found that 14% of children in the Southern African sub-region were orphaned.

Despite the strength of extended family structures, the sheer number of OVC coupled with high levels of poverty have negatively impacted extended family care for OVC in Lesotho. A

study by WFP (2007), for example, found that these traditional safety nets were not coping due to poverty. Extended families and households caring for OVC were found to have suffered significantly from vulnerability and food insecurity compared to those without OVC. Indeed, as a result of AIDS and the generalised poverty situation in Lesotho, there are many more vulnerable children who have been abandoned or whose parents are too poor to provide adequately for them (Kimane, 2005; Khobotlo *et al*., 2009).

5.2. Vulnerable children

It is very difficult to provide accurate figures of the number of vulnerable children in Lesotho. This is due to a shortage of information, but most importantly it is due to problems associated with the definition of vulnerability that affects the number of children classified as vulnerable. The current agreed definition of a vulnerable child is very broad. The Government of Lesotho defines a vulnerable child as *"*any person who is below the age of 18, who has one or both parents who have deserted or neglected him/her to the extent that he/she has no means of survival and as such is exposed to dangers of abuse, exploitation and/or criminalisation and is, therefore, in need of care and protection*"* (MOHSW, 2005: 6). The Terms of Reference for the Situational Analysis of OVC highlights the broad scope of this definition and notes that it may mean that most children in Lesotho could be defined as OVC.

Many point out that a number of the qualifying attributes for vulnerability involve some subjective judgment as to the position of a child along a continuum (see for example Budlender & Nhenga-Chakarisa, 2010). Inevitably, this creates difficulties in arriving at estimates, especially as a single child may qualify as vulnerable on several grounds. No definite figures are available of vulnerable children in Lesotho.

5.3. Challenges faced by orphans and vulnerable children

Regional studies indicate that OVC face many problems. Many end up having to take on greater responsibility for income generation, food production and care of family members including siblings (UNAIDS, 2002). They face decreased access to adequate nutrition, education, basic health care, housing and clothing. The phenomenon of child heads of households force many to find employment or depend on the good will of neighbours and relatives to provide them with basic necessities such as food and clothing (Byrne, 2002). In

these households, girls are the ones who are often more likely to drop out of school than boys, as they frequently have to look after younger siblings and perform household chores. Other challenges include malnutrition, illness, abuse, child labour and sexual exploitation, and stigma (UNICEF, UNAIDS & WHO, 2002).

Studies conducted on the situation of OVC in Lesotho paint a similarly bleak picture (Sechaba Consultants, 1993; Ministry of Health and Social Welfare, 1999, 2001; UNICEF, 1999; UNAIDS, UNICEF, USAID & WFP, 2004). In the main these studies indicate that OVC face challenges such as:

- Increased malnutrition, particularly in children under five who miss out on breastfeeding due to the loss of their primary caregiver, and in children whose caregivers are frequently sick and unable to provide adequate food and time
- Increasing numbers of children heading households and who are forced to accept some means of employment to support siblings
- An increase in the number of children on the streets due to fragmentation of the extended family and traditional support systems
- Psychosocial trauma caused by loss of a parent or caregiver
- Loss of inheritance rights and dispossession
- Increase in children coming into conflict with the law as they seek out opportunities for survival
- Increase in children being abandoned
- Increase in dropout rates in schools, especially among girls, and denial of access to school due to lack of required fees
- Lack of parental guidance and supervision leading to increased vulnerability to abuse, exploitation and violation of rights, and high risk behaviour
- Discrimination due to stigma associated with being orphaned
- Children, and in particular orphans, not encouraged to participate in decisions affecting their future and well-being

It is further pointed out that in Lesotho children orphaned by AIDS face problems of poverty and stigma, and are often deprived of school fees, food, clothing and sometimes shelter by their guardians (Kimane, 2005). For example, children who have lost parents to AIDS also

suffer psychological scarring, and are vulnerable to physical, psychological and sexual abuse, exploitation, and violation of their basic human rights (Ibid.). On top of the trauma and poverty inflicted upon orphans by the loss of their parents, abuse and exploitation are increasingly disturbing occurrences. In addition, without the protection of parents, cruelty, transactional sex, cheap or forced child labour, early marriage, child rape and even coerced commercial sex are blighting the lives of younger people.

The MOHSW (2001) notes that children orphaned due to AIDS in Lesotho are more likely to lose rights over family property. MOHSW further indicates that where any property is left behind, it often gets misappropriated and abused by relatives. Girls are highly disadvantaged by the system. Social inequalities between males' and females' rights in inheritance matters are still common with males being given priority over females, as will be discussed below.

5.4. Care for orphans

The experiences of other African countries affected by the AIDS pandemic, such as Uganda (Ankrah, 1993; Seeley, 1993), Zimbabwe (Mutangadura, 2000; Foster, 2000; Foster *et al*., 1995; 1996), Tanzania (Nnko *et al*., 2000) and South Africa (Tamasane, 2009; Tamasane & Head, 2009) have demonstrated the indispensable role of extended families in providing care to children orphaned by AIDS. See, also, studies by Bicego, Rustein & Johnson (2003); Foster *et al.* (1996); Joint Learning Initiative on Children and HIV&AIDS (2009); Kuo & Operario (2007); Meintjies & Giese (2006); and Parker & Short (2009).

Several studies in Lesotho also point to deep involvement of extended families in providing care for orphans (Hunter, 1999; MOHSW, 2001; Byrne, 2002; Ansell & Young, 2004; Kimane, 2004; Parker & Short, 2009). Family care is in fact a preferred method of care for OVC in Lesotho. The care is often driven by compassion and socio-cultural norms. For example, Kimane (2004) notes that extended family members often feel obliged to care for orphans lest they offend ancestors, thereby inviting the ancestors' wrath. However, few details are available on the number of orphans cared for by relatives.

BOS (2007) points out that a proxy to the vulnerability of the children can also be obtained by analysing their relationship to the head of the household in which they live. This is due to the fact that children are rendered destitute after losing their parents as some are likely to

be taken care of by other siblings, grandparents, other relatives or non-relatives. Table 4 illustrates that paternal orphans were more likely to be cared for by a surviving parent than maternal orphans.

Table 4: Orphans by relationship to household head, 2006

Relationship to head	Paternal orphans	Maternal orphans
Head	0.3	0.4
Spouse	0.3	0.3
Child	55.5	44.1
Son/daughter-in-law	0.5	0.8
Grandchild /great grand child	29.7	35.0
Other relative	11.3	16.2
Other person not related	2.3	3.0
Total	139,366	36,804

Source: BOS, 2007 (Table 5.4, p. 84)

Worthy of note is the fact that a sizeable number of orphans were looked after by grandparents; this despite the fact that either the orphan's mother or father was still alive. These findings are common across most SADC states; see Tamasane (2009) for a detailed analysis of care patterns for OVC in South Africa. The emerging patterns across states are that paternal orphans are more likely to be cared for by the surviving parent than maternal orphans, indicating that men play little role in the upbringing of their children. Another common pattern is that grandparents are more likely to look after orphans than any other member of the extended family. Often, this role begins a long time before either parent dies. This suggests that interventions aimed at OVC should target households, in particular, households headed by grandparents (Ibid).

Where extended family members fail to take in orphaned relatives, orphans are forced to look after themselves, prompting a phenomenon that has been dubbed "child-headed households". However, in Lesotho, very few orphans were heading households they lived in – that is, 0.3% and 0.4% of paternal and maternal orphans respectively (see Table 4). Some of the challenges confronting child-headed households are serious security problems (MOHSW, 2001) and hunger (Byrne, 2002). Child heads of household often have to leave school in order to seek employment. It is usually girls from child-headed households who are likely to drop out of school.

Indeed, the problems faced by orphans in Lesotho bear testimony to the extent to which the rights of orphaned children are violated, as Kimane (2005) points out. It is worth noting that other children in Lesotho who live in poverty face similar challenges. However, the situation of orphans is exacerbated by the fact that they have lost their parents (UNICEF, 2001), hence their need for special attention in some instances.

6. Legislative Framework for Orphans and Vulnerable Children

6.1. Key laws, policies and statements regulating OVC

The magnitude of the problem of HIV and AIDS has rendered the traditional and contemporary social, economic and legal structures and remedies ineffective in catering for the needs of OVC (Kimane, 2005). The colonial-era laws such as the Adoption Proclamation Act of 1952 have become somewhat obsolete. In particular, the law makes it difficult for Africans to legally adopt African children. The Children's Protection Act of 1980 has also proved inadequate in protecting OVC. The Act is criticised for focusing predominantly on children in conflict with the law (Kimane, 2005: 5). Therefore, the law does not cater adequately for children without parental care, the abandoned, orphans, victims of violence and other forms of abuse and exploitation, children in institutional care, and those infected by HIV and AIDS.

In response, a number of measures have been adopted by the Government of Lesotho to address the AIDS crisis generally and its impact on OVC. These include, in the main, the:

1. Outcomes Declaration of the NA General Assembly Special Session on HIV and AIDS (2001)
2. UN General Assembly Special Session on Children (2002)
3. Maseru Declaration (2002).

Lesotho-specific OVC policy and strategic measures include the National HIV&AIDS Policy (2003), the establishment of the NAC, the administration of the OVC Survey (2003), the preparation of the Rapid Assessment, Analysis and Action Plan for OVC (2004), and the preparation and implementation of the OVC National Action Plan (2004).

Lesotho has ratified 19 of 22 international and regional instruments relevant to OVC (Kimane, 2005; Budlender & Nhenga-Chakarisa, 2010). Lesotho is also a signatory to the United Nations Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child, the International Labour Organisation Conventions 138 and 182 on the Minimum Age of Employment and the Elimination of the Worst Forms of Child Labour, the Convention on the Elimination of Discrimination Against Women, and the SADC Addendum

on Violence Against Women and Children. Table 5, below, lists some of the policies affecting OVC in Lesotho.

Table 5: Lesotho's legal instruments for OVC

Legal instruments for OVC	YEAR
Laws	
Administration of Estates Proclamation No 19	1935
Adoption Proclamation act no.62	1952
Intestate Succession Proclamation No. 2	1953
Deserted Wives and Children's Proclamation No. 690	1959
Child Protection Act No. 6	1980
Criminal Procedure and Evidence Act	1981
Labour Code No. 24	1992
The Constitution of Lesotho Order No. 5	1993
Education Act No. 10	1995
Sexual Offences Act No. 3	2003
Legal Capacity of Married Persons Act No. 9	2006
Bills	
Child Protection and Welfare Bill	2010
Policies	
National Social Welfare Policy	2003
Policy framework on HIV&AIDS prevention, control and management	2000;2002
National AIDS Strategic Plan	2002-2005
National Adolescent Reproductive Health policy- draft	2003
Youth and Gender Policy	2002
Youth Policy	1999
Strategic Workplan for Youth and Gender Policy	2002-2006
Poverty Reduction Strategic Paper (PRSP)	2003
Establishment of the Child and Gender Protection Unit, Lesotho Mounted Police Services	2003
National OVC Strategic Plan	2006-2011

Source: (UNAIDS, UNICEF, USAID & WFP, 2004; Budlender & Nhenga-Chakarisa, 2010).

The new Sexual Offences Act 2003 is a major milestone in protecting children and women against sexual offences (Kimane, 2005). The law clearly stipulates the following types of sexual offences as a compelled sexual act: an induced sexual act, the administration of a substance for the purpose of committing a sexual act, persistent sexual abuse of a child, child prostitution, procurement of child prostitution, and offering or engaging a child for purposes of committing a child sexual act.

The Children's Protection and Welfare Bill (which is yet to be considered by Parliament) has been hailed as a landmark piece of legislation (UNAIDS, UNICEF, USAID & WFP, 2004; Kimane, 2005). The Bill is aimed at addressing the shortcomings of the existing Acts as discussed earlier. The Bill's credibility has been greatly enhanced by the fact that the draft process has been widely regarded as highly consultative, in that it involved active participation by government ministries, development partners, non-governmental

organisations, communities, and children (Kimane, 2005). Kimane (2005) highlights some significant proposals included in the Bill. These include the fact that the Bill:

- Provides protection to OVC quite specifically – a reference which was hitherto absent in all child related legislation.
- Encompasses issues such as inheritance, adoption, fostering and prevention of abuse and exploitation.
- Makes specific provision for the protection of orphaned children and their estates; parentage, custody, guardianship and maintenance of children; protection of children who are trafficked or abducted; protection of children who abuse harmful substances; promotion and protection of children's rights to sexual and reproductive health information and protective devices and technologies; and protection of children in employment.
- Further accommodates children in "difficult circumstances" that were excluded by the old Act, such as children on the streets; children with disabilities; children infected and affected by HIV and AIDS; and children who need special protection, including substance abusers, child labourers, and children born out of marriage.
- Has also done away with the discrimination of Africans in the Adoption Proclamation Act of 1952. It has clearly stipulated procedures of adoption and has provided for all interested people to do so following the said procedures.
- Has given authority to traditional institutions like chiefs and other relevant societal structures such as churches and NGOs.
- Has accommodated children's rights to legal representation, sentencing and conditions, appeal and review.
- Has looked into the development of case standards for social welfare by care institutions, and for monitoring and evaluation.
- Has also promulgated standards regarding registration of these care institutions.

Indeed, Lesotho ranks among many other SADC member states that have existing policy and legislation that relate to the rights, protection, care and support for children (Save the

Children, 2006)[1]. The process of reviewing and revising these policies and legislations to reflect the Charter on the Rights of the Child and current international standards and to address the challenges posed by HIV and AIDS were at varying stages in each of the countries. All the countries under the study by Save the Children (2006) had ratified the UN Convention on the Rights of the Child, Convention on the Elimination of Discrimination against Women, and International Labour Organisation Conventions 138 and 182 on the Minimum Age of Employment and the Elimination of the Worst Forms of Child Labour. These countries include Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Moreover, all countries included in the study had signed the UN Declaration of Commitment on HIV and AIDS. This convention emphasised that the vulnerable must be prioritised in the response to the epidemic. Despite having a reasonable legislative and policy framework, serious challenges confront Lesotho. These are outlined below.

6.2. Key challenges facing the legislative framework for OVC

Despite the existence of acts and policies to cater for the needs of OVC, there are a few gaps that emerge from the literature. UNAIDS, UNICEF, USAID & WFP (2004); Kimane (2004, 2005) and Budlender & Nhenga-Chakarisa (2010) have identified the following weaknesses:

1. **Lack of regulation of OVC structures and institutions**. There is no legal provision for key institutions or structures relevant to OVC's care and protection, while social workers lack statutory authority to handle social protection matters.
2. **Lack of implementation measures.** In practice there remains an inconsistency between observance and application of laws protecting OVC's needs. Very often customary law prevails amid strong resistance to contemporary laws. There is also a general lack of awareness of the existence of laws which protect women and children. It is also observed that there is still a need for greater political commitment and specific allocation of resources to improve OVC's welfare.
3. **Little provision for socio-economic rights.** It is further noted that there is far less legal provision for the socio-economic rights of OVC such as those of health and

[1] Save the Children UK study on the Legal and Policy Frameworks to Protect the Rights of Vulnerable Children in Southern Africa looked at Lesotho and nine other SADC States. This report is valuable for a detailed analysis of OVC legislative framework in the sub-region than the space would allow in this report.

health care, social security, and adequate standards of living. According to Budlender & Nhenga-Chakarisa (2010), the Constitution suggests that such rights are not justiciable.

4. **Lack of advocacy on OVC rights.** There still needs to be intensive advocacy at community level to ensure that laws are effectively translated into practice. The situation is exacerbated by the fact that civil society in Lesotho is relatively weak (Budlender & Nhenga-Chakarisa, 2010), implying that that there is limited advocacy work done on child rights. This points to the need for increased sensitisation and advocacy to make full use of enacted laws and policies in place.
5. **Dualism of legal system.** As Budlender & Nhenga-Chakarisa (2010) point out, the Constitution, legislation and case law of the country do not clearly regulate the ways in which, and the extent to which, human rights principles are to be applied to customary law, or even which law takes precedence over the other. As a result, the courts in Lesotho have little legislative guidance when called upon to resolve sensitive problems which relate to consent to marriage, ages of adulthood, and methods of discipline, inheritance and child labour.

This dualism has impacted on the law reform process in Lesotho. The Child Protection Bill is yet to be enacted ten years since its first draft in 2001. The delay is attributed to the disagreements between traditionalists, law makers and other stakeholders over its provisions in respect to consent to medical treatment, access to contraception, corporal punishment and the right to know one's parents (Budlender & Nhenga-Chakarisa 2010).

7. Services for Orphans and Vulnerable Children

The DSW in the MOHSW is the government focal point for OVC. Budlender & Nhenga-Chakarisa (2010) note that the main funders of OVC projects were Catholic Relief Services, the European Community (EC), the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the International Federation of Red Cross, Lesotho Save the Children, PEPFAR, UNICEF, WFP and World Vision International. However, the Government remained the largest funder of OVC in all years, with the EC as the largest international funder from 2010 onwards. Furthermore, the Global Fund is regarded as the most important contributor throughout the period 2008-12. PEPFAR's contribution for OVC is expected to continue to be substantial from 2010 onwards. As will be elaborated below, the DSW and other service providers provide a limited scope of services, such as access to medical care through fee waivers, provision of food and formula to orphaned infants and children, bursaries for secondary school students, and in some cases clothing and blankets. Table 6 lists some of the services provided to OVC in Lesotho:

Table 6: Types of support for OVC services in Lesotho

Implementers/Collaborators				
Type of Support	**Nat'l NGOs/ Faith-based Organisation**	**International NGOs**	**Government**	**Donors**
Food	6/3	2	Office of the First Lady, DMA, MOE	WFP,UNICEF[2] UNAIDS,FAO, GF
Education	6/6	3	MOE, MOHSW, Office of the First Lady, MGYSR	EU, World Bank, UNICEF, UNFPA WHO, WFP, GF
Health	9/6	2	MOHSW, MOE, MOA, MGYSR, MOLG	EU, UNICEF, WFP WHO, UNFPA UNAIDS, GF
Psychosocial	7/4	3	MOE, MOHSW (DSW), MOHA	UNICEF GTZ, GF
Financial	9/3	2	MOHSW (DSW), MOE Office of the First Lady,	EU, Ireland AID Bristol-Myers Squibb UNICEF,FAO, GF
Protection	0/1	1	MOE, LLRC, Ministry of Justice, MOHSW, CGPU, MOHA, DMA	UNICEF, WFP, UNFPA, GF
Other	6/1	4	MOHSW, MGYSR, DMA	UNICEF, UNAIDS/UNF, GF

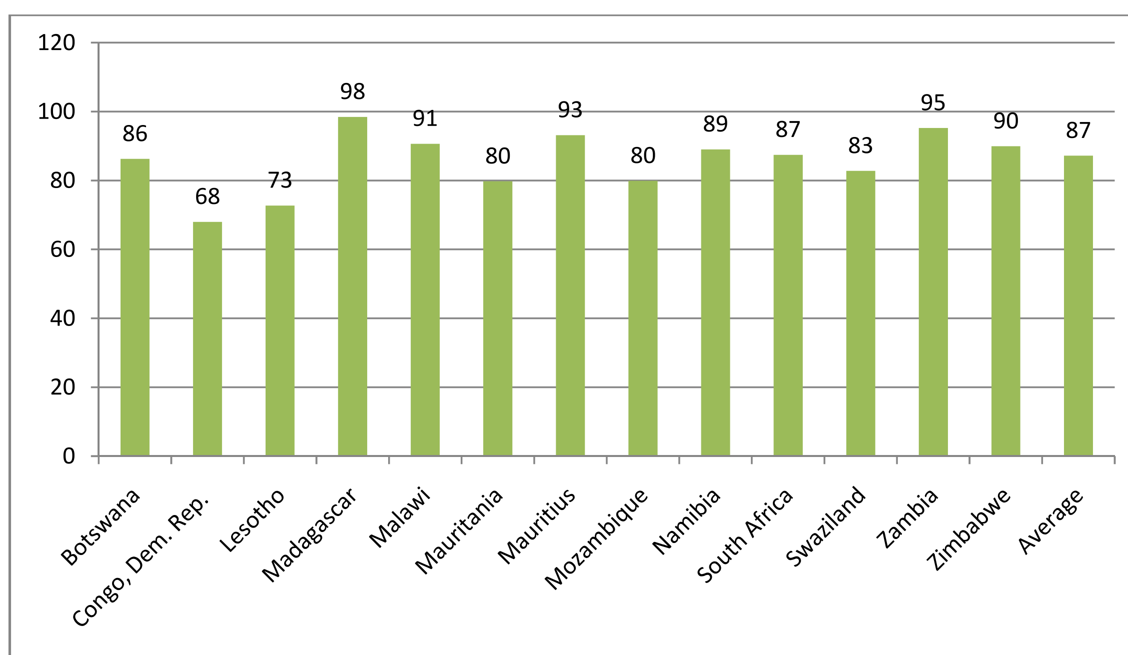
Source: (UNAIDS, UNICEF, USAID & WFP, 2004).

[2] Since UNICEF functions as both collaborator and donor for some organizations, they sometimes appear in both categories.

7.1. Education

Along with food aid, health and welfare services, education receives the highest attention in Lesotho. In 2001 the Government introduced a free primary education scheme starting with the first Grade, increasing each year up to Grade 6. However, enrolment rates at this level are still low by the SADC region's standards. Along with the Democratic Republic of Congo, Lesotho had the lowest enrolment rates in 2009 – that is, 68% and 73%, respectively (see Figure 4). Nevertheless, more girls than boys were enrolled in primary school in 2009 - 74% and 71% for girls and boys respectively (World Bank, 2010).

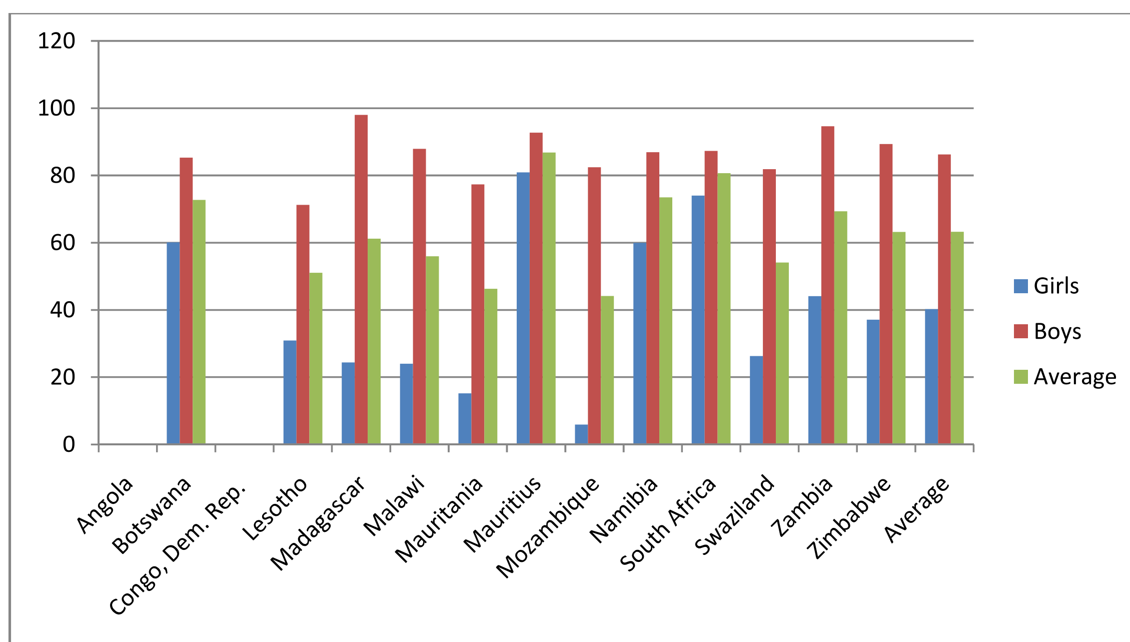
Figure 4: Rates of primary school enrolment in Lesotho in 2009



Source: World Bank (2010)

Enrolment at secondary school is particularly poor. Net enrolment rate for this level of education was estimated at 51% in 2009. This is less than the average SADC enrolment rate by more than a tenth. Figure 5 illustrates this. A striking finding is that significantly more boys than girls were enrolled in secondary school, with a 71% and 31% split. This trend was similar throughout the sub-region, with 86% of boys signed up at secondary institutions and only 40% of girls. Studies indicate that schooling of children is usually severely affected by the death of either or both parents. For these children, their education is usually compromised even before the parents die (Kimaryo *et al*., 2004; UNICEF, 2001).

Figure 5: Secondary school enrolment in the SADC region by gender in 2009



Source: World Bank (2010)

Kimaryo *et al.* (2004) found that with a dramatic decline in household income, children are often withdrawn from school as households can no longer cover the costs of school registration. The children themselves are needed to generate income or to stay at home to care for their parents. Girl children are especially affected by this (UNICEF, 2001; 2006; Lesotho Red Cross, 2006).

7.2. Health

Lesotho is divided into 18 Health Service Areas (HSAs) following the adoption of the Primary Health Care strategy in 1979. The focal unit of an HSA is a hospital. Ten of the 18 HSA hospitals are owned by government and the rest by member organisations of the Christian Health Association of Lesotho (CHAL). Through government owned hospitals, all children can access free routine EPI services while in CHAL hospitals children are still required to pay fees. Furthermore, through government and UN (UNICEF, WHO) assistance, all children are eligible to receive free immunisation. National Immunisation Days implemented annually ensure coverage for the majority of the population, even though at times it is difficult to reach the mountainous areas of the country (see UNAIDS, UNICEF, USAID & WFP, 2004).

It is noted that OVC receive limited attention when it comes to access to health services (UNAIDS, UNICEF, USAID & WFP, 2004). They, like the rest of the population, depend on the very limited availability of medical care. The public health care infrastructure is weak and overstretched in Lesotho, and capacity is very low.

Non-governmental organisations have included health care services as an important element of this work, providing, for example, vitamin supplements, routine health care, and reproductive health and HIV prevention information. Often organisations supplement existing government services or provide their own. There is a large variation concerning the level of comprehensiveness of the services offered.

7.3. Counselling and psychosocial support

Counselling and psychosocial support for OVC is also limited and mainly provided through NGOs, FBOs and CBOs. There is no standard curriculum or training and efforts are ad hoc. The Rapid Assessment, Analysis and Action Planning Report (UNAIDS, UNICEF, USAID & WFP, 2004) notes that interventions to promote well-being include the use of "memory books" to sustain the child's link with the deceased parents and to help maintain their identity. Teachers at primary school level have also reportedly received training from MOHSW to include psychosocial support. The use of play therapy to deal with issues such as grief and abuse are also in operation. All these efforts have yet to be scaled up to national level. In collaboration with the Office of the First Lady, the DSW has also supported capacity building of staff within non-governmental organisations that are providing psychosocial care for traumatised children and care of young infants.

Nevertheless, it is generally argued that the availability of psychosocial services remains very limited and inadequate to deal with the long-term psychological trauma resulting from caring for dying parents and the grief following their passing away (UNICEF, 2002). The same mental stress also affects the children's performance in school and increases their chances of dropping out (Kimane, 2004).

7.4. Other services

Nearly all NGOs and a number of government agencies provide support to OVC in the form of clothing and other basics such as shelter (or material support to shelters such as blankets, soap and other essential toiletries). As Budlender & Nhenga-Chakarisa (2010) note, the fact

that these goods must be paid for by agencies external to families is indicative of the degree of poverty in Lesotho. Budlender & Nhenga-Chakarisa (2010) further note that most children who are vulnerable live at subsistence level and are often outside the reach of the cash economy, leaving them entirely dependent upon external support for items as basic as a change of clothing. Often communities can stretch profits derived from a harvest, land, or their own labour to support an extra child, but finding requisite cash for clothing and other basic essentials seems to be a challenge in Lesotho.

Despite a track record showing commitment to responding to the situation facing OVC, the Government of Lesotho has been severely hampered by limited funds and personnel. While the MOHSW is mandated to provide care and protection for OVC, both the Ministry and the Department of Social Welfare are compromised due to significant financial constraints and severe understaffing. In the face of those limitations the DSW must collaborate with nongovernmental programs and institutions for the provision of many of the services they are charged with providing.

8. Civil Society Services to Orphans and Vulnerable Children

There is considerable involvement of civil society in the provision of services to OVC in Lesotho. This section provides a rudimentary list of partners, from development partners to international NGOs, faith-based organisations and providers of institutional care.

8.1. Development partners

In Lesotho, HIV and AIDS-related initiatives including those targeting OVC are presently implemented through Government, as well as through networks of People Living With HIV and AIDS (PLWHAs), NGOs, the UN, CBOs, FBOs, and professional organisations such as those of lawyers, doctors and teachers (Kimane, 2004; UNAIDS, UNICEF, USAID & WFP, 2004; Budlender & Nhenga-Chakarisa, 2010). This is done with the support (financial and/or technical support) of development partners. Some of the development partners include:

1. **UNICEF,** a UN agency that supports most aspects of services to OVC. These include support of the current consensus-building process necessary to form an OVC task force, to develop an OVC policy, and to design an OVC strategic plan.
2. The **World Food Program,** which has been particularly active in Lesotho since 2002 when a severe decline in rain worsened the chronic drought and severely threatened food security.
3. **The GFATM,** or Global Fund, which assists OVC activities through a grant supporting general HIV and AIDS activities that was initiated in 2003. The Fund has so far awarded four grants, with the fifth grant in the pipeline. This grant will focus on activities related to the sixth thematic area of the National Plan for OVC, namely OVC access to essential services. According to Budlender & Nhenga-Chakarisa (2010), the main activities envisaged are fee exemptions for OVC for all essential services, life skills and vocational training, administration of anti-retrovirals and treatment of opportunistic infections, provision of appropriate shelter and safety centres, community-based support initiatives, food security and nutrition programmes, school material, uniforms and fees, support for school enrolment for girls, transport, hygiene supplies, psychosocial care and supplementary food support for out-of-school youth.
4. **PEPFAR,** whose main focus is on HIV/AIDS prevention, with some funding available for treatment, care and support, and a very small amount for impact mitigation.

5. **The European Commission,** which concentrates on impact mitigation, with a small amount for treatment, care and support. The EC plans to continue to support the existing €12 million OVC project that is being implemented by UNICEF over the period 2007-11. As from April 2009, this amount was being used, among other things, for cash transfers to households caring for OVC.
6. The **Department for International Development (UK)** which focuses on impact mitigation, with smaller funding amounts available for prevention, supportive environment and in-country technical assistance.

8.2. Civil society organisations

Civil society organisations active in Lesotho include international and national NGOs, FBOs and CBOs. The regional literature recognises that communities across Africa are responding to the impact of HIV and AIDS on children with innovative informal, small-scale, voluntary and reciprocal support systems, particularly in rural areas where traditional customs and structures are maintained (Foster, 2005; UNAIDS, 2005; Foster, 2002; Phiri, Foster & Nzima, 2001; UNAIDS, 1999; UNICEF, 1999). They spontaneously organise themselves as "backstops" or "safety nets" protecting children affected by poverty and the AIDS epidemic (JLICA, 2009:27). In most AIDS-affected communities, endogenous responses tend to precede assistance provided by external agencies (Foster, 2005). However, some endogenous community responses may also evolve into community-based but externally facilitated structures.

A few interesting models of community care for OVC in Lesotho appear in the literature. However, information about quality and cost of services, pertinent in assessing cost effectiveness and sustainability, are not readily available.

There are also a number of FBOs providing services in Lesotho. They have proven at both local and national levels in Lesotho to be extremely effective in tackling the manifold effects AIDS has on children's lives (Mathambo & Richter, 2007; Mathambo *et al.*, 2009). FBOs provide services such as the provision of religious support, material and educational assistance, HIV prevention, home visiting and counselling. Like CBOs, FBOs do not only target children, they work with families as well. Most importantly, since FBOs are prevalent

throughout African communities (World Conference of Religions for Peace & UNICEF, 2004), they can be easily accessed by communities and development agents.

In Lesotho, the main focus of FBOs has been to support OVC initiatives that seek to bolster institutional approaches, such as residential care of abandoned or orphaned children, care for HIV-positive children, and support of hospitals and clinics providing special services to OVC. They also support youth group information, education and communication (IEC) activities that inevitably include children affected by HIV. Others support community efforts to care for children, including provision of food, school fees, and life skills training.

8.3. Institutional care

Institutional care in Lesotho is not particularly popular. This is due to the fact that community-based care is the most preferred method of caring for orphans. Financial constraints, too, play a pivotal role. Institutional care is mostly offered by the private sector, most often by religious organisations. The OVC Rapid Assessment Analysis and Action Planning (UNAIDS, UNICEF, USAID & WFP, 2004) highlighted the following:

1. **The SOS Village** serves 100 children using a family-based model of care. Children live in households of 10 each, and have a guardian living in the home with them. A youth hostel for children deemed too old for the children's villages was recently established. In the hostel setting, efforts are focused on ensuring that youth have some protection and guidance as they gradually progress towards independent living as adults. SOS maintains a clinic and a centre for preschool children; the clinic and centre serve targeted orphan beneficiaries and the surrounding community. This inclusion and mixing of orphaned and other children from the community serves to lessen stigma and can help integrate orphans into the larger community.
2. **The Centre for the Poor and Less Privileged** is operated by the **Sisters of Charity of Ottawa** and serves orphans and other displaced children. The centre functions as a referral site for the Department of Social Welfare and police, providing care and support for abandoned children until they are placed in homes. It also collaborates with the local schools to offer mainstream education for their clients/children.
3. **Mantsase Children's Home** was founded by missionaries and was preserved from collapse by a cooperative effort, spearheaded by a social worker from the

Department of Social Welfare, along with the surrounding village community, and in partnership with district business leaders (from Mahale's Hoek). A collaborative task force or committee comprised of each of these stakeholders oversees the project.

4. **Beautiful Gate Care Centre** is a non-profit ministry south of Maseru that provides a full continuum of care for HIV infected orphans, including abandoned children ages two months to six years old. To date, over fifty children have been cared for at the centre; a dozen have been adopted; six are in the process of adoption; eight have been reunited with their families; and five have died of AIDS-related illnesses. The centre includes pre-school facilities where older children are taught Sesotho vernacular, English, art, and arithmetic. The centre also established an innovative programme serving community care providers that includes provision of food supplies and training opportunities. It is funded by **Bristol Myers Squibb**.
5. **The Tin Can Village** currently provides food and counselling to orphans in the village of Phomolong and is also about to open an interesting model referral centre targeting orphans. Described as a "community resource centre", it will offer health and education services, shelter, training in garden and crop management, and an after school program. It is funded by **GTZ,** which is planning to expand this model "resource centre" to other districts.
6. The **Charity Hospital OVC Centre** funds a "support centre" for OVC in the community, providing life skills training and food security. The hospital also identifies out of school children and provides for education-related necessities, such as school fees and uniforms.

8.4. Challenges facing civil society's provision of services to OVC

Notwithstanding the role played by civil society in Lesotho in filling the void of providing essential services to OVC, a number of problems hamper their well-intended efforts. First, there is a serious lack of coordination of services in Lesotho. Despite the existence of structures such as the NAC and the National AIDS Secretariat, which aim to coordinate AIDS and OVC programmes, there is very little coordination taking place. Related to the lack of coordination is the lack of an effective and coordinated monitoring and evaluation (M&E) system. In the absence of operational M&E, it is difficult to measure the extent of success and to identify areas of improvement.

The third problem is that the majority of civil society relies on external funding from (mostly international) donors such as DFID, AusAID, and USAID. This has serious implications for accessibility and sustainability. Funding involves an elaborate application process which by default has the potential to exclude other equally key services providers, especially local structures with less educated staff and management. Funding is also tied to a specific term. There is always anxiety over where money will come from next. Related to the above, most civil society organisations operate on a shoe-string budget. This hampers efforts to reach many needy children.

Shortage of qualified staff, especially in the areas of counselling and financial management, is another hindrance. Most local NGOs/CBOs/FBOs are run by volunteers, the majority of whom have none of the required skills to manage donors' funds. Psychosocial support has been identified as the main service lacking in Lesotho. There is a serious shortage of qualified counsellors both in civil society as well as the public sector.

Indeed, civil society initiatives need to be properly accounted for. This could be done through effective coordination, and monitoring and evaluation. To achieve this, the Government of Lesotho needs to develop an effective database to keep track of who provides which services and where. The Government of Lesotho also needs to effectively regulate the activities of civil society. Failure to regulate civil society involvement with vulnerable children could expose them to further potential vulnerability through exploitation of various forms – financially, emotionally or physically. Other SADC member states have set the trend in this regard in terms of guarding against such situations.

In Namibia, for example, civil society initiatives are coordinated within the Ministry of Gender Equality and Child Welfare. All NGOs/FBOs/CBOs providing services to OVC do so in partnership with the Ministry through its national or regional offices. This practice, while not perfect, has gone a long way in eliminating duplication of services to OVC (Roberts *et al*., 2009). Regarding regulation of civil society initiatives, the South African Government provides legislative guidelines through the Non-Profit Act. In addition, a number of policies have been developed to regulate organisations' activities and to provide guidance. These include the White Paper on Social Welfare (1997), Guidelines for Establishing Child Care Forums (2003), Policy Framework for Orphans and Other Children Made Vulnerable by

HIV&AIDS (2006), National Norms and Minimum Standards for Home and Community-based Care (HCBC) and Support Programmes (2007), the HIV and AIDS and STI Strategic Plan for South Africa, 2007-2011 (2007), and the National Action Plan for OVC (2009-12).

9. Conclusion

In addition to being one of the smallest countries in southern Africa, Lesotho is a poor country and has the third-highest HIV and AIDS prevalence in the world. More than 60% of Basotho live below the poverty line. Nearly a quarter of Basotho are infected with HIV. One of the social repercussions of the high rate of HIV and AIDS infection is the resultant high number of orphans and vulnerable children. Fifteen percent of children below the age of 18 are orphans in Lesotho. AIDS accounts for 80% of all cases of orphanhood in Lesotho. In this, Lesotho shares similar problems with its fellow SADC member states, but in general has fewer resources to respond. The Southern African region is the epicentre of the AIDS pandemic, as it has the highest prevalence of the epidemic globally and accounts for more than the combined number of cases of HIV elsewhere in the world. The ubiquitous poverty in Lesotho constrains both the government and the community to provide adequate services for OVC.

Largely as a result of regional and international pressures, protection for OVC has received heightened attention in Lesotho. The Government of Lesotho is either signatory to or has ratified a number of international and regional treaties and charters on the protection of OVC. However, the legislative framework does not make adequate provision for the protection of OVC. This is largely due to the fact that most legislation is old and therefore outdated. One example is the colonial era Adoption Proclamation of 1956, which is still in force. Efforts are underway to remedy the situation through the Child Protection and Welfare Bill, but this has been under discussion for almost a decade. In this regard, Lesotho trails most of its fellow SADC member states. Countries such as South Africa and Botswana have made noticeable strides in respect of policy provisions and direction for the protection of and promotion of the well-being of OVC.

A myriad of services is offered to OVC by government ministries, donor organisations, development partners, NGOs, FBOs, CBOs and, sporadically, by individual members of communities. However, there is no systematic mechanism to establish who is doing what and where. Subsequently, there is no effective coordination of OVC services, despite the existence of a database of service providers in the country. In addition, there is no systematic monitoring or evaluation of OVC services in the country. There is also no policy provision to guide NGO/FBO/CBO programmes. Finally, there exists no coordination body to

see to it that services provided are of a required standard and are ethical in approach and content. As a result, there exists duplication of services.

Services provided include educational support in the form of school fees and school uniforms, food parcels to combat hunger and malnutrition, access to health services by a waiver of user fees, aid for income-generating projects, and financial assistance in the form of grants. However, the reach and impact of these services cannot be ascertained due to the limitations discussed above. Finally, the services provided to OVC focus overwhelmingly on material assistance; there is little by way of psychosocial and emotional support.

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