A New Start for Men

Evaluating Population Services International’s HIV Counseling and Testing Program in the Kingdom of Lesotho

A Capstone Report by
Maya Bahoshy
Taylor Napier-Runnels
Liz Sampson
Emma Schmautz

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Executive Summary

This case study was conducted as a capstone to our graduate studies in international development at the Elliott School of International Affairs, at the George Washington University. It sought to examine whether changes made to an HIV program implemented by Population Services International (PSI)/Lesotho were successful in increasing the number of men ages 25-34 who utilize HIV testing and counseling services, with a further emphasis on reaching the positive men in this age group. The team analyzed reports written by PSI/Lesotho, conducted a series of qualitative interviews with program implementers in Lesotho and Johannesburg, did a quantitative review of client intake data collected by PSI/Lesotho, and observed outreach activities implemented by the program to document the changes and determine whether the program successfully reached more men in the target population.

The decision to focus on this group, as well as the changes to the social marketing strategy, based upon 4 P’s of social marketing - price, promotion, place, and product - were analyzed to further understand how the program changed to focus on this particular group. Based on the qualitative and quantitative data, the team determined that while the program was successful in reaching a greater proportion of men 25-34, it was not successful in reaching proportionately more HIV positive men in this group.

Several challenges were identified along the way, including the program’s ability to reach this specific population, which includes migrant workers living and working in neighboring South Africa, the mountainous terrain of Lesotho, PSI’s referral system that links people testing positive into the national care system, and the demands placed on the program by their external donors.
Lessons learned by the team include the recommendation that PSI/Lesotho should seek to strengthen its referral process and post-test counseling, maintain its positive relationship with both local leaders and national groups in the ministry of health, and continue to conduct additional formative quantitative and qualitative research.

**Background**

As of 2011, the WHO estimated that roughly 34 million people across the world are living with HIV. Sub-Saharan Africa bares the greatest burden of this disease, housing 69% of all persons with HIV (WHO 2012). With an HIV prevalence of 23.3%, Lesotho, a landlocked country in Southern Africa, contains the world’s third highest HIV prevalence for adults (UNAIDS, Khobotlo et al 2009). The epidemic in Lesotho is mainly driven by heterosexual transmission and frequent, multiple concurrent partnerships (MCPs) that occur both before and during marriage. In addition, low levels of male circumcision and lack of knowledge surrounding one’s HIV status contribute to the epidemic (Khobotlo et al 2009).

Multiple barriers impede HIV prevention, treatment and care within Lesotho including stigma, poverty, access to services, and cultural beliefs such as the notion that traditional healers can cure HIV. Providing HIV Counseling and Testing (HCT) is an essential component of HIV prevention and treatment, not only as an entry point for HIV services, but also in encouraging individuals to seek care for other diseases such as sexually transmitted infections. Research demonstrates that HCT can have a significant post-test impact on HIV positive individuals by convincing them to reduce risky sexual behaviors and seek treatment and care programs (Pedersen 2009).
In 2006, Population Service International (PSI)/Lesotho was awarded a grant by the Centers for Disease Control and Prevention (CDC) in five countries, Botswana, Lesotho, South Africa, Swaziland and Cote d’Ivoire with the focus of increasing the use of high quality HCT services in each country (Call 2011). PSI has worked in Lesotho since 2001 providing HIV prevention products and services, and since 2004 has managed HCT services in each of Lesotho’s districts through its *New Start* centers and mobile outreach programs. PSI is the largest HCT provider outside of the public sector in Lesotho, testing over 40,000 people per year through mobile outreach events and testing at static *New Start* centers (PSI 2011a). In 2009, PSI/Lesotho made a change in its HCT strategy, moving away from non-targeted service delivery for the general population, and towards targeted testing focusing on men ages 25-34. The decision to target men in this age group was based on evidence that showed this population exhibited high HIV prevalence, and was less likely than other groups to get tested and know their status. This case study aims to document and evaluate the changes that were made by PSI/Lesotho through their *New Start* testing and counseling program as they shifted from mass testing of men and women ages 12-49 to targeted testing of men ages 25-34. Additionally, this case study will provide an analysis of the successes and lessons learned during this change to help inform the decisions of programs looking to pursue a similar shift in their testing and counseling strategy.

**Methodology**

The findings in this study are a result of a qualitative and quantitative mixed methods approach. A document review was conducted, studying key PSI/Lesotho documents including quarterly and annual project reports to CDC, communication reports, the PSI DELTA marketing
summary and plan and other key program documents. Qualitative interviews were also conducted with relevant PSI staff in Washington, D.C., Lesotho, and PSI’s regional office in South Africa to determine how the change in targeting men was implemented, explore the challenges faced during this process, and discuss project successes. In addition, the research team conducted two site visits to both static and outreach facilities.

This study analyzed client intake data from three New Start centers, Butha-Buthe, Mafeteng and Maseru for November 2008 to 2012 to determine if the number of men ages 25-34 testing had increased; if there was an increase in the number of HIV positive men testing between 25-34; and to document if there were any changes to the client profile during this time period. The timeframe for the pre-intervention data is from November 2008 to April 2009 as the change in targeting was implemented in May 2009. Data after May 2009 is considered to be post-intervention data.\(^1\) It is worth noting that while PSI works in all 10 districts of Lesotho, the data analysis only contains data from clients in the districts of Butha-Buthe, Mafeteng and Maseru as complete data sets from the other districts were not available during the time of the study. The methodology plan was reviewed and approved by PSI’s internal review board, and it was determined that due to the nature of the research - a historical review of program outcomes - institutional review board (IRB) approval was not necessary.

**Limitations**

The quality and accuracy of PSI/Lesotho’s HCT data was a significant limitation to this study. Though the data recorded numerous indicators for the population utilizing counseling and

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\(^1\) The Capstone team redacted data from this report at PSI’s request due to the organization’s desire to keep data confidential and restricted to internal documents. The report the Capstone team delivered to PSI contains a full statistical analysis of the data and corresponding graphs.
testing services, missing data from multiple locations and time periods, inconsistency of
recording methods and the inability to account for repeat testers lead to an incomplete data
collection set.

Memory recall was another key limitation to the study. Many individuals who were
directly involved with the change in target focus have since left the program. For those who
worked for the program during the campaign change, remembering the rationale behind and
sequence to events that happened four years prior was a challenge. While the research team
attempted to find documentation for each aspect of the change, records were typically not
available and certain components of the study could only be based on staff recollections.

The research team was also unable to meet or correspond with donor representatives from
the CDC. While researchers attempted to recognize the position and views of the project’s donor
based on information gathered during document review and key informant interviews, input
directly from the CDC was not included in the study.

Lastly, the research team was working under a relatively short timeframe and is not
highly experienced with the language and culture of Lesotho. While strong efforts were made to
verify information gained from informant interviews with data and documentation and
crosscheck observations with multiple sources, rigorous verification for all points was not always
possible or feasible. Despite these limitations, the research team believes the case study presents
an accurate representation of the changes PSI/Lesotho underwent to target men ages 25-34 and
the effect of those changes.
Results

Deciding the Target Audience

PSI/Lesotho was prompted to reassess its HCT program following the release of the 2009 Modes of Transmission Study (Ramoseme & Fraser 2009), which stated that preventative activities were having limited success in affecting transmission rate. During this time period, PSI/HQ also conducted a literature review into post-test behavior changes. The research indicated that when HIV positive individuals received HCT services and learned their status, that knowledge led to a significant reduction in their risky sexual behaviors (Allen et al. 2003, Denison et al. 2008). Conversely, findings remained inconclusive for people testing HIV negative. Some studies even indicated that men who tested negative actually increased risky sexual behaviors including increasing the number of concurrent partners (Matovu et al. 2007, Sherr et al. 2007). Furthermore, the research also highlighted the important role of HCT services as an early referral and entry point to HIV treatment as well as care and support for HIV-positive populations (Pedersen 2009). Consequently, PSI/Lesotho decided to focus on ensuring that their HCT services were designed to target at-risk populations in an attempt to increase the yield of HIV-positive individuals.

Prior to this, PSI/Lesotho had been working to support the national Ministry of Health and Social Welfare (MOHSW) Know Your Status campaign. The goal of this campaign, ensuring that every individual in Lesotho had access to HIV testing services, led PSI/Lesotho to provide HCT services aimed at the population as a whole. However, upon monitoring and analyzing program data, PSI/Lesotho reached the conclusion that although the program was highly successful at providing HCT services to large numbers of people, the services provided were not reaching the population groups most at risk of new infections nor those with the highest
prevalence. These findings prompted the redevelopment of the HCT program and its social marketing plan.

The decision to focus on men 25-34 was based on a number of reasons. First, the HIV prevalence amongst males was very high (reaching 41.3% at age 30-34), with the highest rates of infection occurring within the age range of 25-34 (MOHSW 2005). Second, men are culturally the ones with the greatest influence regarding initiating sex and use of condoms within a relationship (MOHSW 2005). Third, men in this age group often act as the bridge of transmission to younger women seen by a similar trend in infection rates within women 5-10 years younger. Fourth, this age range matched with the average time of marriage, which itself has been linked to increased rates of MCP. Finally, this population was not typically seeking testing services, and therefore the majority did not know their status (MOHSW 2005).

Upon deciding upon this population, PSI/Lesotho updated its social marketing strategy using it’s DELTA marketing strategy to develop the project’s marketing mix based of the four P’s of social marketing - Product, Promotion, Placement and Price. (Price was later dropped because testing services are free clients and the remaining non-monetary costs were covered under the other three sections). The team used data from PSI/Lesotho’s TRaC 2008 and anecdotal information gathered from informal interviews with target audience members to develop the audience profile and guide the strategy. Results were also drawn from mystery client surveys, a tool created to evaluate the quality of service delivery and identify key aspects of service delivery that would required adjustment to better cater to the target population. The resulting social marketing plan formed the basis for many of the changes put in place in the following years, in order to better reach men aged 25-34 (PSI 2009a).
While PSI views DELTA as a useful social marketing planning tool, its effectiveness is highly dependent on the formative research. During this DELTA study, the majority of the profiling data used was extracted from the TRaC 2008 study – a general population survey of 1850 people (PSI 2009b). Of these, only 39% were male and only 27.9% of total sample fell between ages 25-34. Although the TRaC study suggested differences in the role of key determinants between males and females, the target audience of males ages 25-34 formed too small a sample to extract significant data about.

**Product: HCT Service Provision**

As testing and counseling services remained the main product of the New Start program, PSI/Lesotho sought to ensure that the provision of HCT services catered to the needs of the target audience. Based on the results from the mystery client surveys, the main points of concern were the quality of service delivery/counselor performance, the availability of male counselors and the stigma felt by men regarding visiting a testing site.

As all counseling and testing services follow standardized guidelines set by the MOHSW, PSI/Lesotho has focused on improving the quality of counseling through monthly refresher trainings. These trainings reaffirm the role of the counselors, emphasizing the importance of conducting complete, 45 minute long sessions, as well as the focus on men 25-34. In order to address the difficulties faced in recruiting and retaining male counselors, PSI is working with seven volunteers, three of which are men, with the aim of providing training and guidance so that they will eventually become full time counselors.

Although the trainings improve the counselors knowledge of best practice, it did little to address the concerns expressed by counselors regarding the pressure to shorten the counseling time to ensure that they can provide services to all those who want it. Current standards dictate
that a counselor should only test 10 -15 clients a day. However, during outreach visits, counselors feel obliged to ensure that all those seeking services are seen, often leading to clients testing up to 27 people a day. To reach more clients in a day, reports indicate that counselors may resort to group counseling or counseling during testing as opposed to before or after. While potentially increasing overall numbers of clients, both of these tactics can negatively impact the quality of counseling provided. A poor counseling session may decrease the likelihood of individuals remembering the messages, adopting healthy behaviors, and using the service referral to seek treatment.

PSI/Lesotho attempted to increase the attractiveness of testing at New Start centers by introducing a ‘4-in-1’ service that included blood pressure, BMI and blood glucose level testing along HIV testing as a way of destigmatizing services. This program proved unsustainable because many clients believed that they could request only one service as opposed to the whole package and chose to leave upon learning the service still required an HIV test. The package of services also appeared to bring in people of different population groups, such as older women, as well as those who already knew their status.

**Place**

During the decision to target men, PSI/Lesotho refocused the geographic reach and concentration of the New Start program to respond to the change in target and address additional external factors. From 2006 to 2009, five New Start centers were co-located within MOHSW clinics with mobile outreach occurring from these centers to each of the ten districts. The five centers were located in Butha-Buthe, Mafeteng, Maputsoe, Maseru and Qacha’s Nek with the mobile outreach occurring in Berea, Mohale’s Hoek, Mokhotlong, Thaba-Seka and Quthing, In 2009, MOHSW asked PSI/Lesotho to move out of the government clinics and set up their own
centers. This catalyzed the shift away from static centers towards increased outreach. This was partially due to an effort to more effectively reach the target population. For example, PSI moved the center at Qacha’s Nek to Quthing in 2010 because Quthing contained a larger population. Due to the no-cost extension in 2011, PSI/Lesotho was forced to close the two static centers in Maputsoe and Quthing as well as to limit the amount of mobile outreach conducted because arranging visits to rural areas proved costly.

In order to reach more men, PSI/Lesotho also focused on increasing mobile outreach. Other implementing partners did not often provide this service. Studies observed that generally men in Lesotho tend not to seek preventive care and only go to clinics when they are sick. In the words of one key informant, “the model of building health clinics and then they will come does not work with men.” To improve the numbers of men testing, PSI/Lesotho felt that mobile outreach would be more effective. Since the MOHSW also provides HCT services within its static sites, PSI/Lesotho believed that the move to increase mobile outreach would complement rather than compete with the Ministry’s activities.

As part of the efforts to target more men, PS/Lesotho became more strategic in outreach locations, focusing on identifying locations where they knew men congregated. PSI/Lesotho worked directly with companies as well as relevant ministries, to coordinate and provide HCT services within the workplace, targeting the construction, mining, forestry and garment industry. PSI/Lesotho also targeted areas where men congregate including taxi ranks and marketplaces, and also provided services in the prisons. This strategy proved beneficial not only for PSI/Lesotho, but also for the companies themselves as it helped organizations fulfill their requirements under the national labor code that requires every employer to meet standards for HIV/AIDS workplace policies and programs (Ministry of Trade and Industry 2006). By focusing
on men at workplaces PSI/Lesotho was able to mitigate the challenges involved with encouraging a mobile group of men who frequently migrate for work to test.

Prior to the change in targeting, PSI’s mobile outreach was not organized in terms of what location staff would be visiting to provide services. This led to limited coordination with different district level stakeholders. Often times mobile outreach teams would show up at the districts and speak with the hospital matrons or village chiefs about where they were able to go and test. Many times, though, outreach teams neglected to consult sufficiently with other stakeholders about whether testing services were recently provided in that location by either the government or other organizations. There were also no scheduled routes that the mobile outreach would undertake each month. Several key informants mentioned that the mobile units would travel wherever they wanted each day with little planning or strategy. With the refocusing on mobile outreach, changes were implemented to better reach men within their target group and focused on more strategic placement of services.

To be more selective about service placement, greater emphasis was given to tracking the locations that both field educators and HCT counselors frequented. This mapping became more critical once HCT mobile sites began coordinating their outreach visits with those of the field educators. Field educators began conducting outreach activities at a location one week before HCT counselors arrived to mobilize communities and increase the number of men interested in receiving testing services. To assist with tracking targeted communities, both field educators and HCT counselors are responsible for planning out the different areas they will be working in over the course of the month and getting the route approved by their supervisor. This advanced planning allows site managers to obtain a deeper understanding of the communities being reached and make better decisions regarding future follow-up visits. More recently, PSI/Lesotho
began using GPS and geographical information systems (GIS) to further track where mobile outreach is conducted. The GIS mapping assists with organizing and planning for follow-up visits as well as collecting location data for monitoring and evaluation.

As a part of the changes in both targeting men and tracking the placement of services, better planning and coordination occurred with District Health Management Teams (DHMTs) and district level representatives of the MOHSW. The stronger coordination helped determine when and where mobile outreach and testing services could be provided. Increased communication between relevant stakeholders at the district levels has helped PSI better reach their target group with HCT services, and ensured that services are welcome and available on a more regular basis. The additional coordination also assists in demand creation for HCT services as the DHMTs and local chiefs can promote these services and encourage people in their communities to test. Finally, the DHMTs also help PSI/Lesotho identify the location of local clinics, which is essential when creating a referral for clients who tested HIV positive. Becoming more strategic in the placement of services in concert with increased coordination efforts with relevant stakeholders helps the program reach its goal of targeting men ages 25-34.

Promotion

When PSI/Lesotho chose to target their HCT services towards men age 25-34, they acknowledged that the need for demand creation was crucial. Past experience indicated that men in this age bracket were often those least likely to seek out services. PSI/Lesotho therefore developed a number of communication and promotion strategies targeted at increasing demand for HCT services among this audience. These consisted of both short-term community mobilization campaigns and ongoing interpersonal communication (IPC) activities.
Soon after the decision to target men ages 25-34, PSI/Lesotho launched a countrywide campaign based around a series of soccer tournaments called Test For Your Team. Implemented in coordination with the District Football Associations and the Lesotho Football Association, the campaign encouraged local teams to compete for two awards: winning the soccer tournament and having the most number of fans receive New Start HCT services during the tournament. PSI/Lesotho conducted community mobilization and promotion activities prior to the games to encourage local support for the teams, generate interest in the tournament and disperse HIV prevention messages. Promotion for the event also included extensive national radio coverage. During the games, field educators were present to provide IPC sessions and mobilize the supporters present while New Start counselors provided testing services. Those attending soccer events received additional promotional materials including t-shirts, vuvuzelas, lanyards and hats.

The first campaign ran as a pilot, from May 2009 to October 2010 in Mafeteng, Leribe, Butha-Buthe, and Qacha’s Nek. The success achieved in reaching men, as well as the popularity gained from the communities and partners, led to two subsequent competitions in 2010-2011 and in all ten districts in 2012.

Data published in the campaign’s report in 2011 supports the success of the campaign in reaching men, as indicated by the significantly greater number of men testing compared to numbers in previous years (PSI 2011b). However, despite the success, PSI/Lesotho staff noted that the vast majority of people receiving services fell below the target age group. It was observed that the target population of men aged 25-34 were less involved during the games, and often showed up later at events intoxicated, and therefore unsuitable to be tested.

PSI/Lesotho did attempt to alter the program to better target men aged 25-34. One adaptation included working directly with teams comprised of members from 25-34 age bracket.
However, because these teams were not as structured or widely supported, PSI was unable to develop an effective campaign. PSI/Lesotho also piloted a similar campaign for a snooker championship. While snooker, a sport similar to pool, is well enjoyed by the target audience, program pilots failed to achieve participation as strong as Test for Your Team. Due to this lack of engagement among the target group, the snooker campaign was subsequently dropped.

Despite the fact that Test for Your Team did not effectively reach the age target, it was well supported by PSI/Lesotho because it comprised a large proportion of those who tested throughout the year and helped PSI/Lesotho reach donor targets. However, in 2013 the decision was made not to renew the tournaments due to the low count of men in the target group and the large demand on resources.

*Be Like a Mountain:*

In November 2009, PSI/Lesotho launched its first large-scale, multi-channel campaign called “Be like a Mountain”. The campaign, based around the slogan “Tsitsa Joalo ka Thaba” (“Like the mountain, know where you stand”), drew upon the two main contributing factors to testing identified through the TRaC; self-efficacy to test and perceived social support (PSI 2009b). The campaign centered around three different events, hosted in six towns throughout Lesotho. The events focused on developing social support, encouraging community members to test with their friends and using a quiz show to highlight the strength of friendships.

The third event, “Lesotho’s Got Talent,” encouraged individuals and groups to perform their talent in front of an audience as a method of bringing in crowds. In addition to promoting demand for HCT services through promotion messages, field educators and New Start counselors were present at all events to offer educational and testing services to attendees. PSI/Lesotho used small-scale marketing techniques, known as “guerilla marketing,” to promote the three main
community events. This included widespread poster distribution, vehicle stickers and use of street teams to disperse information.

In addition to community events, the campaign used radio shows and advertisements along with large community mobilization events to deliver the behavior change messages (Be like the Mountain final report). The campaign diffused 60-second radio spots through two popular stations during the morning and evening to coincide with peak listening times of the target audience. In addition to the spots, PSI ran a weekly 30-minute variety show that incorporated several types of communication strategies such as discussions, call-ins, quizzes and expert speakers. This format appeared to increase engagement and participation from the audience, prompting them to send in their own questions regarding testing and the consequences of HIV/AIDS.

Data used in the Be Like a Mountain final report shows that there was an increase in both the number of people testing and, more specifically, the number of men seeking HCT services during this time (PSI 2010). However, the data available in the report fails to indicate what proportion of these men fell into the age target. The campaign was considered a success both in terms of increasing the number of men testing during that period and in using a combination of older and new approaches to promote HCT services. Although PSI/Lesotho expected to evaluate the program through the following TRaC study, problems surrounding the testing of specific messages and brand recall led to unreliable data and the effectiveness of the Be Like a Mountain Campaign was never fully assessed.

*IPC Toolkits & mobilization*

IPC is a key component of PSI/Lesotho’s strategy for creating demand among the population for HCT services. It focuses on delivering relevant information directly to target
audiences in smaller groups. The shift in target audience therefore required a change in the messages delivered during these sessions. As a result, PSI/Lesotho developed two IPC toolkits, each containing a set of activities catered towards the target audience. One kit addresses HCT promotion, while the other focuses on condom social marketing.

PSI designed the toolkits to address at least one of the key behavioral contributing factors identified through the TRaC 2008 study: social support for HIV counseling and testing, self-efficacy to engage in safer sex after counseling and testing, HIV risk perception when engaging in concurrent sexual partnerships, outcome expectancy regarding benefits of counseling and testing and the attitude and stigma of HIV that acts as a barrier to accessing HCT services. The toolkit activities and games encourage active participation and interaction to increase audience engagement and interaction with the information. This is further encouraged through guidelines restricting audience size to eight to ten people as opposed to the previous average of 50. In addition, PSI best practice recommends that each person should be exposed to at least four activities over time to lead to the necessary behavior change.

PSI/Lesotho uses teams of trained field educators to conduct the IPC sessions. While PSI/Lesotho’s model always used outreach activities, the new IPC kits are especially focused on a client centered, interactive approach that requires a more advanced skill set to facilitate. As a result, in December 2010 PSI/Lesotho introduced a more rigorous selection criteria for their employees. All new field educators underwent intensive training to ensure high quality performance. In addition, PSI/Lesotho increased monitoring and implemented spot checks on field educator outreach sessions. These efforts lead to an almost immediate improvement in outreach numbers and staff performance.
Although no formal evaluation measures the efficacy of the IPC kits, staff indicate that they have generally observed a positive response to the kits. Field educators noted that due to the interactive nature of the kits, men are more engaged in the information and contribute more to discussions.

Despite their success at increasing client participation, the toolkits also continue to present several challenges. One example includes the difficulty of generating repeat clients due in particular to the migrant nature of the target population. Efforts to address this problem include noting down the name and location of participants. Although problems of confidentiality arise, field educators generally feel that the training provided has allowed them to develop a rapport and trust with the group member. In addition, the restriction on the number of people per sessions led to a decrease in targets reached. Although these restrictions are in place to ensure quality of service, many field educators feel under pressure to reach targets. This pressure to achieve targets may inadvertently lead to field educators decreasing quality and time spent on activities in order to increase the amount of people reached in a day or at an event.

Challenges

The New Start program faced numerous challenges in attempting to increase testing numbers among men ages 25 to 34 as a means of finding positive individuals and reducing the overall incidence of HIV in Lesotho.

One overarching challenge the program encountered was the difficulty of reaching the target population, a group known to be reluctant about seeking out HCT services. Due to the continued stigma of HIV/AIDS in Lesotho, lack of social support, and fear of a positive result,
men ages 25 to 34 often avoid routine HIV testing. Men in this age bracket, especially day laborers, also often cannot afford to take time away from work to visit a testing site and do not see HIV testing as a priority.

Reaching migrant workers is another challenge because they are only in the country for a short period during the year and typically do not remain in one location long enough to receive regular treatment. It is estimated that each year, over half a million Basotho men migrate to South Africa for work in the mining, agricultural and garment factory industries, and many of these migrant workers fall into the target population (IOM 2010). In addition to being difficult to reach, this population experiences relatively low levels social support from families and partners who rarely see them. Fear of revealing their HIV status to their families and wives may lead some men from avoiding seeking HIV testing services altogether.

The geography of Lesotho also creates a barrier to increasing testing numbers in the target population. The mountainous landscape and poor road conditions in Africa’s “Kingdom of the Sky” makes travel to the interior of the nation difficult for outreach services. Due to lack of time and resources, New Start outreach services are only able to visit certain regions of the nation a few times a year.

The referral system is another major difficulty PSI/Lesotho faces in their attempt to reduce the incidence of HIV in Lesotho. Due to the challenges of keeping accurate client databases, it is estimated by PSI/Lesotho staff that only 18-20% of New Start clients who tested positive and are referred to government clinics for additional services are tracked. Furthermore PSI/Lesotho estimates that only 4% of those who test positive at New Start sites and mobile outreach events follow-up with the referral and seek additional services. (CDC2 Technical Narrative)
One reason for the lack in referral numbers is weaknesses of the referral tracking system that relies on cards to track individual’s patients. Positive clients receive a referral card during the counseling session that they are instructed to deliver to the clinic when they seek follow-up services. Clinic nurses then collect and process the cards for PSI/Lesotho’s client records. For a variety of reasons including lost cards, clients forgetting to bring the card or providing incorrect information for the card, as well as medical staff at the clinics neglecting to correctly process the card, many clients who do seek referral services are not properly documented.

To improve the organization’s ability to track referrals, in 2011 PSI/Lesotho hired referral coordinators for each static site and attempted to improve the coordination with nurses at MOHSW clinics to properly document referrals. Despite these good intentions, referral numbers continue to remain low due to clients either choosing to not seek additional medical care or clients providing false information in an attempt to remain anonymous. While referral coordinators attempt to contact referred clients via mobile phone and SMS to remind them of the referral and check to see if the client followed-up, many clients list incorrect phone numbers and are unable to be reached. Other men provide South African phone numbers, which are of little use to the PSI/Lesotho staff who can only refer clients to clinics in Lesotho. The high amount of South African numbers provided by clients highlights the need for further services that are accessible to migrant workers and increased partnership and coordination between PSI’s operations in Lesotho and South Africa.

The availability of treatment is another barrier to increasing referral numbers. While the government of Lesotho is able to provide treatment for individuals whose CD4 count reaches a high level, consistent availability of antiretroviral medications, especially in rural areas, is a relatively new development in Lesotho. Many individuals still hold the perception that treatment
is unavailable and cost prohibitive and therefore do not attempt to visit a clinic after receiving a positive diagnosis.

Even if a person does believe HIV treatment is available, distance, time, cost and lack of social support may prevent that person from seeking medical care. Rural villagers are often required to travel far distances to the nearest clinic and may not wish to take the time away from tending to their crops and livestock to make the journey on a routine basis to receive treatment. Stigma, confidentiality and perception of poor quality services are other barriers preventing men in rural communities from utilizing the local clinic near their village. To receive HIV treatment, government clinics require a patient to attend four pre-treatment sessions and on the fourth session the patient must bring a person who will serve as their support mechanism. According to PSI/Lesotho staff, reluctance to tell friends and family about their positive status in fear of being stigmatized prevents some clients from deciding to attend the clinic sessions.

Funding restraints that caused the closure of two static sites and resulted in limitation in mobile outreach also impacted the program’s ability to increase testing among the target population. The drawback of services in certain regions meant that men in those regions did not have a location to routinely access services. The lack of focus on these regions also decreased the amount of HCT events PSI/Lesotho holds, which are main drivers for mobilizing men ages 25-34 to use testing services.

Finally, while the project understood the necessity of targeting men ages 25-34, the pressure to reach donor expectations still remained. Because PSI/Lesotho shifted New Start’s focus from the general population to a narrow slice of the population, overall testing numbers decreased. This pressure to reach the CDC yearly target of numbers tested may have contributed to New Start continuing to holding campaigns such as Test for Your Team that generated high
testing numbers even though the data indicated such campaigns were not reaching the target population. Though the issue of the overall amount of individuals tested initially caused concern among the donor, both PSI and the CDC eventually came to the agreement that lower testing numbers were acceptable as long as the program reached the target population.

Lessons Learned and Recommendations

Through many hours of talking with PSI field office staff in the field and analyzing program documents, the Capstone team identified a number of lessons learned and corresponding recommendations for the New Start program and PSI/Lesotho. While the bulk of recommendations focus on improving data collection and better understanding the target population, the Capstone team also discovered a need for additional staff training, monitoring and evaluation resources and improved program systems in areas such as the referral process. Despite these observations, the Capstone team was impressed with the organization’s impact on the community, use of innovate marketing techniques, ability to achieve results while working in a challenging environment with limited resources, and the local staff’s dedication to the goal of reducing the incidence of HIV in Lesotho and raising awareness about disease prevention. The chart in Annex A contains a full list of lessons learned and recommendations.
### Lessons Learned

**Improving the rate of referrals is an important step to increase the amount of positive patients who seek medical treatment**

- Improve post-test counseling services to ensuring positive clients fully understand the implications of living with HIV and its impact on their health, learn how to effectively prevent spreading the disease to others, become educated about the services available to help them physically and mentally cope with HIV and inspire them to take the next step and visit a clinic.

- *New Start* counselors should receive routine training and evaluation to ensure they are delivering the correct messages and inspiring positive clients to take personal control of their HIV status and seek additional medical services.

**Accurately recording client tracking should be a key consideration in designing any HIV testing and counseling program.**

- While ensuring confidentiality, it is also essential to be able to track individual clients through using a code, number system or other means that allows for anonymity of identity.

- Streamlining the tracking process from when a client attends an IPC outreach event to when that same client receives HIV testing to following whether that client utilized referral services may be one method of improving overall accuracy of client tracking.

- Counselors should receive routine trainings on client tracking best practices including proper methods of filling out client tracking cards and ways of enticing clients to provide accurate information for referral follow-up.

**To enhance quality and efficiency of services, it is essential for PSI/Lesotho to continue working in close partnership with the Ministry of Health and other key stakeholders.**

- PSI should maintain a strong relationship with the national government to build the trust needed to launch a nationwide HIV/AIDS campaign and gain the support of local leaders and community champions. Developing a unified national vision for HIV testing and treatment will help all parties work together and engage in activities that complement each other’s efforts.

- Another partnership that PSI/Lesotho should continue fostering is with village chiefs. Without the support and endorsement of village chiefs and local leaders, *New Start’s* outreach services would likely fail to be successful in many
Men typically feel more comfortable using HCT services when these services are part of a larger event.

- Because data analysis indicates that the number of men seeking testing corresponds with the amount of events and outreach activities conducted, it is recommended that PSI conduct routine events in order to sustain continued interest and support in testing by men.

The assessment conducted during this case study indicates there is a need for additional formative and qualitative research to better understand the behaviors, motivations and mentality of the target population.

- To accurately design programs that will speak to this group and increase the amount of men ages 25-34 utilizing testing services, it is recommended that PSI understand more about where these men are located, how their daily lives operate, what goals and ambitions they hold, what fear they have and what influences their behavior among other points. By taking the time to thoroughly explore this group, PSI/Lesotho may be able to prevent launching costly and time-consuming campaigns that ultimately do not reach the target population.

To assess whether campaigns and programs are successful in achieving their goals and targets, better evaluation mechanisms for measuring program effectiveness are needed.

- PSI should ensure these evaluations are grounded in accurate and comprehensive data collection and not reliant upon on memory recall for information.

- Indicators needed for effective evaluation and methods of conducting assessments should be built into the design of the program from before the start of implementation.
Annex B. Works Cited


condom use and VCT uptake. Second Round.” PSI 2009b.


Population Services International. “Test for your Team Football Tournament.” PSI 2011b


Annex C. Additional References

**CDC Reports:**

PSI Proposal for CDC RFA 2006  
Technical Narrative, CDC RFA 2011  
CDC Annual Report Feb 2006- Jan 2007  
CDC Annual Report Feb 2009 – Jan 2010  

**PSI Internal Reports:**

New Start Test for Your Team Report, Aug 2011  
Final Report: Tsitsa Joalo Ka Thaba Men’s Campaign PSI Lesotho, 2010  
Lesotho Delta Marketing Plan Summary, 2009

**PSI TRaC reports:**

First Round

Lesotho 2008: HIV/AIDS TRaC Study examining consistent condom use and VCT uptake.  
Second Round

LESOTHO 2010: HIV/AIDS TRaC Study Examining Consistent Condom Use and VCT Uptake  
Among Men and Women, Ages 15-35 years in Lesotho. Third Round