

LESOTHO HIV STRATEGIC PLAN

2023 – 2028



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Table of Contents

Table of Contents.....	i
List of Tables	iii
List of Figures.....	iv
Acronyms and Abbreviations.....	v
Foreword.....	viii
Preface	ix
Acknowledgements	x
Executive Summary.....	xi
Chapter 1. HIV Epidemic and Response.....	1
1.1 Background.....	1
1.2 HIV Prevalence, Incidence, Mortality and Drivers of New Infections	2
1.2.1 HIV Prevalence.....	2
1.2.2 HIV Incidence.....	4
1.2.3 AIDS-Related Mortality.....	5
1.2.4. Drivers of New HIV infections	5
1.3 HIV Response	6
1.3.1. Social and Behavior Change Communication.....	6
1.3.2. Comprehensive Condom and Lubricant Programming.....	7
1.3.3. Voluntary Medical Male Circumcision.....	8
1.3.4. Elimination of Mother-to-Child Transmission.....	9
1.3.5. HIV Treatment, Care and Support	11
1.3.6. TB/HIV Co-infection	14
1.3.7 Impact of COVID 19 on Healthcare.....	15
1.3.8. Human Rights, Law and Gender	15
1.3.9. Social Protection.....	16
1.3.10. Community Engagement.....	17

1.3.11. Achievements, Challenges, Lessons Learned and Recommendations	17
Chapter 2. The Strategic Direction 2023-2028	19
2.1 Strategic Plan Development Process	19
2.2 Guiding Principles	20
2.3 Vision	20
2.4 Mission	21
2.5 Goals of the Lesotho National HIV Strategic Plan 2023-2028	21
2.6 Impact Level Targets of the LHSP 2023-2028	21
Chapter 3. Strategic Priorities	22
3.1 Goal 1: Deliver equitable access to evidence-based, people-centered HIV services.....	23
3.1.1 Focus Area 1.1: Prevent New HIV, TB and STIs.....	23
3.1.2 Focus Area 1.2: Elimination of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B	31
3.1.3 Focus Area 1.3: Integrated Services.....	34
3.1.4 Focus Area 1.4. Social and Behavior Change Communication	44
3.2 Goal 2: Break down structural and social barriers to achieving optimal outcomes in HIV prevention and management.....	46
3.2.1 Focus Area 2.1. Human Rights-Based Approaches To HIV Service Delivery.....	46
3.2.2 Focus Area 2.2: Gender-equitable Social Norms, Gender Equality and Gender-based Violence	48
3.2.3 Focus Area 2.3: Community Systems Strengthening	49
3.3 Goal 3: To have a fully resourced, sustainable, and efficient HIV response integrated into systems for health, social protection and pandemic settings.....	51
3.3.1 Focus Area 3.1: Systems for Health and social protection.....	51
3.3.2 Focus Area 3.2: HIV Health Products and Technologies Security.....	53
3.3.3 Focus Area 3.3: Human Resources for Health	54
3.3.4 Focus Area 3.4: Data Science, Research and Innovation for Precision HIV, TB and STI Programming	55
3.3.5 Focus Area 3.5: Financing for a Sustainable HIV Response	57
3.3.6 Focus Area 3.6: HIV Response in Humanitarian and Emergency Settings.....	60
3.3.7 Focus Area 3.7: Leadership, Advocacy and Coordination.....	61
ANNEX 1: RESULTS FRAMEWORK.....	0
ANNEX 2: LIST OF CONTRIBUTORS.....	0

List of Tables

Table 1.1: Trends for Select Health Indicators in Lesotho.....	1
Table.1.2: Trends in prevalence of HIV in Lesotho by age and sex (Source: UNAIDS Data 2022)	3
Table 1.3: Description of Key and Priority Populations and Classification by Disease Category	4
Table 1.4: Trends in New HIV Infections in Lesotho (Source: UNAIDS Data 2022)	4
Table 1.5: Trends in AIDS-related Deaths in Lesotho (Source: UNAIDS Data 2022)	5
Table 1.6: Viral load suppression on treatment (Source: LePHIA 2020)	13
Table 1.7: Summary of the Achievements of the NHASP 2018/19-2022/23, Gaps and Challenges, Lessons Learned, and Recommendations for the LHSP 2023-2028.....	17
Table 3.1 The Five Pillars of HIV Prevention. (Source: HIV Prevention 2025 Roadmap)	24
Table 3.2:Total Resource Needs Estimate (LSL 13 billion) by LHSP Priority Investment Areas (Source: RNM Costing Model)	57

List of Figures

Figure 1.0.1 HIV Prevalence by District: (LePHIA 2020).....	2
Figure 1.2: HIV Prevalence by Age and Sex, Lesotho 2020 (Source: LePHIA 2020).....	2
Figure 1.3:HIV Prevalence by District for Key Populations	3
Figure 1.4: Condom Use for AGYW, Key Population and General Population, Lesotho, 2021.....	8
Figure 1.5: VMMC Coverage Trends by Age Group, Lesotho, 2017-2022. (Source: PEPFAR Program Data, 2022).....	8
Figure 1.6: Trends in VMMC Performance by District, 2017-2022 (Source: MoH HMIS 2023).....	9
Figure 1.7: PMTCT Cascade, Lesotho, 2022 (Source: MoH HMIS 2023)	10
Figure 1.8: Early Infant Diagnosis Service Coverage, Lesotho, 2022. (Source: PEPFAR Panorama Spotlight 2022).....	10
Figure 1.9: Anti-retroviral Therapy Coverage by age group, Lesotho, 2022. (Source: MoH HMIS 2023)	11
Figure 1.10: Viral Load Coverage, Lesotho (Source: PEPFAR Panorama Spotlight 2022)	12
Figure 1.11: Viral Load Coverage by District, 2022 (Source PEPFAR Panorama Spotlight, 2022).	12
Figure 1.12: TB Case Notifications and HIV Prevalence by District, 2019 (Source: MOH 2019).....	15
Figure 3.1: Conceptual Framework for the LHSP 2023-2028.....	22
Figure 3.2 Projected Contributions by Funding Source (LSL m) and expected funding gap for each year of the Lesotho HIV Strategic Plan 2023-2028 (Source: Key Informant Interviews and Estimates)	58

Acronyms and Abbreviations

ABYM	Adolescent boys and young men	DTG	Dolutegravir
AGYW	Adolescent girls and young women	EID	Early infant diagnosis
AHD	Advanced HIV disease	EMR	Electronic medical records system
AIDS	Acquired Immune Deficiency Syndrome	EMTCT	Elimination of mother to child transmission
ANC	Antenatal care	FBOs	Faith Based Organizations
ART	Antiretroviral therapy	FP	Family planning
ARVs	Antiretroviral drugs	FSWs	Female sex workers
AYP	Adolescents and young persons	GBV	Gender based violence
CAGs	Community adherence groups	GDP	Gross domestic product
CBOs	Community Based Organizations	GIS	Geographic Information System
CBS	Case-based surveillance	GoL	Government of Lesotho
CHAL	Christian Health Association of Lesotho	HCW	Healthcare worker
CHWs	Community health workers	HBV	Hepatitis B virus
CLHIV	Children living with HIV	HEI	HIV exposed infant
CNR	Community notification rates	HIS	Health Information System
CPT	Cotrimoxazole preventive therapy	HIV	Human immunodeficiency virus
CQI	Continuous quality improvement	HIVDR	HIV drug resistance
CSE	Comprehensive sexuality education	HIVST	HIV self-testing
CSOs	Civil Society Organizations	HMIS	Health Management Information System
CSS	Community systems strengthening	HPV	Human papilloma virus
DACs	District AIDS Committees	HRH	Human resources for health
DBS	Dried blood spot	HTS	HIV testing services
DHIS 2	District Health Information System 2	ICT	Information and communication technologies
DICES	Drop-in centers	IIT	Interruption in treatment
DR	Drug resistant	INSTIs	Integrase strand transfer inhibitors
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe	IPT	Isoniazid preventive therapy
DRT	Drug resistance testing		
DSD	Differentiated service delivery		

IPV	Intimate partner violence	PLHIV	People living with HIV
KPs	Key populations	PMTCT	Prevention of mother-to- child transmission
LARCS	Long-acting reversible contraceptives	PNC	Postnatal Care
LBSE	Life skills based sexuality education	POC	Point of care
LePHIA	Lesotho Population-based HIV Impact Assessment	PrEP	Pre-exposure prophylaxis
LHSP	Lesotho HIV Strategic Plan	PWID	People who inject drugs
LOMSHA	Lesotho Output Monitoring System for HIV and AIDS	PWD	People with disabilities
LTFU	Lost to follow up	RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
MAF-TB	Multisectoral Accountability Framework to accelerate progress towards ending TB	SBCC	Social and behavior change communication
MDRTB	Multi-drug resistant TB	SDGs	Sustainable development goals
MNCH	Maternal, Neonatal and Child Health	SGBV	Sexual and gender-based violence
MMD	Multi-month dispensing	SRH	Sexual and reproductive health
MNCAH	Maternal, Neonatal, Child and Adolescent Health	SRHR	Sexual and reproductive health rights
MoH	Ministry of Health	STIs	Sexually transmitted infections
MoSD	Ministry of Social Development	SW	Sex worker
MSM	Men who have sex with men	TasP	Treatment as prevention
MTCT	Mother-to-child transmission	TB	Tuberculosis
NAC	National AIDS Commission	TB-LAM	TB Lipoarabinomannan Antigen Assay
NHASP	National HIV and AIDS Strategic Plan	TBD	To be determined
NCDs	Non-communicable diseases	TPT	TB preventive therapy
NNRTI	Non-nucleoside reverse transcriptase inhibitors	TWG	Technical Working Group
NRTI	Nucleoside reverse transcriptase inhibitors	U=U	Undetectable equals untransmissible
OVC	Orphans and vulnerable children	UHC	Universal Health Coverage
PBFW	Pregnant and breast-feeding women	UNAIDS	The Joint United Nations Programme on HIV
PCR	Polymerase Chain Reaction	VHWS	Village health workers
PEP	Post exposure prophylaxis	VL	Viral load
PEPFAR	President's Emergency Plan for AIDS Relief	VLC	Viral load coverage
PHC	Primary healthcare	VLS	Viral load suppression
PIs	Protease inhibitors	VMMC	Voluntary medical male circumcision
		WHO	World Health Organization
		WLHIV	Women living with HIV

Foreword



The Lesotho HIV Strategic Plan (LHSP) for 2023-2028 is a guiding framework that outlines the country's approach to achieving its vision of a Lesotho free from new HIV infections and AIDS-related deaths. The development of this plan was informed by extensive consultations with stakeholders and guided by the country's health policies and strategies.

The LHSP is anchored on equity, sustainability, and inclusivity principles, critical in ensuring all populations, including vulnerable and marginalized groups, have access to quality and people-centered HIV, TB, and STI services. In addition, the plan is aligned with the country's National Strategic Development Plan and the global HIV targets to end AIDS as a public health threat by 2030.

To achieve its objectives, the LHSP has identified three strategic goals, which are: delivering equitable access to evidence-based, people-centered HIV services, breaking down structural and social barriers to achieving optimal outcomes in HIV, TB, and STI prevention and management, and ensuring a fully resourced, sustainable, and efficient HIV response that is integrated into systems for health, social protection, and pandemic settings.

This LHSP sets ambitious high-impact targets to be achieved by 2028. These targets are achievable through committed leadership, eliminating barriers to antiretroviral therapy and other services, building resilient health systems, strong community engagement, and establishing solid partnerships with all stakeholders. This LHSP builds on the gains made thus far in the HIV response and identifies strategic actions to address the remaining gaps and challenges.

The government recognizes the importance of a multi-sectoral approach to ending the HIV epidemic and will take bold and innovative actions to ensure a coordinated response through the National AIDS Commission. The Government remains committed to leading the efforts to end AIDS in Lesotho by 2030 within the Universal Health Coverage and the broader development agenda for all Basotho.

A handwritten signature in black ink, appearing to read 'S. Ntsokoane Matekane', written over a dotted line.

Hon. Samuel Ntsokoane Matekane,
The Right Honorable Prime Minister

Preface



Lesotho has an alarmingly high HIV prevalence rate, where one out of five adults live with HIV. It has more infections per 100,000 people than other countries such as Namibia, Botswana, and Eswatini. Women and adolescent girls continue to exhibit higher HIV prevalence compared to men and boys in the general population. Female sex workers and men who have sex with men have much higher HIV prevalence (71.9% and 32.9 %, respectively) than the national prevalence of 22.7%. The 2020 Lesotho Population-based HIV Impact Assessment (LePHIA) reported 5000 new HIV infections annually in Lesotho, with adolescents and young people accounting for 80% of these new infections. Female factory workers, male clients of sex workers, herds' boys, and adolescents are among the vulnerable populations at higher risk of HIV infection. While the country has attained the UNAIDS 90-90-90 targets, children and men are left behind with unacceptable high rates of mother-to-child transmission and lower viral suppression rates in these populations.

This LHSP makes a deliberate effort to intensify interventions among the populations at high risk of HIV infection, using human rights-based approaches and ensuring their full engagement. It also presents a coordinated multisectoral and patient-centered approach to eliminate persistent inequalities that hinder access to services by those who most need them. Such inequalities include poverty, gender inequality, and stigma and discrimination. The strategy aims to increase investments, maximize resources and best practices, intensify implementation efforts at all levels, expand coverage, and target key populations, geographical hotspots, and key and vulnerable groups at higher risk of HIV infection. The LHSP multisectoral approach necessitates the participation of all key sectors, including government, beneficiaries, civil society, private sector, traditional sectors, development partners, and healthcare workers, and a decentralized approach involving district and community-level actors such as the district AIDS committees. The LHSP has prioritized the following impact results by 2028: reduce new HIV, TB, and STIs by 75%; reduce AIDS-related deaths by 75%; eliminate mother-to-child transmission of HIV, Syphilis, and Hepatitis B; reduce all forms of inequalities at all levels; and attain sustainability of the national response.

Lesotho achieved epidemic control and has demonstrated that with concerted multisectoral action, the country can end AIDS as a public health threat by 2030. With sufficient resources for the full implementation of this LHSP, the country will accelerate the achievement of this goal.

A handwritten signature in black ink, appearing to read 'Ntokwenzani Xana', written over a dotted line.

Rev. Ntokwenzani Xana

Chairperson, Board of Commissioners, National AIDS Commission.

Acknowledgments



The development of the Lesotho HIV Strategic Plan (LHSP) 2023-2028 was a collaborative effort that required the participation and contributions of various stakeholders in the multi-sectoral response to HIV, TB, and STIs. Ending the HIV epidemic is critical for improving the health and well-being of the people of Lesotho and achieving sustainable development. The government is thus committed to implementing evidence-based policies and strategies that can lead to epidemic control. We sincerely thank all individuals, sectors, and partners who dedicated their time, intellectual, and financial resources to this national strategic plan.

We want to express our profound appreciation to the Ministry of Health, National AIDS Commission, United Nations family, networks of people living with HIV, implementing and civil society organizations, faith-based organizations, and many other entities whose contributions were invaluable. Your dedication and support were instrumental in developing a comprehensive and evidence-based plan that can contribute significantly to ending the HIV epidemic in the country.

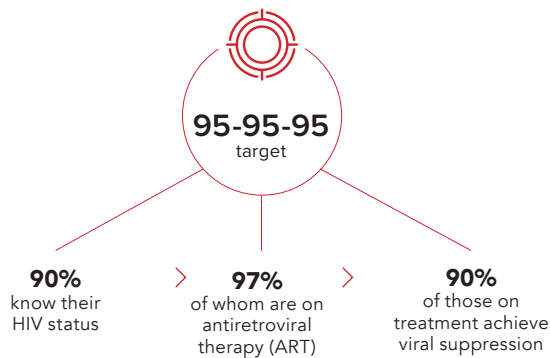
We also acknowledge the expert reviewers who provided critiques and valuable recommendations that enhanced the Lesotho LHSP 2023-2028 quality. Your input was crucial in shaping the plan’s strategic direction and focus areas.

Special thanks go to the team of consultants Dr. Peter Memiah from the University of Maryland (lead consultant), Bright Amisi (costing expert), Relebohile Tshelo (M&E expert); Dr. Nyasha Madzingira (prevention expert) and Mathabo Mareitumetese (transcription expert) for their tireless effort in gathering and synthesizing contributions from various sectors. Your expertise and dedication ensured that the LHSP 2023-2028 is a comprehensive and evidence-based plan that can make a significant impact in ending the HIV epidemic in the country. We also appreciate Irene Gathiru, who offered free expertise towards the professional design of the document working alongside the lead consultant.

Finally, we thank all stakeholders for their commitment to continued and strengthened partnerships in implementing this national multisectoral strategic plan. The plan’s successful implementation will require sustained political commitment, sufficient resources, and effective implementation strategies to ensure that Lesotho sustains epidemic control and eventually ends HIV as a public health threat by 2030.

Ms. Lebohang Mothae,
Chief Executive, National AIDS Commission.

Executive Summary



Lesotho has made significant progress towards achieving the UNAIDS 2025 95-95-95 targets, with 90% of people living with HIV (PLHIV) being aware of their status, 97% of whom are on antiretroviral therapy (ART), and 92% of those on ART achieving viral suppression. However, during the National HIV and AIDS Strategic Plan (NHASP) 2018/2019 – 2022/2023, the COVID-19 pandemic impacted Lesotho’s HIV response. Despite this and other challenges, the country achieved

significant milestones that contributed to the HIV epidemic control. Some of these achievements include exceeding the UNAIDS 90:90:90, rapid adoption of new technologies, decentralization of services to local units and community, integration of HIV policies into the broader socio-economic framework, and development of supportive policies and structures. The country aims to safeguard these gains and ensure the continuity of HIV, TB, and STI services while striving to maintain and supersede the UNAIDS 95-95-95 goals and 10-10-10 targets by 2028.

The Lesotho HIV Strategic Plan (LHSP) 2023-2028 sets ambitious, achievable impact-level targets for 2023-2028. These targets include reducing new HIV, TB, and STIs by 75%; reducing AIDS-related deaths by 75%; eliminating mother-to-child transmission (eMTCT) of HIV, Syphilis, and Hepatitis B; reducing all forms of inequalities at all levels; and attaining sustainability of the national HIV response.

To this end, this LHSP 2023-2028 will focus on three strategic goals aligned with its vision:


GOAL 01
Delivering equitable access to evidence-based, people-centered HIV services



GOAL 02
Breaking down structural and social barriers to achieving optimal outcomes in HIV, TB, and STI prevention and management



GOAL 03
Ensuring a fully resourced, sustainable, and efficient HIV response integrated into systems for health, social protection, and pandemic settings.



The LHSP 2023-2028 outlines a comprehensive approach to address key challenges and accelerate progress in preventing new HIV infections, eMTCT, integrating health services, promoting behavior change, upholding human rights, achieving gender equality, strengthening community systems, ensuring health and social protection, securing HIV health products and technologies, improving human resources for health, leveraging data science and innovation, sustaining financing, addressing emergencies and disasters, and enhancing leadership, advocacy, and coordination.

The plan focuses on targeted interventions for key populations, such as men who have sex with men (MSM), female sex workers (FSWs), people who inject drugs (PWID), and adolescents and young people (AYPs), utilizing biomedical, behavioral, and structural strategies aligned with global prevention approaches. Differentiated prevention of mother-to-child transmission (PMTCT) services will be prioritized for adolescent girls and young women (AGYW), addressing social and economic barriers, community engagement, gender power imbalances, stigma, and discrimination.

Integration of health services will be emphasized, addressing the syndemic of HIV, STIs, cervical cancer, viral hepatitis, substance use, mental health disorders, and non-communicable diseases. Social and behavior change communication (SBCC) will target AYPs, addressing misconceptions, limited access to information, and co-occurring mental illness and drug use. Human rights-based approaches will combat cultural norms and criminalization and promote social justice, equity, and universal access to stigma-free healthcare.

Efforts to achieve gender equity, challenge harmful norms, and address gender-based violence (GBV) will be scaled up, involving women, girls, men, and boys in gender-transformative HIV programming. Strong community systems will be established to empower vulnerable populations and facilitate their engagement in planning and delivering interventions. Access to

health and social protection services for PLHIV and key populations will be ensured through comprehensive systems.

Supply chain management and healthcare workforce capacity will be strengthened to ensure a consistent supply of HIV commodities and improved service provision. Data science, research, and innovation will be expanded to enhance the precision and impact of HIV, TB, and STI programming. Sustainable financing will be pursued through resource mobilization, private sector engagement, financial management enhancements, and harmonization of resource tracking.





Special attention will be given to the HIV response during humanitarian and emergency settings, including developing a national contextual plan to maintain access to essential services. In addition, leadership, advocacy, and coordination among sectors and stakeholders will be strengthened, with the National AIDS Commission (NAC) playing a central role.

Differentiated prevention of mother-to-child transmission services will be prioritized for adolescent girls and young women, addressing social and economic barriers, community engagement, gender power imbalances, stigma, and discrimination.



Implementation of the LHSP 2023-2028:

NAC will take bold and innovative actions to ensure expanded access to the services and support necessary interventions to prevent new HIV, TB, and STIs and provide treatment, care, and support for those living with HIV and those at risk of acquiring HIV, TB, and STIs. The critical implementation processes will include:

-  **Development of a comprehensive NHSP operational plan to translate the strategic goals and objectives of the NHSP into actionable implementation modalities.**
-  **Establishment of district-level targets to support localized responses and enable effective tracking of the HIV response at the granular level.**
-  **Formulation of district work plans to outline specific activities and interventions that will contribute to achieving the set targets within each district.**
-  **Creation of the NHSP Monitoring and Evaluation (M&E) plan to operationalize the NHSP results framework, ensuring systematic monitoring and evaluation of progress and **outcomes**.**
-  **Establish a joint review platform comprising representatives from all Technical Working Groups (TWGs) to review the LHSP progress regularly. These reviews will occur twice a year.**
-  **Conducting district progress reviews. Led by District AIDS Action Committees (DACs) every quarter, these will provide an opportunity to assess and address implementation challenges at the local level.**
-  **National coordination teams will support and supervise all districts, ensuring effective implementation and adherence to the NHSP guidelines.**
-  **Real-time feedback to districts through** an interactive dashboard established and managed by NAC will facilitate timely decision-making and response adjustments based on the evolving HIV landscape.

Through the implementation of coordinated processes, the LHSP 2023-2028 strives for efficient coordination, systematic monitoring, and effective implementation of strategies. This collective effort aims to drive substantial progress in the HIV response and enhance outcomes across the country. With a solid commitment to a multi-sectoral collaborative approach, Lesotho aims to eliminate HIV as a public health threat by 2030, leveraging the strengths and resources of all stakeholders.

Chapter **1**

HIV Epidemic
and Response



1.1 Background

Lesotho is a landlocked country in Southern Africa, surrounded by South Africa, with an area of 30,355 km². The country has an average altitude of 2,161m above sea level, one of the highest in the world. It has a population of approximately 2.1 million people, of which 51% are women, 31% are under the age of 15 years, and 15% are under the age of five (World Bank 2022). Lesotho has ten districts, five of which are highlands and five are lowlands. It is classified as a lower-middle-income country by the World Bank, with a narrow economic base mostly reliant on subsistence agriculture, diamond mining, textile manufacturing, remittances from Basotho working in South Africa, and regional customs revenue. Lesotho faces socio-economic challenges, mainly related to high poverty levels, unemployment, and Human Immunodeficiency Virus (HIV) and tuberculosis (TB) infections.

Poverty in Lesotho declined from 56.6% in 2002 to 49.7% in 2017 (2019 Lesotho Poverty Assessment). World Bank data shows that Lesotho's gross domestic product (GDP) rose 8% between 2017 and 2021 due to reduced inequality due to improved social protection programs and increased income among low-income earners.

However, during the same period, there was an increase in inflation from 6.6% to 8.3%. Poverty remains concentrated in rural areas where 80% of the population lives. This poverty is exacerbated by high levels of unemployment, with the country experiencing a total unemployment rate of 18% (World Bank Data, 2022) compared to the global average of 5.8% and an even higher youth unemployment rate of 28% as well as the high prevalence of HIV at 22.7% among adults. In addition, the COVID-19 pandemic worsened the poverty situation in Lesotho, reversing the country's poverty reduction efforts.

Lesotho's health indicators (Table 1.1) have improved over time, with the World Health Organization (WHO) reporting a decrease in maternal mortality rate from 640 in 2017 to 566 per 100,000 live births in 2020. Similarly, infant mortality reduced from 62 to 58 per 1,000 live births within the same period. In addition, the 2018 Multiple Indicator Cluster Survey report (MICS 2018) reported a total fertility rate of 2.7, general fertility rate of 92.1, and a crude birth rate of 23.2, with rural areas having higher fertility rates. However, according to WHO 2020 data, the average life expectancy is 50.7 years, with AIDS still the leading cause of adult deaths.

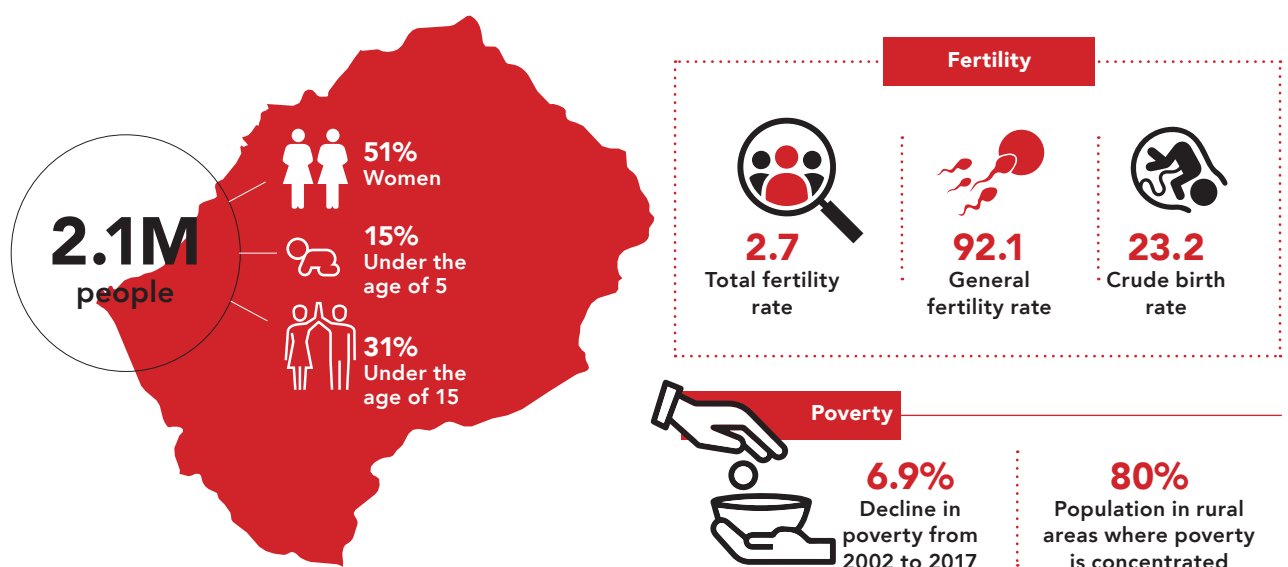


Table 1.1: Trends for Select Health Indicators in Lesotho

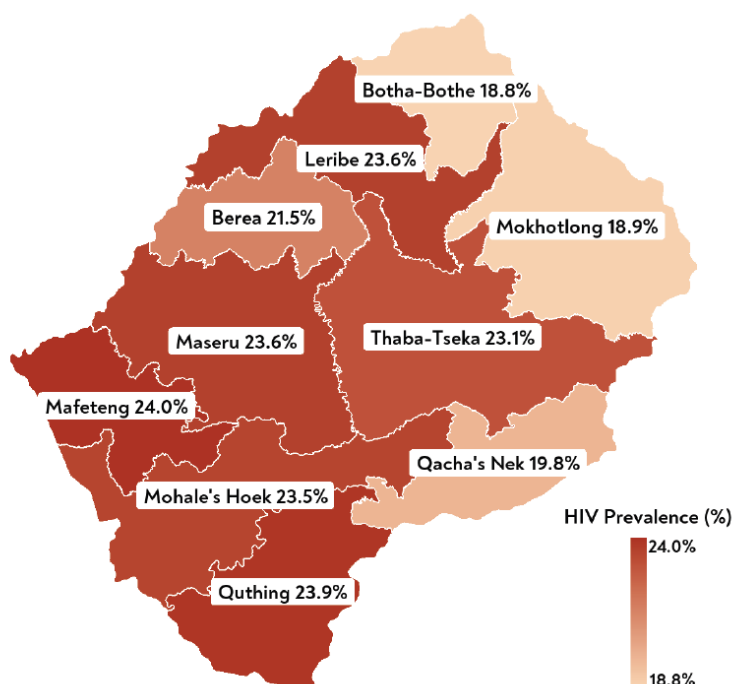
INDICATOR	2017	2018	2019	2020	2021
Neonatal mortality rate per 1000 live birth ^a	37	37	36	36	35
Infant mortality rate per 1000 live births ^b	62	61	60	58	56
Under-five mortality rate per 1000 live birth ^b	76	76	77	76	73
Maternal mortality rate ratio per 100,000 live births ^a	640	599	629	566	-
Crude birth rate per 1000 people ^a	28	27	27	26	26
Total fertility rate births per woman ^a	3	3	3	3	3
Total unemployment rate (%) ^a	17	17	17	19	18
GDP (Billion USD) ^a	2.31	2.55	2.45	2.23	2.5

a) WorldBank Data 2022 / b) UNICEF Data Warehouse UN_IGME

1.2 HIV Prevalence, Incidence, Mortality and Drivers of New Infections

1.2.1 HIV Prevalence

The Lesotho Population-based HIV Impact Assessment (LePHIA) report of 2020 indicates that the Kingdom of Lesotho has a generalized HIV epidemic, with a national prevalence of 22.7%, translating to 324,000 adults aged 15 years above living with HIV (LePHIA, 2020). The prevalence varies between regions, with Botha-Bothe at 18.8% compared to 24% in Mafeteng (Figure 1.1). The lowland districts,



Maseru and Leribe, have the third highest HIV prevalence and disease burden.

Figure 1.0.1 HIV Prevalence by District: (LePHIA 2020)

The prevalence of HIV was higher among women than men across all age groups (Figure 1.2).

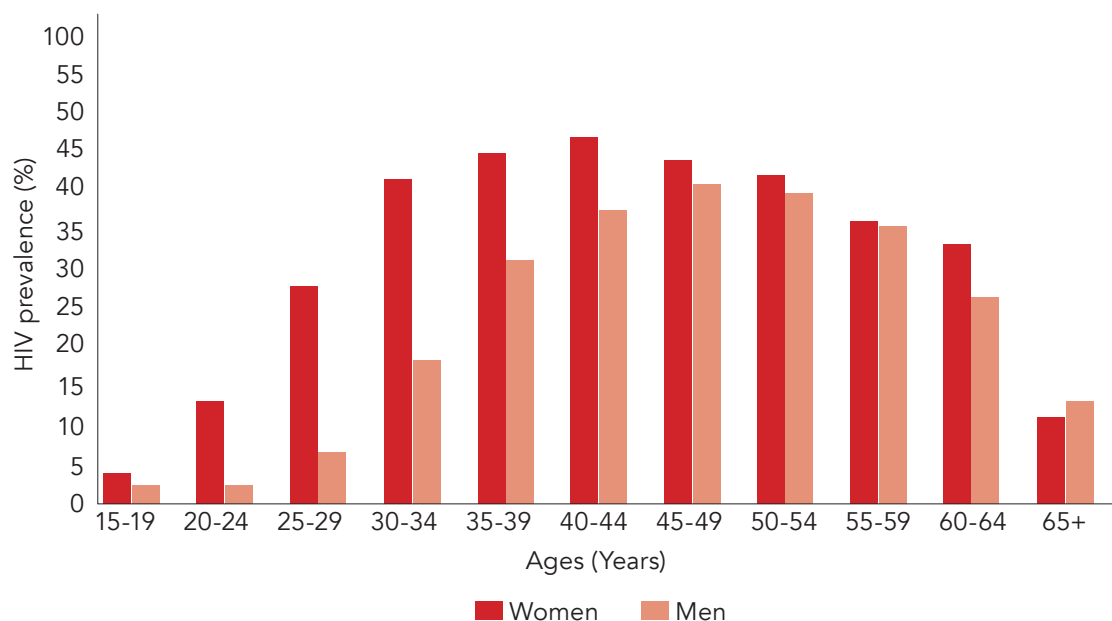


Figure 1.2: HIV Prevalence by Age and Sex, Lesotho 2020 (Source: LePHIA 2020)

The prevalence of HIV remained almost constant between 2010 and 2015 (24.2% and 24.6%, respectively) but decreased to 20.9% in 2021 (UNAIDS Data, 2022). However, there were changes in numbers within age groups. For example, a constant decline was observed among those aged 0-14 years, whereas among those aged 15 years and above, there was a decline between 2010 and 2015, and the numbers remained constant after that. Table 1.2 shows trends in the number of people living with HIV (PLHIV) across age groups and sex as estimated by the Joint United Nations Programme on HIV (UNAIDS) Spectrum model (UNAIDS Data, 2022).

Table.1.2: Trends in prevalence of HIV in Lesotho by age and sex (Source: UNAIDS Data 2022)

INDICATOR	2010	2015	2021
People living with HIV (all ages)	280,000	300,000	290,000
People living with HIV (0-14 years)	23,000	17,000	9,700
People living with HIV (women, 15+)	150,000	170,000	170,000
People living with HIV (men, 15+)	100,000	110,000	110,000
HIV prevalence (15-49 years)	24.2%	24.6%	20.9%

HIV Prevalence among Key and Priority Populations

Although there is a lack of national HIV prevalence data on key populations (KPs), UNAIDS estimates the prevalence of HIV to be 32.9% and 71.9% for men who have sex with men (MSM) and sex workers (SWs), respectively. As shown in Figure 1.3, HIV prevalence among KPs differs from district to district. For example, among MSM, Leribe has the highest prevalence (36%), and Mafeteng has the lowest (7%). Similarly, among female SWs (FSWs), HIV prevalence is highest in Leribe (57%) and lowest in Butha-Buthe (39%).

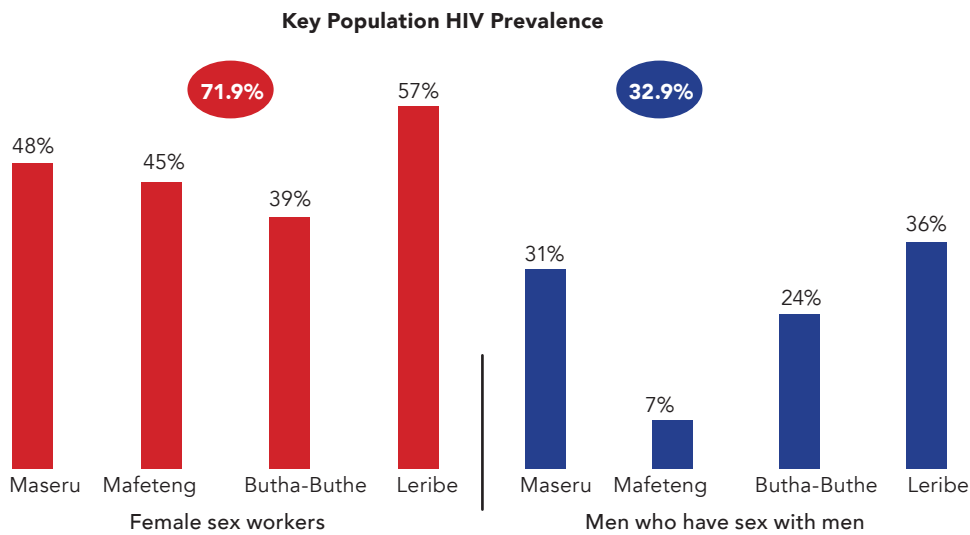


Figure 1.3: HIV Prevalence by District for Key Populations

Lesotho broadly defines key and priority populations (NSP, 2017). A description of these populations and classification by disease category are provided in Table 1.3.

Table 1.3: Description of Key and Priority Populations and Classification by Disease Category

Population Description	Population Group by Disease Category			
	HIV	TB	STIs	Viral Hepatitis
Key and Priority Populations Are at an increased risk of infection and are often victims of punitive laws and stigma, and discrimination	<ul style="list-style-type: none"> • SWs and their clients • Trans gender and diverse people • MSM • PWID • People in correctional facilities 	<ul style="list-style-type: none"> • PLHIV • Healthcare workers • People in correctional facilities • Children aged < 5 years • People living in informal settlements • Mineworkers • Refugee and migrant populations 	<ul style="list-style-type: none"> • SWs and their clients • Transgender people • MSM 	<ul style="list-style-type: none"> • People in correctional facilities • PWID • MSM • SWs
Other Priority Populations Are at a higher risk of infection due to biological, behavioral, or structural factors and encounter unique obstacles in obtaining services	<ul style="list-style-type: none"> • AYP, especially AGYW • Survivors of SGBV • OVC • Mobile and migrant populations • PWD • People with mental health disorders • LGBTIQ+ persons • People living in informal settlements 	<ul style="list-style-type: none"> • People with prior TB • Contacts of TB patients • Smokers and people with harmful alcohol use • The Elderly • AYP • People with chronic disease co-morbidities • Pregnant women 	<ul style="list-style-type: none"> • AYP, especially AGYW • Survivors of SGBV • Pregnant women 	<ul style="list-style-type: none"> • Healthcare workers • Pregnant women

AGYW – Adolescent girls and young women; AYP - Adolescents and young persons; HIV – Human immunodeficiency virus; MSM – Men who have sex with other men; OVC – Orphans and vulnerable children; PLHIV – People living with HIV; PWD – People with disabilities; PWID – People who inject drugs; SGBV – Sexual and gender-based violence; STIs – Sexually transmitted infections; SWs – Sex workers; TB - Tuberculosis

1.2.2 HIV Incidence

The LePHIA 2020 report indicated a 0.45% incidence among adults aged 15 years and above (0.64% among women and 0.28% among men) (LePHIA 2020). This is a drop from the 1.10% reported in LePHIA 2016/2017 (1.22% among women and 1.00% among men) (LePHIA 2016/2017). Significant reductions were observed across all age groups and sex, as shown in Table 1.4.

Table 1.4: Trends in New HIV Infections in Lesotho (Source: UNAIDS Data 2022)

INDICATOR	2010	2015	2021
New HIV infections (all ages)	19,000	15,000	7,400
New HIV infections (0-14 years)	2,100	900	690
New HIV infections (15-24 years)	6,700	5,700	2,600
New HIV infections (women, 15+)	9,900	8,800	4,300
New HIV infections (men, 15+)	7,200	5,700	2,500
HIV incidence (all ages) per 1,000 population	12.44	10.00	4.76

The UNAIDS Spectrum model estimated 7,400 new cases of HIV among all ages, with almost 60% (4,300) being women aged 15 years and above. During the same period, 690 new HIV infections were estimated among children below the age of 15 years. The data indicate that women aged 15-24 remain the country’s most vulnerable group.

1.2.3 AIDS-Related Mortality

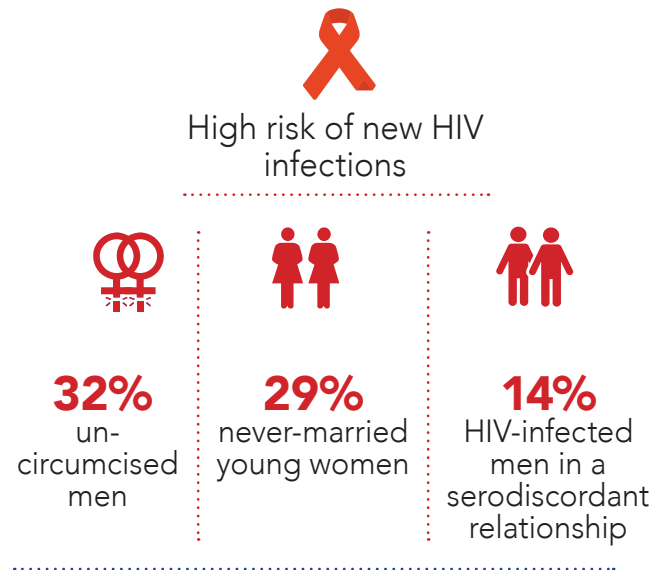
AIDS-related deaths across all age groups declined by 48% between 2010 and 2021 (UNAIDS Data, 2022). This is majorly attributed to early diagnosis and rapid uptake of efficacious and optimized antiretroviral therapy (ART). Nevertheless, approximately 4,000 adults aged 15 years and above and 560 children aged 14 years and below succumbed to AIDS in 2021, as shown in Table 1.5.

Table 1.5: Trends in AIDS-related Deaths in Lesotho (Source: UNAIDS Data 2022)

INDICATOR	2010	2015	2021
AIDS-related deaths (all ages)	8,700	8,000	4,500
AIDS-related deaths (0-14 years)	1,800	1,100	560
AIDS-related deaths (women, 15+)	3,700	3,300	2,100
AIDS-related deaths (men, 15+)	3,200	3,600	1,900

According to the UNAIDS 2021 Spectrum modelling, 110,000 children were orphaned by AIDS in 2020, and it is projected that there will be 2,295 AIDS-related deaths among adults (1,069 men and 1,226 women) by 2025 (UNAIDS Spectrum 2022). The 2022 UNAIDS HIV estimates indicate that Lesotho has largely controlled the spread of the HIV epidemic, as demonstrated by the decline in mortality.

1.2.4. Drivers of New HIV Infections



The mode of HIV transmission in Lesotho is predominantly unprotected sexual intercourse and mother-to-child transmission (MTCT), as in many other countries in the region. The population groups at higher risk of new HIV infections include un-circumcised men (32%), never-married young women (29%), and HIV-infected men in a serodiscordant relationship (14%). Epidemiological data shows that single women and women not in long-term partnerships or marriage are disproportionately affected by HIV, accounting for most (34%) of the new infections. Furthermore, the UNAIDS Spectrum data (2022) indicates that adolescent girls and young women (AGYW) - who comprise approximately 24% of the Basotho population - account for 31% of new infections (UNAIDS Spectrum Data, 2022). The major social and structural determinants of new HIV infections in Lesotho include :

Poverty: Lesotho is a low-income country with high levels of poverty and unemployment. The situation of poverty in Lesotho is said to have been worsened by the COVID-19 pandemic, where, for example, at the start of the pandemic in 2019, 49.7% of Basotho were living below the national poverty line. After the pandemic, the national poverty level was expected to increase to 51.7% due to the overall decline in household consumption. Poverty and economic insecurity can limit access to education, healthcare, and other resources needed to prevent and manage HIV. The HIV response will therefore seek to establish linkages with other sectors that address poverty and economic insecurity.



49.7%
of Basotho were
living below the
national poverty
line

51.7%
Increase in national
poverty level After
the COVID-19
pandemic

Gender-based violence (GBV): Lesotho has a high prevalence of GBV (37.6%) among women, which increases the risk of HIV transmission among girls and women. Women who experience violence may be less likely to negotiate condom use and have a higher risk of acquiring HIV due to genital injuries. The response will thus engage relevant stakeholders to eliminate GBV.



37.6%
high prevalence
of GBV among
women,

Stigma and discrimination: HIV-related stigma and discrimination are common in Lesotho, leading to fear, shame, and isolation among PLHIV. This can deter people from getting tested,

Low comprehensive HIV knowledge is associated with an increased risk of HIV infection. To address this, social and behavior change and communication (SBCC) is one of the critical strategies in this LHSP.

accessing treatment, and disclosing their HIV status to partners and family members. The implementation of the strategy will address stigma and discrimination.

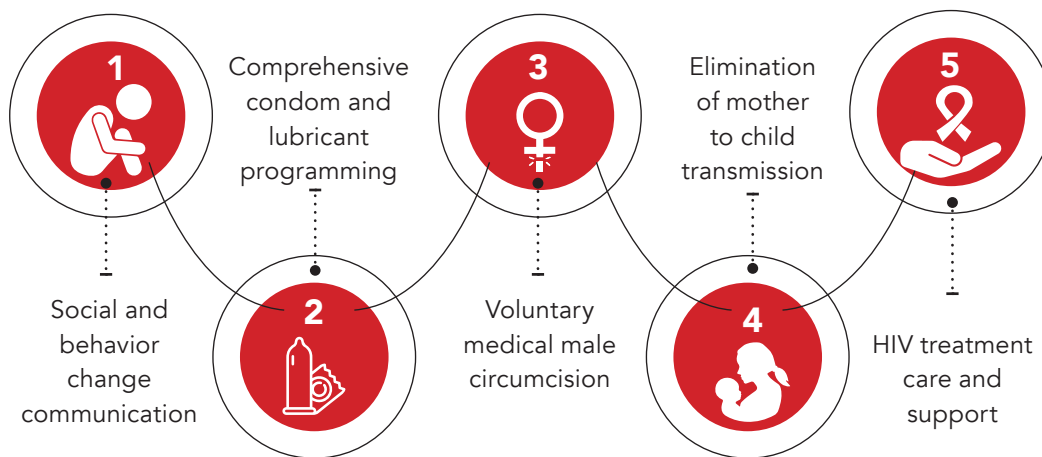
Limited access to healthcare: Lesotho has a shortage of healthcare workers to fully serve in all health facilities, which are also inadequate, especially in rural areas. This can make it difficult for people to access HIV testing, treatment, and retention in care for those living with HIV.

Migration and mobility: Lesotho has a high rate of labor migration, with many men migrating to South Africa in search of work. This disrupts family and social networks and increases risky sexual behaviors, including having multiple sexual partners and engaging in transactional sex. High mobility also presents challenges to access and adherence to ART and continued use of biomedical prevention, such as oral pre-exposure prophylaxis (PrEP). The response will seek partnerships with relevant stakeholders and ensure continued access to quality HIV services for migrants.

Low comprehensive knowledge of HIV prevention and transmission: The Lesotho Demographic Health Survey and other data indicate low levels of comprehensive knowledge of HIV prevention and transmission. Although this has improved, it is still low, particularly among young people. Low comprehensive HIV knowledge is associated with an increased risk of HIV infection. To address this, social and behavior change and communication (SBCC) is one of the critical strategies in this LHSP.

1.3 HIV Response

Lesotho has made remarkable progress in responding to the HIV epidemic; 90% of PLHIV know their status, 97% of those who know their status are on treatment, and 92% of those on treatment are virally suppressed (LePHIA, 2020). This demonstrates that the country has reached the UNAIDS 90-90-90 targets. Furthermore, the UNAIDS estimates show that the number of new HIV infections has fallen below the number of deaths among persons with HIV, which is a significant step towards epidemic control.. Over the past decade, the country has focused on the following program areas in response to the national HIV epidemic:

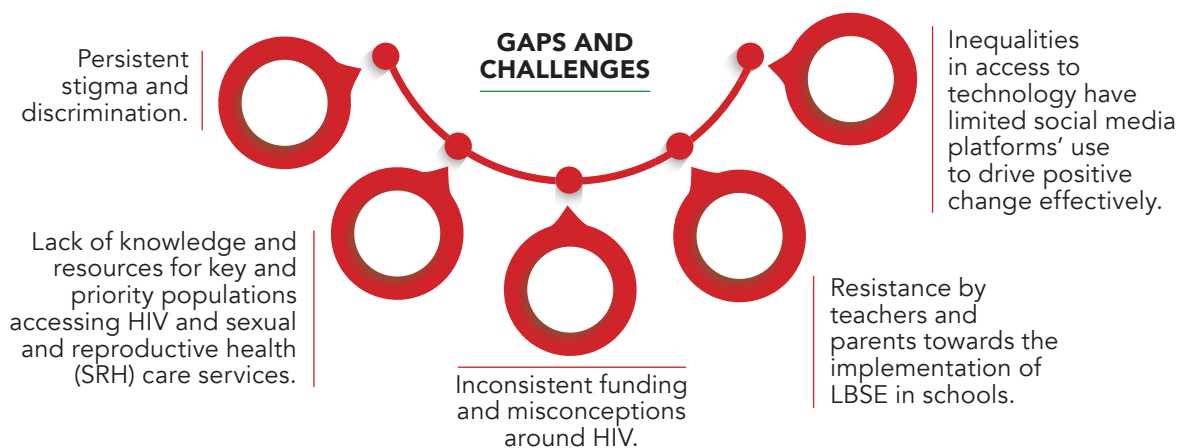


1.3.1. Social and Behavior Change Communication

The Government of Lesotho (GoL) drafted and implemented national policies and programmatic actions that guided government, civil society, the private sector, and development partners in implementing effective behavior change interventions that address cultural contexts within which risk behaviors occur. As a result, the country raised levels of comprehensive knowledge increased the perception of risk and reduced the risk of HIV transmission through intensive prevention and awareness campaigns. The social and behavior change communication (SBCC) activities are conducted in communities mainly by implementing partners through peer-led face-to-face information sessions and community dialogues, television and radio slots, social media platforms, door-to-door- campaigns, and public gatherings such as mothers-in-law support groups

and husbands/men addressing gender norms, harmful practices, and GBV. The country has also adopted a peer education model that implements SBCC sessions addressing skills transfer for key and priority populations.

Furthermore, the country now has life skills-based sexuality education (LBSE) for in-school youth and comprehensive sexuality education (CSE) for out-of-school youth. In Lesotho, children 12 years old and above have legal access to sexual and reproductive health and rights (SRHR) services. In addition, the Lesotho Constitution guarantees the right to access healthcare services, including SRHR services, without discrimination based on age. All these SBCC efforts have ultimately contributed to increased uptake of HIV prevention services.



1.3.2. Comprehensive Condom and Lubricant Programming

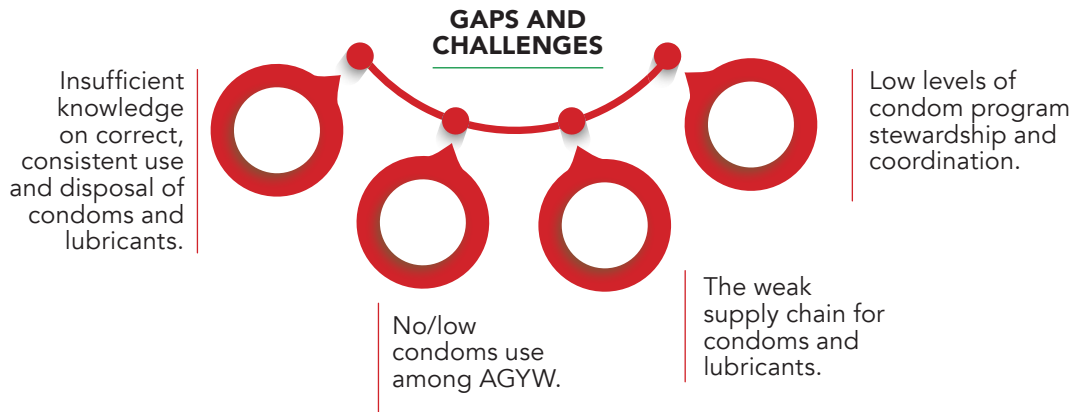
The implementation of the country’s Condom Strategy (2019-2022) remains limited, and condom distribution has dramatically declined over the years across all population groups, as shown in Figure 1.4.

The distribution of female condoms decreased from 437,000 in 2017 to 120,000 in 2020, while male condoms distribution reduced from 30,014,324 to 8,906,400. As a result, as of mid-2021, only 2,904,092 male condoms were distributed against a target of 36 million and 218, 378,000 female condoms against a target of 750,000. However, efforts have been initiated to strengthen condom programming, including education and dissemination of information, expanded distribution channels, rebranding and repackaging of condoms and lubricants, usage and disposal, and awareness campaigns.



Figure 1.4: Condom Use for AGYW, Key Population and General Population, Lesotho, 2021.

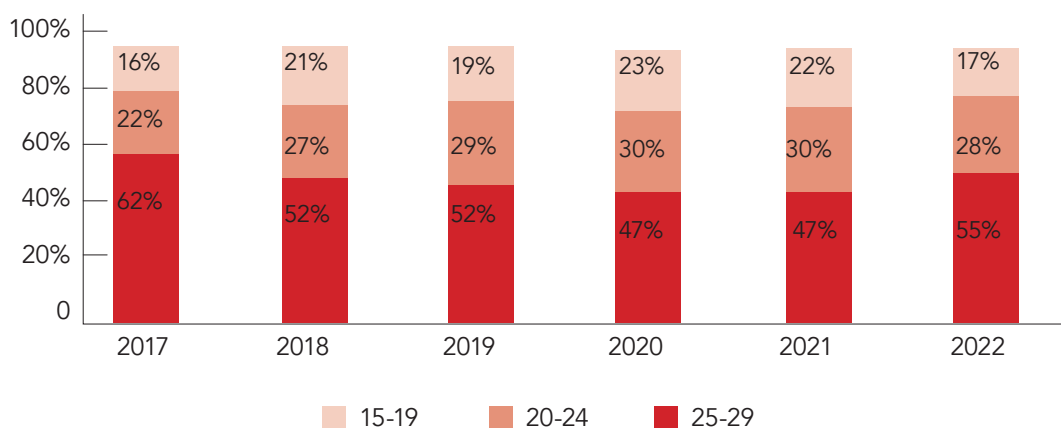
Source: adapted from UNAIDS 2021 Estimates; Global AIDS Monitoring 2021; ICF – the DHS Program STAT compiler, Global Aids Monitoring 2021 and 2021 Global Fund and PEPFAR reports



1.3.3. Voluntary Medical Male Circumcision

The voluntary medical male circumcision (VMMC) program in Lesotho has prioritized males aged 15-29 years for circumcision, while for those over 30 years, VMMC is integrated with other health services. VMMC is offered in all ten districts, combined with a minimum package of services and addressing access barriers to achieve the full benefit of HIV prevention for men and boys, with a target of reaching 90% of men aged 15-49 years by 2023. As shown in Figure 1.5, the VMMC coverage has performed relatively well among the 15-19 age group compared to the 20-24 and 25-29 age groups.

Figure 1.5: VMMC Coverage Trends by Age Group, Lesotho, 2017-2022. (Source: PEPFAR Program Data, 2022)



VMMC coverage of 52.4% was achieved in 2020 for men aged 15-49, an increase from 23% in 2017 (LePHIA, 2020). Between 2010 and 2020, over 320,000 men were circumcised (Lesotho MoH 2022). Figure 1.6 shows the distribution of VMMC by district, with Maseru having the highest, followed by Leribe and Berea Districts.

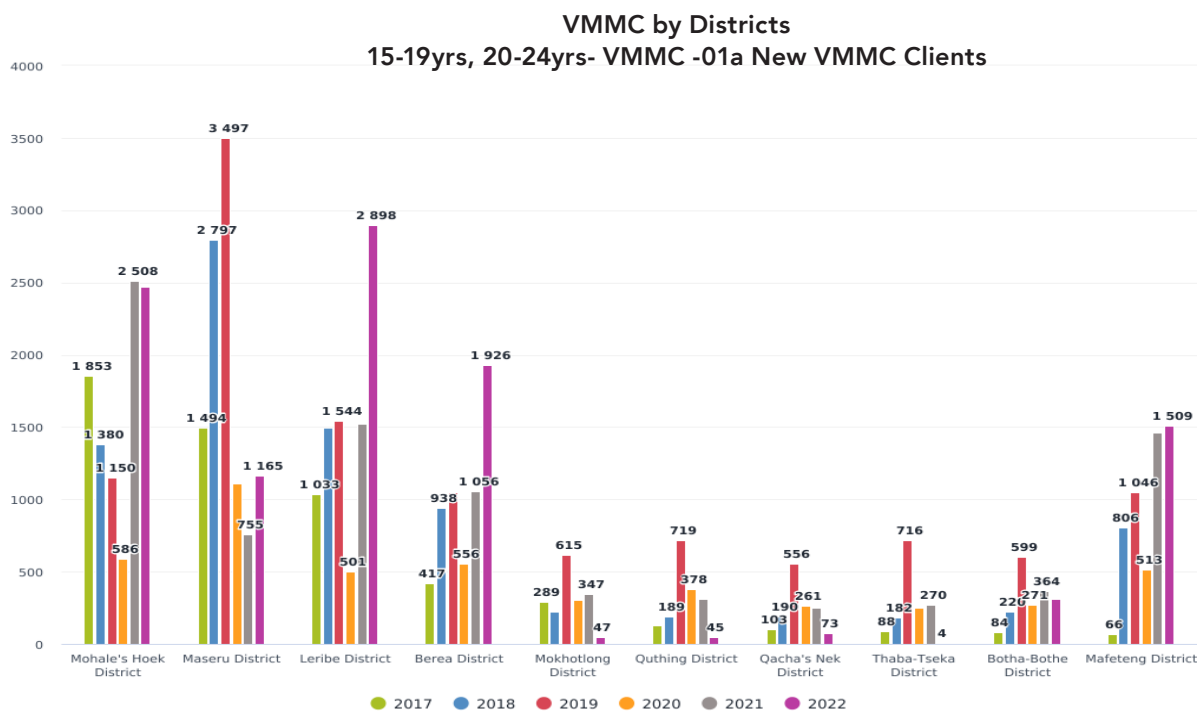
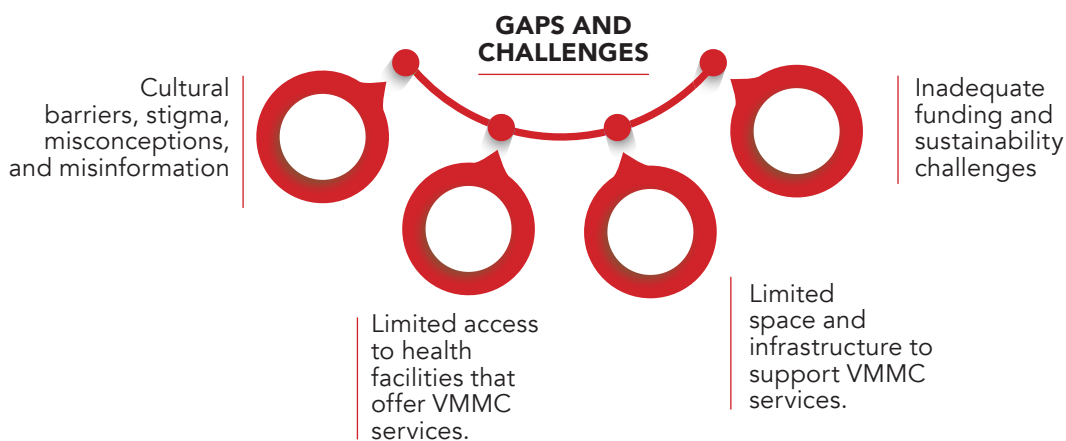


Figure 1.6: Trends in VMMC Performance by District, 2017-2022 (Source: MoH HMIS 2023)



1.3.4. Elimination of Mother-to-Child Transmission

Lesotho has made impressive advancements in preventing vertical transmission of HIV through its evidence-based policies and programs. The prevention of mother-to-child transmission (PMTCT) coverage has increased from 77% in 2017 to 86% in 2020 (UNAIDS Spectrum, 2022). As a result, the number of new HIV infections among children (0-14 years) has decreased by 49% (from 1,600 in 2017 to 901 in 2022). The country's Option B+ policy, which ensures same-day ART initiation for pregnant women living with HIV (WLHIV), has been implemented since 2017 and is integrated into Reproductive Maternal, Neonatal, Child, and Adolescent Health (RMNCAH) platforms. As of March 2022, 96% of new antenatal

care (ANC) visits recorded were offered an HIV test, with 19% testing HIV-positive and 98% of pregnant WLHIV receiving ART (MoH HMIS, 2022), as shown in Figure 1.7.

The improved performance of the PMTCT program in Lesotho can be attributed to several factors, including increased political commitment and investment, expanded access to HIV testing and treatment, strengthened health systems, and community engagement.

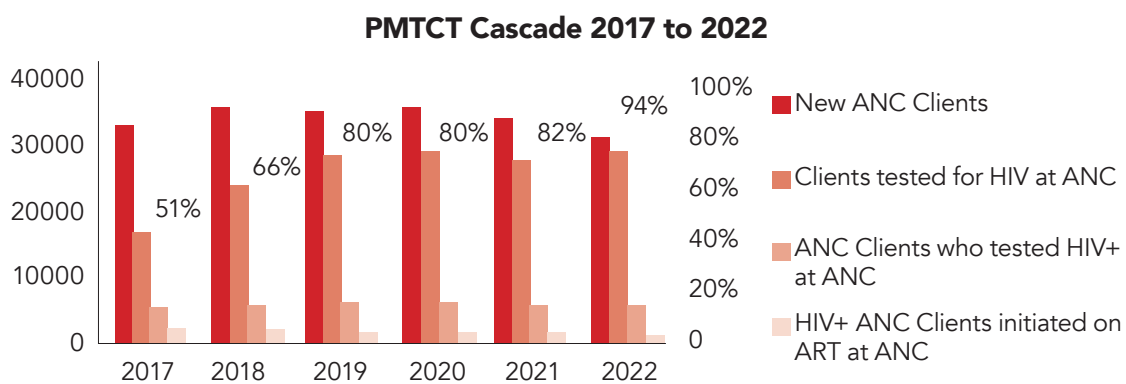


Figure 1.7: PMTCT Cascade, Lesotho, 2022 (Source: MoH HMIS 2023)

Early HIV diagnosis in children is critical in managing HIV and helps in averting HIV-associated mortality. Early infant diagnosis (EID) is defined as having RNA nucleic acid amplification test reverse transcriptase polymerase chain reaction test (NAT RT-PCR) within two months after birth. PCR uptake for children less than one year has increased over time with the introduction of point-of-care (POC) testing to boost conventional laboratory testing. In 2022, 99% of children reported to have had a PCR compared to 94% in 2019 (Figure 1.8).

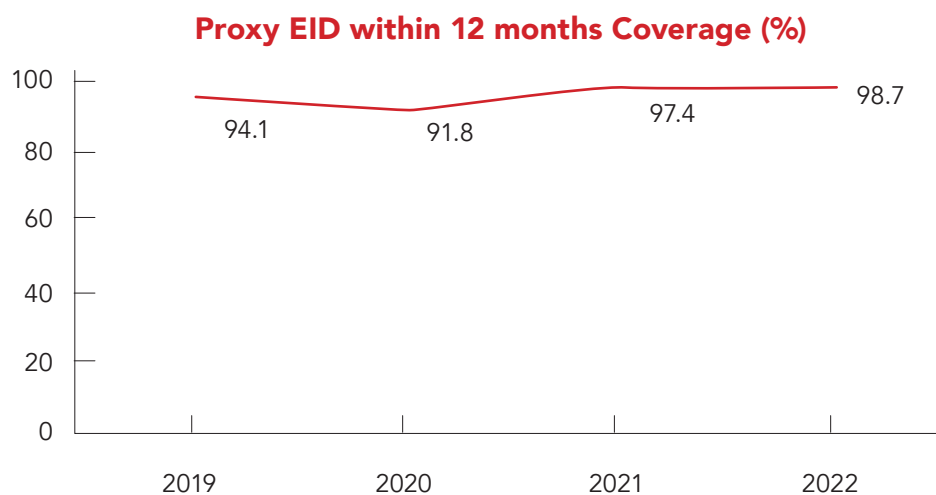
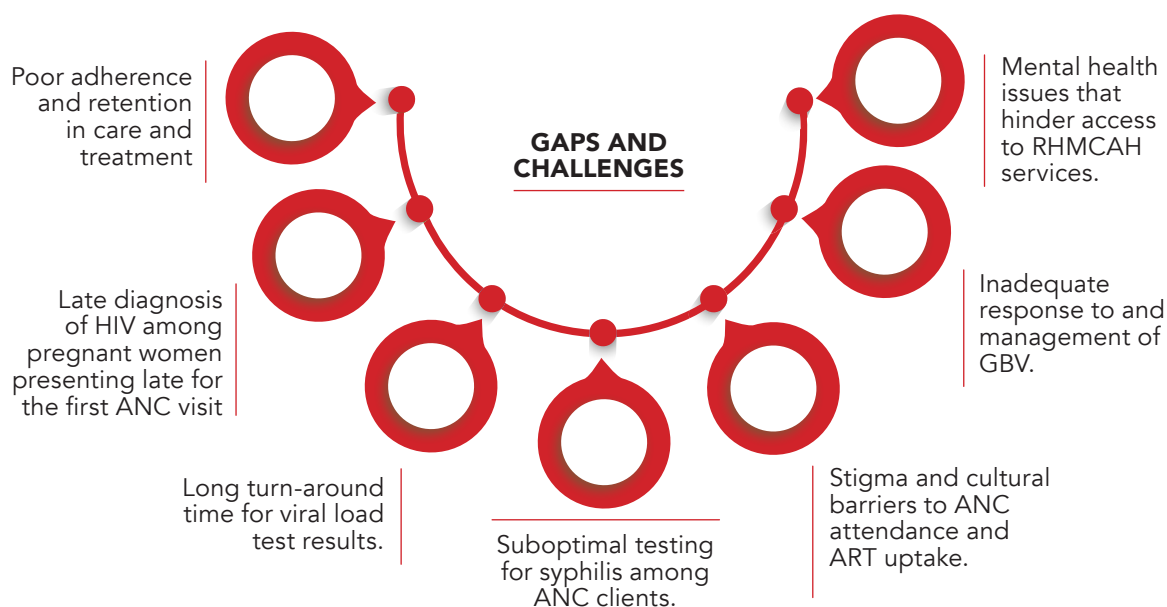


Figure 1.8: Early Infant Diagnosis Service Coverage, Lesotho, 2022. (Source: PEPFAR Panorama Spotlight 2022)

Lesotho has implemented various strategies to improve EID coverage, including expanding the number of EID testing sites, improving supply chain management for diagnostic tests and training healthcare workers. In addition, EID testing has been integrated into routine healthcare services, including immunization clinics. Ongoing efforts to strengthen healthcare systems and expand access to EID services will ensure all HIV-positive infants are identified and receive the care and treatment they need to thrive.

Lesotho has been a trendsetter in the early adaptation of global guidelines that have informed the implementation of integrated PMTCT in maternal and child health programming. In addition, strategic partnerships between the Ministry of Health (MoH) and partners have also ensured quality service delivery is provided to all PMTCT clients.



1.3.5. HIV Treatment, Care, and Support

1.3.5.1. Antiretroviral Therapy Coverage

Lesotho has made substantial progress with 83% ART coverage, equivalent to 233,198 PLHIV receiving ART as of March 2022. However, inequalities remain with lower ART coverage among children 0-14 years and adults aged 15 – 34 (Figure 9). The ART coverage gap for children highlights the need for increased efforts to improve pediatric HIV testing and linkage to care. To achieve this, community-based programs and school partnerships must be strengthened to improve access to testing and care for children. In addition, there will be a need to improve treatment retention in treatment and ART adherence among children to ensure viral load suppression (VLS).

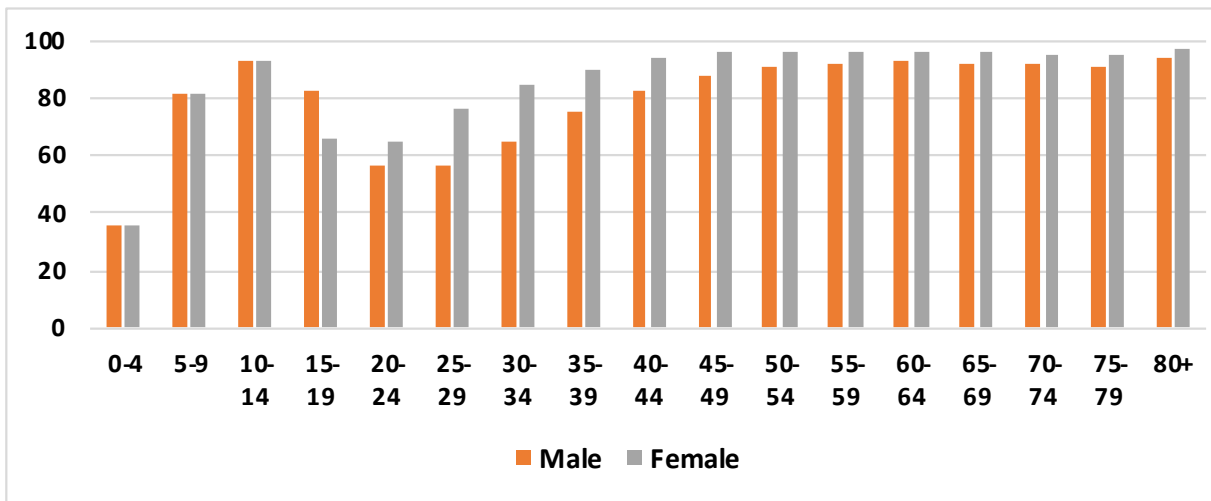
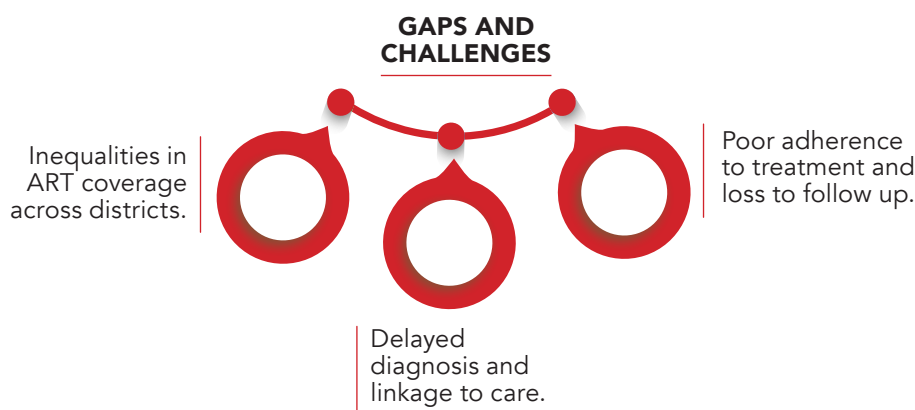


Figure 1.9: Anti-retroviral Therapy Coverage by age group, Lesotho, 2022. (Source: MoH HMIS 2023)

There is also a disparity in ART coverage between different districts. Quthing district has the lowest ART coverage at 69%. In comparison, Mafeteng district has the highest coverage at 94%, indicating the potential for other districts to learn from and replicate successful interventions implemented in this district.



1.3.5.2. Viral Load Coverage

Lesotho's HIV program has also progressed in care, treatment, and supporting PLHIV, as evidenced by the viral load coverage (VLC) and VLS rates. VLC has been steadily increasing over the years (Figure 1.10).

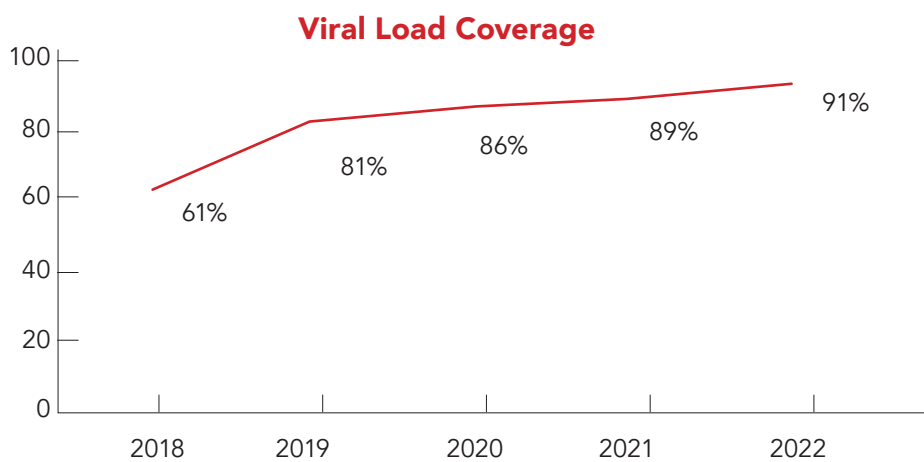


Figure 1.10: Viral Load Coverage, Lesotho (Source: PEPFAR Panorama Spotlight 2022)

Despite this progress, significant work must be done to improve VLC in Lesotho, especially in Mafeteng and Quthing, which lag in VLC. In addition, significant investment in strengthening laboratory infrastructure and expanding access to viral load (VLO) testing for PLHIV is warranted. Figure 1.11 shows VLC for the ten districts.

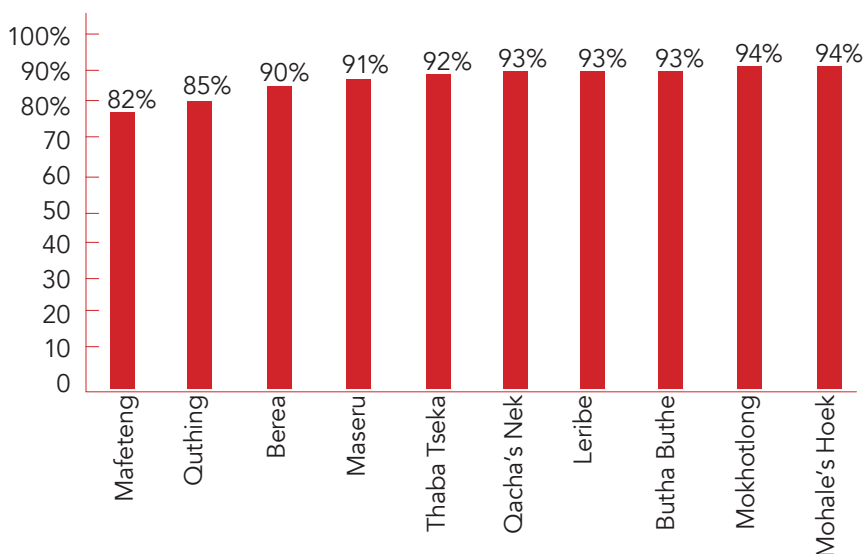
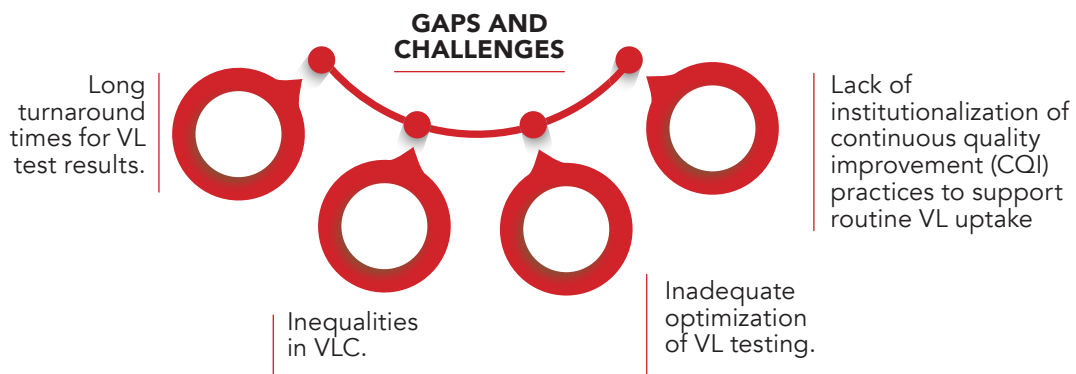


Figure 1.11: Viral Load Coverage by District, 2022 (Source PEPFAR Panorama Spotlight, 2022).

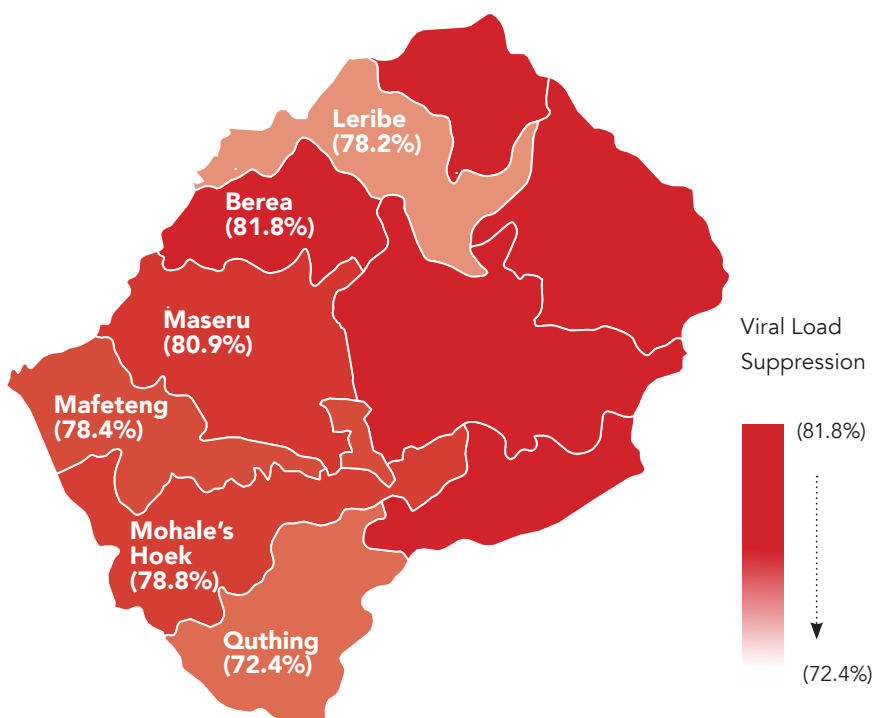


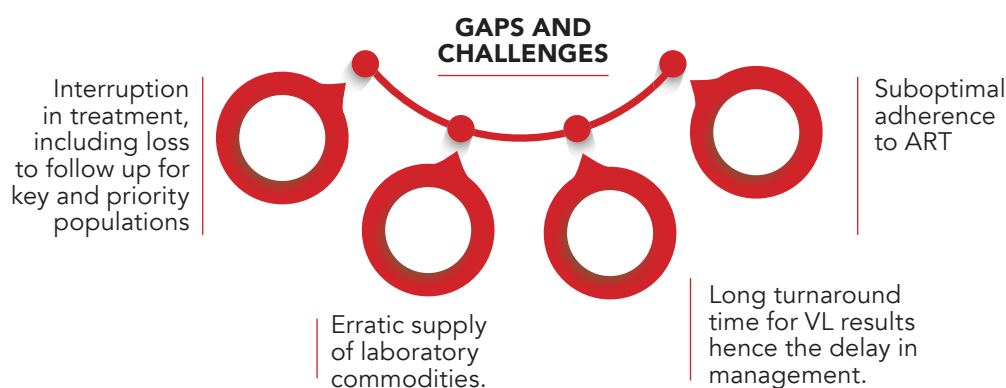
1.3.5.3. Viral Load Suppression

The national program data (2020) shows that 91.5% of adults receiving ART treatment have achieved VLS (LePHIA 2020). However, the VLS rate among children and adult men living with HIV was lower, with only 67% and 88.1%, respectively, achieving successful suppression. The disparities in VLS across the districts (Table 1.6) also indicate the importance of strengthening the healthcare systems

to provide equitable, high-quality HIV services to all individuals. Addressing the challenges of ART adherence and retention requires a multi-sectoral approach that involves collaboration among healthcare providers, communities, and other stakeholders to improve healthcare access, promote education and awareness, and reduce stigma and discrimination.

Table 1.6: Viral load suppression on treatment (Source: LePHIA 2020)





1.3.5.4. Advanced HIV Disease and Treatment Monitoring

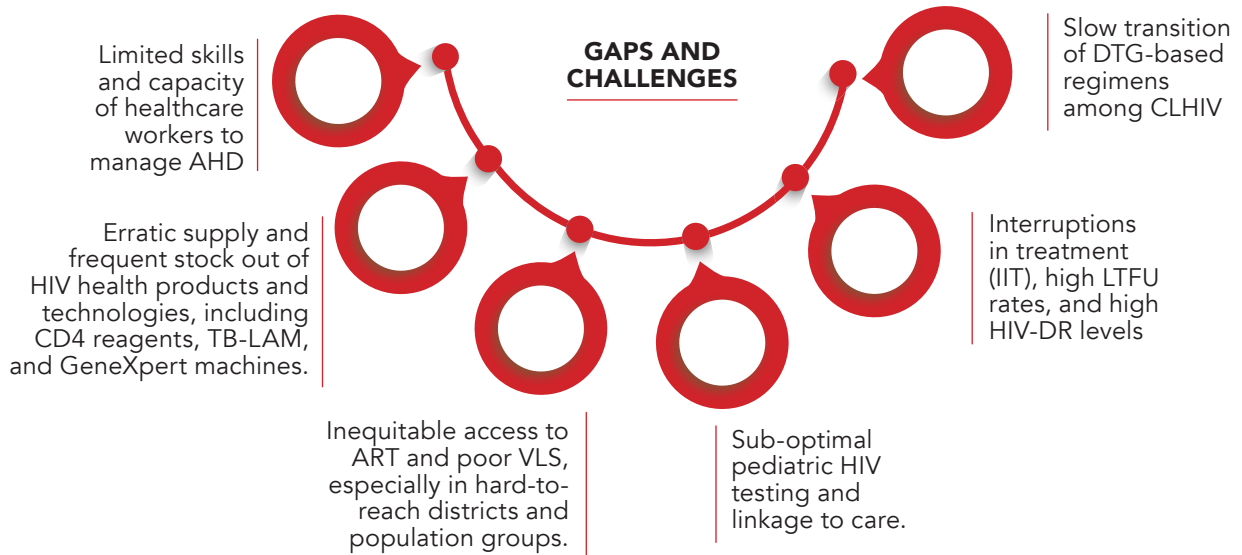
Advanced HIV disease (AHD), HIV drug resistance (HIV-DR), and high rates of loss to follow-up (LTFU) pose a threat to the success of the Lesotho HIV program. For example, LePHIA 2020 indicated that 14% of PLHIV tested in the survey had AHD (LePHIA, 2020).

Additionally, the prevalence of non-nucleoside reverse transcriptase inhibitors (NNRTIs) resistance was high in the 2018 pre-treatment analysis of HIV-DR, with 17% of patients showing resistance. Furthermore, individuals on ART with a VL of ≥ 1000 copies/ml who had been on ART for more than 48 months had significantly higher levels of NNRTI and nucleoside reverse transcriptase inhibitors (NRTI) resistance than those on ART for 12 months (LePHIA, 2020).

Most patients who interrupted their treatment and were defined as LTFU had no clinical contact for more than 28 days and 14% were lost within

the first three months of ART initiation. In 2017, 11.4% of the population had transmitted resistance to antiretroviral drugs (ARVs) (LePHIA, 2020). Transitioning to dolutegravir (DTG)-based regimens will reduce drug resistance levels and improve treatment outcomes for PLHIV in Lesotho. As of 2023, all adults living with HIV and 43.2% (2485) of children living with HIV (CLHIV) have been transitioned to DTG as appropriate.

More work is required to ensure that all PLHIV, including CLHIV, can access ART and achieve VLS. This involves strengthening community-based programs, improving pediatric HIV testing and linkage to care, and targeted interventions to improve ART coverage in underperforming districts and populations.



1.3.6. TB/HIV Co-infection

Lesotho is among the 30 nations in the world with significant TB burden, with a reported incidence rate of 614 cases per 100,000 people (WHO Global TB Report 2019). In addition, the National TB Prevalence Survey 2019 found that the TB prevalence among adults aged 15 years and above was 581 per 100,000, and the incidence rate was 654 per 100,000. Over half of TB cases go untreated due to poor case detection rates of only 48%. Approximately 80% of TB patients are PLHIV, others being elderly, men and rural residents (National TB Prevalence Survey 2019). Figure 1.12 shows TB case notifications and HIV prevalence by district.

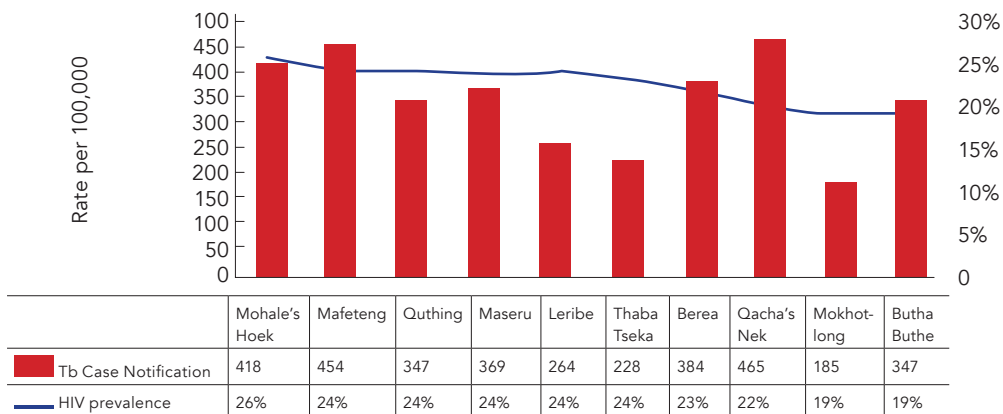
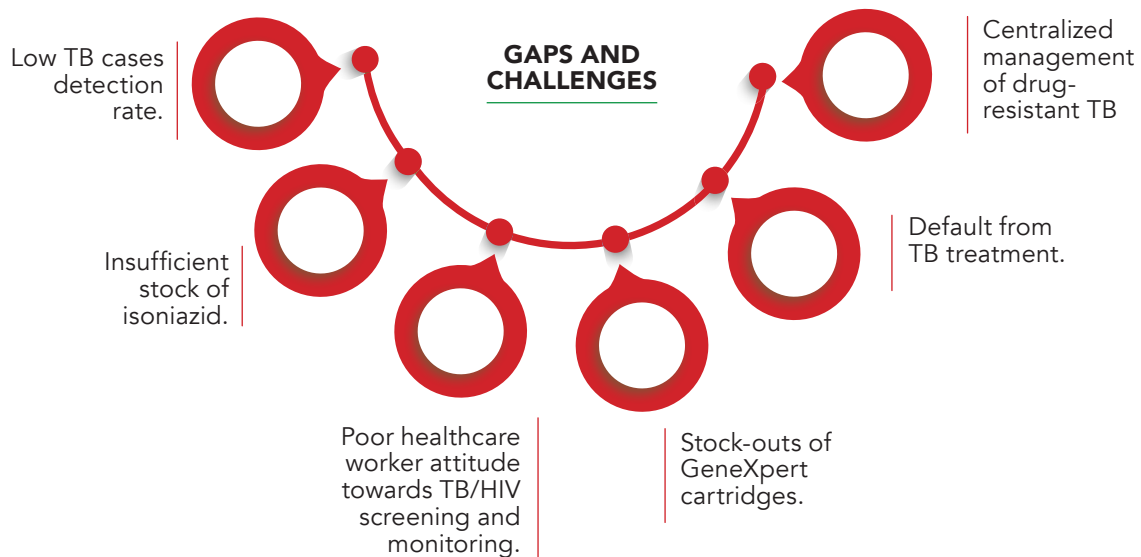


Figure 1.12: TB Case Notifications and HIV Prevalence by District, 2019 (Source: MOH 2019)

According to the national data, an estimated 4,800 people died from a cause attributable to TB in 2020, and 75% of these deaths are estimated to have occurred in PLHIV. The MoH, with support from partners,

is intensifying efforts to improve ART uptake among PLHIV who have TB infection. These include integrating TB activities into HIV services, increasing uptake of TB preventive therapy, and enhancing effective TB case finding and treatment using WHO-approved molecular diagnostics,

chest x-rays, computer-aided diagnostics, and shortened TB treatment regimens. In addition, to address disparities in the TB burden, equitable access to care and targeted interventions should be prioritized to strengthen the community TB response.



1.3.7 Impact of COVID 19 on Healthcare

The COVID-19 outbreak pandemic shifted focus from HIV response and hindered access to prevention, care, and treatment programs. The pandemic increased pressure on strained health facilities and halted community-based HIV activities. The effects of COVID-19 included massive loss of income, pushing families into poverty; decline in government revenue due to the economic impact; restricted movements; limited access to health facilities, increasing the risk of HIV infection; rise in interpersonal violence, GBV and teenage pregnancies during lockdowns; and increase in mental health disorders. The government and community stakeholders implemented innovative interventions to ensure the continuity of HIV services during COVID-19 lockdowns, including intensified

HIV self-testing (HIVST), multi-month dispensing (MMD) of ART, and oral PrEP. The lessons learned during the pandemic should be implemented to ensure the HIV response is maintained and resilient amidst future epidemics and pandemics.

1.3.8. Human Rights, Law, and Gender

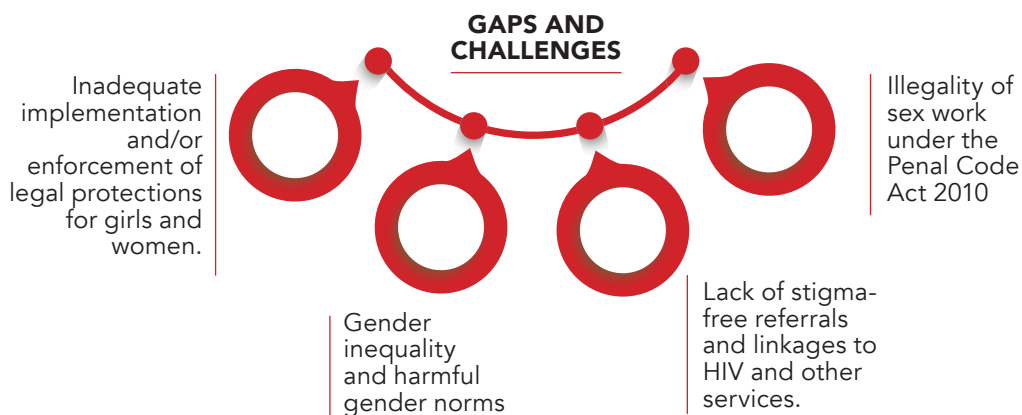
Lesotho has made significant efforts to protect human rights, especially for PLHIV. These efforts include strengthening anti-discrimination laws, raising awareness about rights, reducing HIV-related stigma and discrimination, and improving access to justice for KPs. The country has supportive policy and legal frameworks safeguarding human rights, empowering women, and ensuring equitable access to healthcare and HIV services.

Confidentiality and privacy rights are protected by legislation, and effective law enforcement is in place. The implementation of the Child Protection and Welfare Act is satisfactory, and anti-discrimination laws have been enacted. The Christian Health Association of Lesotho (CHAL) and its health facilities have played a crucial role in providing accessible healthcare services across the country, including comprehensive HIV-related services. Adolescents have the right to access SRH services without requiring authorization based on age or marital status.

According to the Lesotho Stigma Index 2021, there has been a reduction in stigma and discrimination experienced by PLHIV since 2014. Most participants reported no stigma or discrimination, although verbal discrimination, particularly from healthcare workers, remained a common form of stigma. Transgender and non-binary individuals faced higher levels of internalized stigma and experienced stigma and discrimination due to their identities (Lesotho Stigma Index, 2021).

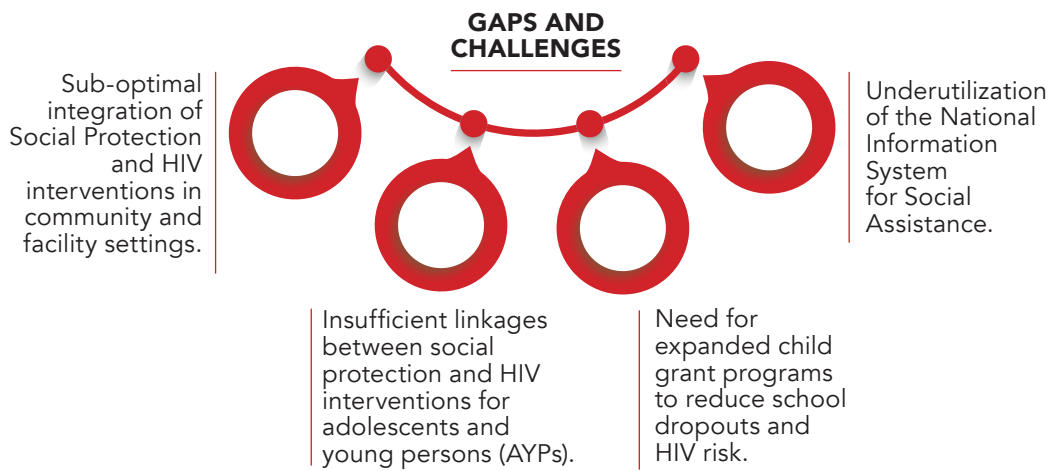
GBV remains a concern in Lesotho, with one in three women and girls experiencing abuse from an intimate partner. The national program has implemented strategies to combat gender inequality, harmful gender norms, and GBV. These strategies include establishing standard operating procedures for prevention and response, improved referrals and linkages to HIV and SRH services, and enhanced gender empowerment policies. Lesotho has ratified international and regional conventions and protocols on women’s rights and gender equality, demonstrating its commitment to addressing these issues.

The government has enacted national policies and laws to combat GBV, and various organizations are working collaboratively to address GBV through a comprehensive approach. Positive steps towards gender equality include the approval of the second Gender and Development Policy, the draft Domestic Violence Bill, and the implementation of the Gender for Equality and Justice Assessment, which has facilitated the development of key gender monitoring indicators.



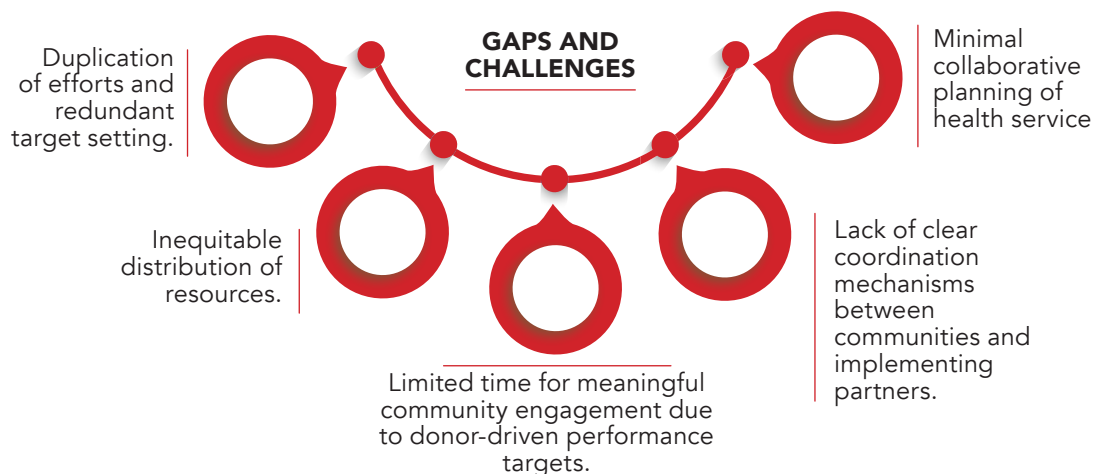
1.3.9. Social Protection

The GoL has committed to developing social protection programs to benefit vulnerable populations across all life stages, aiming to benefit 75% of PLHIV, provide essential external support to 90% of vulnerable children and orphans aged 0-17 years, and offer external economic support to at least 80% of the most vulnerable households by 2023. As a result, measures such as social grants, bursaries, and clinics for vulnerable populations have been implemented, and district child protection teams have been formed.



1.3.10. Community Engagement

Civil society, including Community Based Organizations (CBOs), play a crucial role in various aspects of the HIV response. Their engagement primarily focuses on demand creation, contact tracing, defaulter tracking, and implementing differentiated service delivery models such as Community ART groups. These organizations also contribute to community-led monitoring efforts to address challenges related to long-term retention on ART and ensure the provision of quality HIV and services tailored to the needs of AGYW. The current village health policy fosters a favorable environment and promotes collaboration between health facilities, Civil Society Organizations (CSOs), and village health workers (VHWs) at the community level.



1.3.11. Achievements, Challenges, Lessons Learned, and Recommendations

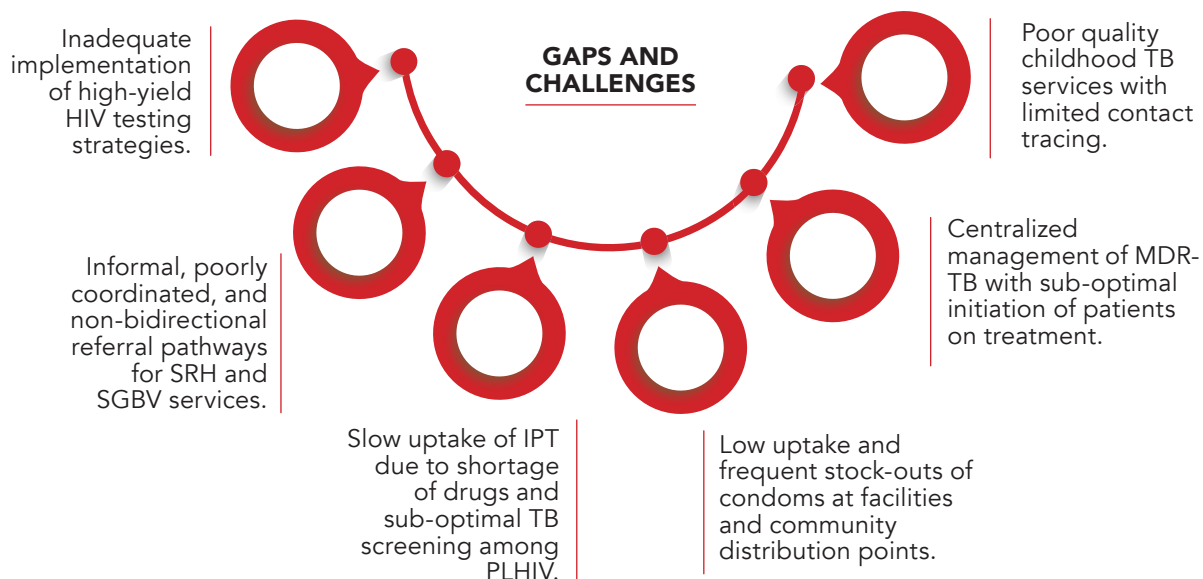
Coordinated by the National AIDS Commission (NAC), Lesotho made significant progress in implementing the National HIV and AIDS Strategic Plan (NHASP) 2018/19 - 2022/23. However, sustaining the gains made and improving the strategies is necessary. Integration of HIV and other health services and optimizing community interventions for leadership and ownership will address continued inequitable access to services and accelerate action towards achieving the goals of the new strategic plan. Table 1.7 summarizes the achievements of the NHASP 2018/19 – 2022/23, gaps and challenges, lessons learned, and recommendations for the LHSP 2023 – 2028.

Table 1.7: Summary of the Achievements of the NHASP 2018/19-2022/23, Gaps and Challenges, Lessons Learned, and Recommendations for the LHSP 2023-2028



Achievements of the NHASP 2019-2023

- » Attained 90:97:92 of the UNAIDS 90:90:90 targets.
- » Adopted the WHO “Treat All” recommendation for universal ART initiation.
- » Launched updated HIV treatment guidelines based on the WHO consolidated 2021 guidelines.
- » Transitioned all adult HIV patients to a DTG-based regimen.
- » Implemented MMD of ARVs to minimize interruptions in treatment.
- » Established over 350 Community Adherence Groups (CAGs) to improve adherence to treatment and reduce program attrition.
- » Introduced POC VL testing to monitor ART outcomes.
- » Developed and implemented a Comprehensive Condom Strategy to improve distribution and consumption.
- » Ensured that the government maintains close to 15% expenditure on health and funds over 70% of ARV drugs and 100% of first-line TB/HIV drugs.
- » Established a nationwide laboratory system for sample transportation and networking
- » Revamped DHIS2 to collect reportable standard national indicators.
- » Decentralized coordination of the HIV program to the Districts through DACs.
- » Integrated the HIV and AIDS response into the larger socioeconomic development framework
- » Established policies and structures to coordinate new emerging pandemics, such as COVID-19.



Lessons learned from the NHASP 2019-2023

- » CAGs and Network Clubs enhance treatment adherence and reduce attrition among AYP living with HIV.
- » Monitoring adolescent- and youth-friendly services improves the quality and accountability of HIV/SRH services.
- » HIV over-testing threatens the performance and security of HIV testing supplies and commodities.
- » Community-based TB screening increases TB CNR.
- » Elaborate laboratory sample transportation network improves access to diagnostic TB services.
- » Expanded screening with TB diagnostic tools leads to improved case finding.
- » CQI approaches contribute to the strengthening of TB screening at health facilities.



Recommendations for the LHSP 2023-2028

- » Enhance the capability of NAC to facilitate multisectoral collaboration and effective execution of the LHSP.
- » Develop strategies to attain and sustain the UNAIDS 95-95-95 targets.
- » Address stigma and discrimination through targeted, innovative, comprehensive strategies and interventions for PLHIV and other key and priority populations.
- » Foster partnerships and multi-sector collaboration in HIV programming.
- » Institutionalize community-led monitoring and feedback mechanisms.
- » Adopt cost-effective, sustainable financing strategies for the LHSP.
- » Address the needs of AGYW, including access to SRH, MNCAH, and SGBV services.
- » Scale up implementation of digital and mHealth solutions.
- » Optimize the integration of the non-health sectors into the HIV response.
- » Strengthen M&E systems through standardized data collection tools, regular reporting, and utilization of program performance data for evidence-based decision-making.

AGYW – Adolescent girls and young women; **AIDS** – Acquired Immunodeficiency Syndrome; **ART** – Antiretroviral therapy; **ARVs** – Antiretroviral; **AYP** - Adolescents and young persons; **CAG** – Community adherence groups; **CNR** – Case notification rates; **CQI** – Continuous quality improvement; **DACs** – District AIDS committees; **DHIS2** – District Health Information System 2; **DTG** – Dolutegravir; **HIV** – Human immunodeficiency virus; **IPT** – Isoniazid preventive therapy; **LHSP** – Lesotho HIV Strategic Plan; **MDRTB** – Multi-drug resistant TB; **MMD** – Multi-month dispensing; **MNCAH** – Maternal, neonatal, child and adolescent health; **NAC** – National AIDS Commission; **NHASP** – National HIV and AIDS Strategic Plan; **PLHIV** – People living with HIV; **POC** – Point of care; **SGBV** – Sexual and gender-based violence; **SRH** – Sexual and reproductive health; **TB** – Tuberculosis; **UNAIDS** - The Joint United Nations Program on HIV; **VL** – Viral load; **WHO** – World Health Organization

Chapter **2**

The Strategic
Direction
2023-2028



Lesotho has achieved HIV epidemic control and has embarked on a Fast-Track approach towards ending the AIDS epidemic as a public health threat by 2030 by reaching the ambitious 95-95-95 targets. However, significant improvement in the HIV cascade is still needed. Much has changed since 2018, with new opportunities to capitalize on and many new challenges to overcome in the national response. Building on the NHASP 2018-2023, LHSP 2023-2028 aims to sustain the momentum and further accelerate the progress of attaining the goal of ending AIDS by 2030. The LHSP 2023 – 2028 comprises a set of evidence-informed strategies focused on building resilient and sustainable health systems with a clear focus on community systems strengthening and a well-coordinated multi-sector response.

2.1 Strategic Plan Development Process

The LHSP 2023-2028 development was a participatory process that engaged various stakeholders, including the government, civil society networks, development partners, and service providers. Inputs from these consultations were triangulated with a desk review of available data on HIV epidemiology and program coverage. As a result, the LHSP 2023-2028 further builds on the significant gains in the national response and addresses critical gaps, challenges, and priorities. The strategic plan was initiated and coordinated by NAC.

The following steps were taken in the development of the LHSP:

- **Review of the NHASP 2018 - 2023:** A comprehensive review of the previous strategic plan was conducted to evaluate all aspects of the response, including primary HIV prevention, HIV treatment and care, systems strengthening, coordination, strategic information, and financing. The review identified progress, gaps, challenges, and recommendations. These were applied in developing programmatic, systems strengthening, coordination, financing, and strategic information strategies for the new plan.
- **Epidemiological analysis:** HIV epidemiology analysis was undertaken to establish the current status of the HIV epidemic in Lesotho and to identify priority or strategic interventions for the new strategic plan. This analysis informed the strategic shift and key programmatic strategies outlined in the new plan.
- **Review of the HIV program:** A review of the HIV program was conducted to identify the progress made against set targets since the last strategic plan, gaps in program coverage, challenges in implementing critical interventions and service delivery, and recommendations. These informed the development of the new strategic plan.
- **Stakeholder consultation:** Meetings were held involving relevant stakeholders drawn from all levels (national, district, and community) and all sectors, including key and priority populations, AYPs, CSOs, faith-based organizations (FBOs), private sector, government ministries, academia, research institutes, think-tanks and development partners to identify existent gaps and high impact strategies for the new strategic plan. The gaps and strategies identified were triangulated with available data to inform the design of the new plan.
- **Review of the draft strategic plan:** The draft strategic plan was circulated widely to the technical task team and national stakeholders for review. The draft was reviewed by a technical team of stakeholders against the UNAIDS national strategic plan checklist. The

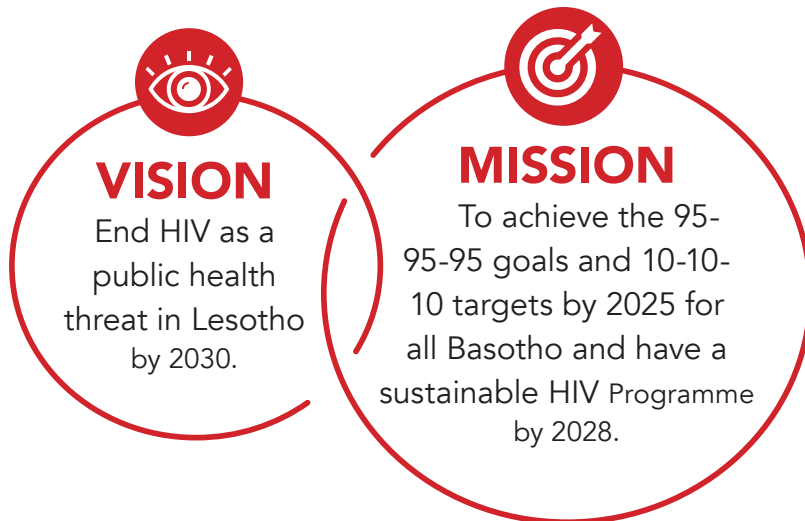
final strategic plan incorporated stakeholder comments from external peer reviewers such as UNAIDS and subject matter experts. In addition, the National Monitoring and Evaluation Advisory Group, which comprises monitoring and evaluation experts from all programs, development partners and members of the national strategic information technical working group, reviewed and finalized the results framework for the new strategic plan. This team also reviewed all the targets included in the strategic plan. A national validation meeting was conducted with attendees from all ten districts and relevant constituencies, including PLHIV, young people, and KPs.

- Target setting approach involved drawing effective targets by considering varying coverage scenarios. The Goals Model was utilized to demonstrate the potential impact of different prevention, care and treatment, and social enablers programs' targets on reducing HIV incidence, HIV-related deaths, and other health outcomes. As a result, targets and coverages with a high potential for impact in averting new infections and preventing HIV-related deaths were prioritized for inclusion in this new strategic plan.
- **Costing and Investment analysis modeling:** Critical investment thinking was applied by modeling the expected costs and impacts of various scenarios to inform the new strategic plan. This plan recommended and adopted the scenario with the highest return on investment. Additionally, costing was undertaken to estimate the financial resources needed.

2.2 Guiding Principles

Based on Universal Health Coverage (UHC), the following principles will guide the strategic plan and investments to meet its aspirations:

- » **Equity:** Multi-sector HIV policies and programs will prioritize the needs of those most vulnerable and apply the principle of leaving no one behind.
- » **Gender-transformative approach:** Measures will be undertaken to eradicate the systemic forms of gender inequalities and GBV by creating or strengthening equitable gender norms, dynamics, policies, and systems that support gender equality.
- » **Social accountability:** Social accountability systems and mechanisms will be strengthened across all sectors, including performance monitoring and reporting, raising public awareness, and fostering transparency and public participation in decision-making on HIV and health-related matters.
- » **People-centered approaches:** Communities, in all their diversities, will be meaningfully engaged in decision-making, implementation, and monitoring to ensure that HIV services and interventions are responsive.
- » **Participatory approaches to delivering interventions:** Stakeholders in healthcare service provision and PLHIV will participate in designing and delivering innovative interventions to achieve favorable outcomes.
- » **Partnerships:** Effective partnerships will be established between affected communities, national peak organizations representing the interest of communities, healthcare providers, government, and researchers. These partnerships will be characterized by consultation, cooperative effort, clear roles and responsibilities, meaningful contributions, empowerment, respectful dialogue, and appropriate resourcing to achieve the goals of the strategies.
- » **Coordination of a multi-sector response:** This strategic plan forms the basis for NAC's coordination of the country's multi-sectoral HIV response. As the country moves towards sustainability, a key principle will be harmonizing the national monitoring and evaluation framework and use of strategic information for decision-making and prioritization.



2.5 Goals of the Lesotho National HIV Strategic Plan 2023-2028

The LHSP sets out to achieve the following goals:



Deliver equitable access to evidence-based, people-centered HIV services.

- » Accelerate and scale up targeted interventions to prevent new HIV infections among key and priority populations, including AGYW, MSM, SWs, and people who inject drugs (PWIDs).
- » Ensure that all children, adolescents, and adults with HIV receive comprehensive care in an integrated approach and address comorbidities and emerging issues.
- » Keep PLHIV and communities at the center of the response.
- » Strengthen and appropriately resource community-led engagements.
- » Support and accelerate innovations and differentiated approaches.



Break down structural and social barriers to achieving optimal outcomes in HIV prevention and management:

- » Eliminate structural barriers, including HIV-related stigma and discrimination, gender inequality and violence, harmful laws and policies, and other socio-economic barriers.

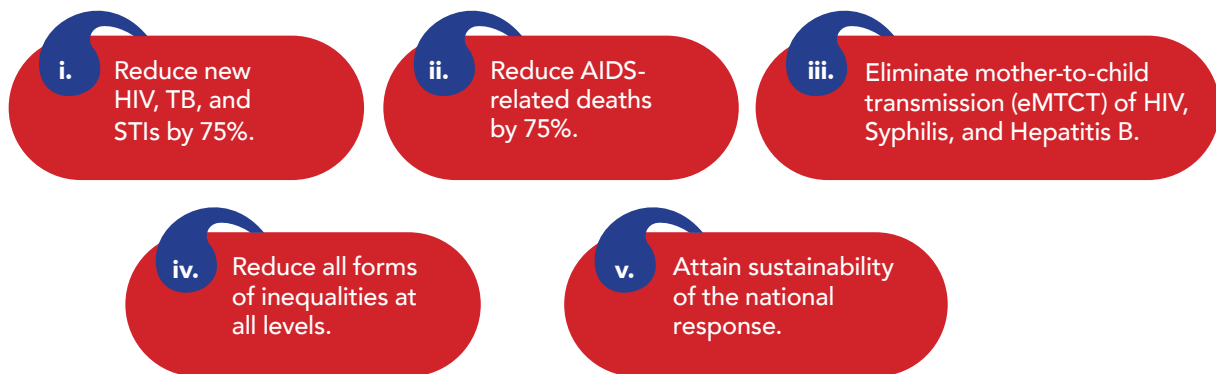


Have a fully resourced, sustainable, and efficient HIV response integrated into health, social protection systems, and pandemic settings.

- » Ensure domestic and long-term financing and sustainability of the HIV response, even during humanitarian crises and emergencies such as pandemics.

2.6 Impact Level Targets of the LHSP 2023-2028

The following are the impact level targets of the LHSP 2023-2028:



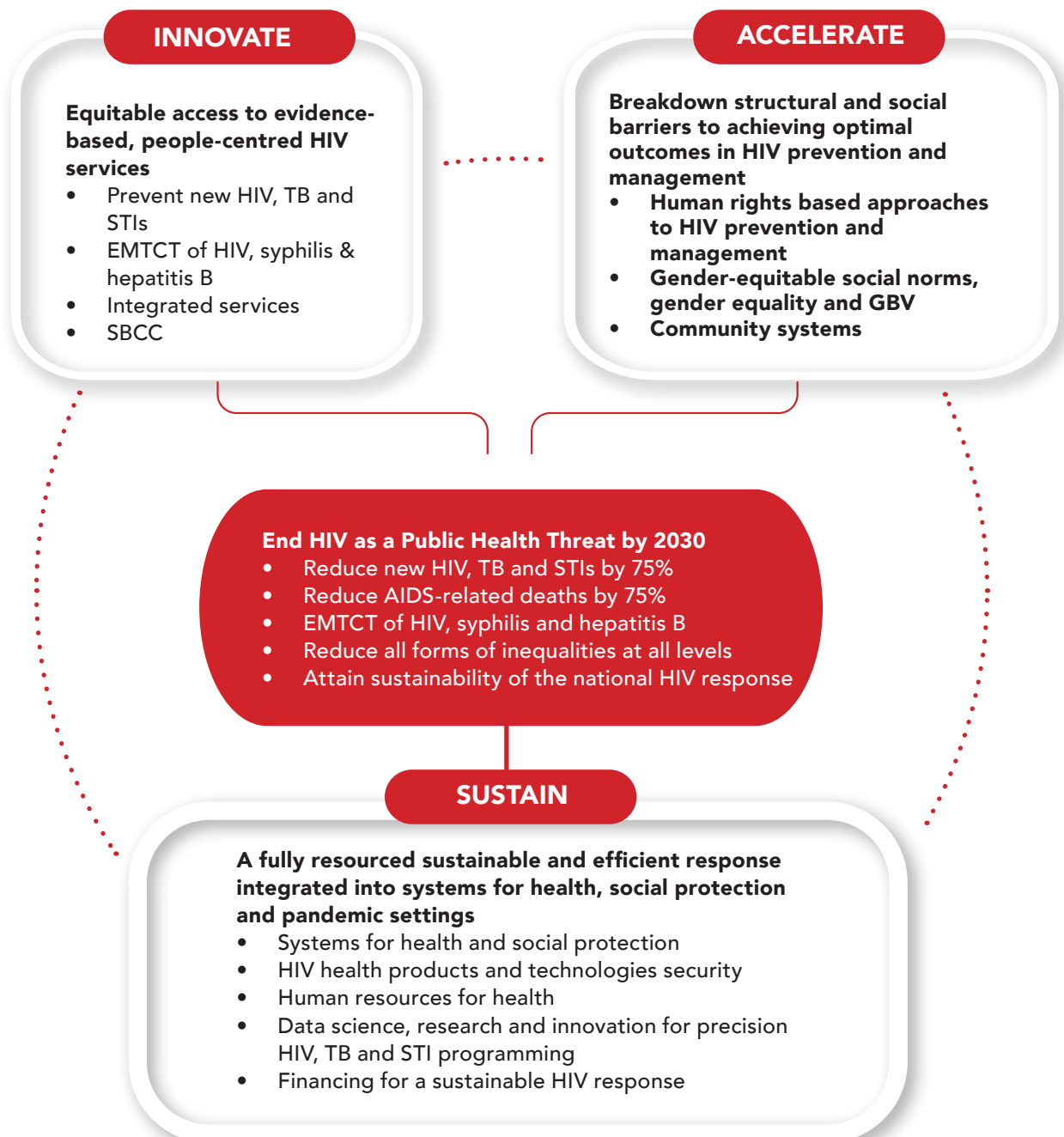
These targets align with the country's commitment to the Sustainable Development Goals (SDGs) and its obligation to provide equal opportunity for disadvantaged groups to enable them to participate fully in public life, as entrenched in Section 26 (2) of the constitution. The successful achievement of these targets will represent a significant milestone in the fight against HIV and AIDS in Lesotho and contribute to the country's social protection and universal health agenda.

Chapter **3**

Strategic
Priorities



The LHSP 2023-2028 is a comprehensive strategic plan with equally important and mutually reinforcing components, priorities, and focus areas anchored in the national strategic development plan (NSDP). It is guided by the 17 SDGs and the vision of Three Zeros - zero new HIV infections, zero AIDS-related deaths, and zero discrimination. In addition, the LHSP's mission to end HIV by 2030 features 14 focus areas to accelerate progress towards realizing the goals and achieving the vision. The LHSP 2023-2028 has three goals. This chapter discusses each goal, its focus areas, and related key interventions. Figure 3.1 depicts the conceptual framework for the LHSP 2023-2028.

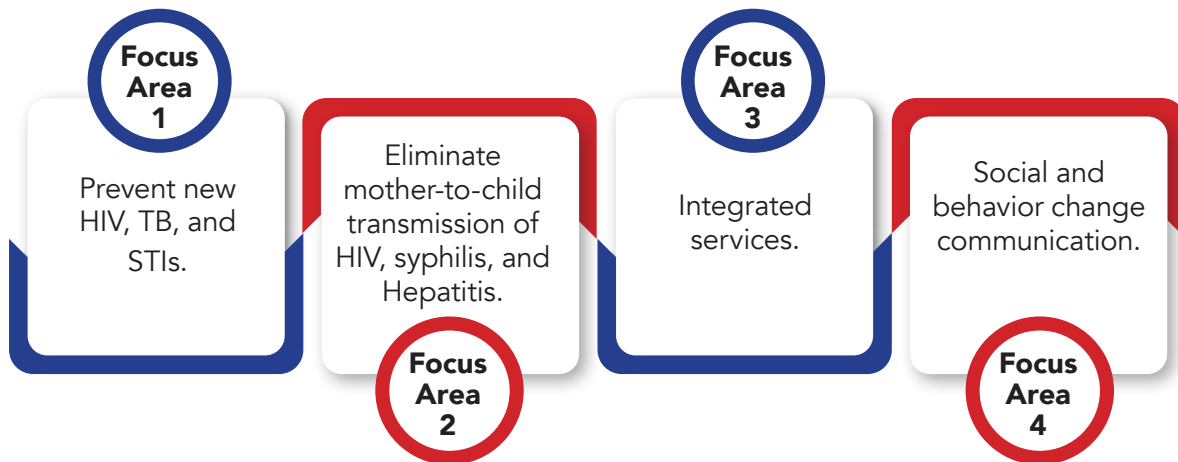




3.1 Goal 1: Deliver equitable access to evidence-based, people-centered HIV services

Equitable access to evidence-based, people-centered HIV services is critical to reducing new infections, improving health outcomes, and achieving and sustaining the UNAIDS 95-95-95 targets in Lesotho. This goal aims to address underlying factors contributing to inequities in access to HIV, TB, and STI services and promote people-centered approaches prioritizing the needs and rights of individuals and communities most affected by HIV.

Focus Areas








3.1.1 FOCUS AREA 1.1: Prevent New HIV, TB, and STIs



Context:

Lesotho has implemented a people-centered and cost-effective approach to HIV prevention through the LHSP 2018-2023. Despite these efforts, KPs such as MSM, FSWs, and PWID are still disproportionately affected by HIV. In addition, priority populations such as AYP, especially AGYW, face significant barriers to accessing prevention services. To reduce new infections, there is a need to eliminate these barriers and tailor prevention interventions to the specific needs of key and priority populations. Lesotho will continue implementing a precise combination of biomedical, behavioral, and structural interventions for HIV prevention alongside scaling up testing and treatment. The five pillars of HIV prevention (Table 3.1) based on the HIV Prevention 2025 Road Map and the Global AIDS Strategy (2021-2026) provide a framework for Lesotho to respond to an evolving epidemic.

Table 3.1 The Five Pillars of HIV Prevention. (Source: HIV Prevention 2025 Roadmap)

RECOMMENDED PACKAGE OF INTERVENTIONS	SETTING
PILLAR 1: Key Populations	
	Combination prevention and harm reduction packages for and with SWs MSM, PWID, transgender people (LGBTQI), and people in prisons.
All Communities Health facilities All districts	
PILLAR 2: Adolescent Girls and Young Women	
	Combination prevention packages (based on differentiated, layered packages)
DREAMS sites and safe spaces Community Schools	
PILLAR 3: Adolescent Boys and Young Men	
	Combination prevention packages (including VMMC and promoting access to testing and treatment)
Health facilities Community	
PILLAR 4: Condom Programming	
	Promotion and distribution of male and female condoms as well as lubricants
All Communities Health facilities	
PILLAR 5: ARV-based Prevention	
	Pre-exposure prophylaxis, post-exposure prophylaxis, TasP, including the eMTCT
Health facilities KP sites and safe spaces	

ARV – Antiretroviral; DREAMS – Determined, Resilient, Empowered, AIDS-free, Mentored and Safe; KP – Key population; MSM – Men who have sex with men; PWID – People who inject drugs; SWs – Sex workers, TasP – Treatment as prevention;

These prevention pillars aim to reduce inequalities, end stigma and discrimination, and advance gender equality while enabling vulnerable populations to access prevention services and social protection.

Key Interventions

- 1** Combination prevention and harm reduction for key and priority populations.
- 2** Combination prevention for AGYW.
- 3** Combination prevention for ABYM.
- 4** Comprehensive condoms and lubricant programming.
- 5** Scaling up antiretroviral-based prevention.

3.1.1.1 Combination Prevention and Harm Reduction for Key and Priority Populations

Context:

Despite efforts in Lesotho to identify and reach key and priority populations through mapping and size estimates, structural, legal, and policy barriers still hinder service provision. Drop-in centers were established, with a goal of 95% of these populations accessing a comprehensive prevention package by 2023. However, inadequate facilities and training, confidentiality breaches, poor attitudes among healthcare workers, and limited infrastructure continue to limit access to services. The targeted implementation of combination prevention and harm reduction minimum packages is crucial to reach subgroups such as SWs, MSM, PWID, and transgender people, as well as herd boys, inmates, migrants, and factory workers.

OBJECTIVE: To reduce the number of new HIV infections among key and priority populations by 75%

Strategic Recommendations	Key Actions
<p>Optimally resource and rapidly scale-up access to combination HIV prevention for key and priority populations</p>	<ul style="list-style-type: none"> • Develop and scale up effective and layered HIV prevention program packages tailored to the needs of key and priority populations across all service points. • Review national laws, policies, and practices to ensure they enable access to and uptake of high-impact service packages. • Protection against violence and other forms of hate crime. • Harmonize the monitoring and evaluation systems to track the effectiveness of HIV prevention programs for key and priority populations. • Conduct research to identify gaps and develop local innovations in HIV prevention programming for key and priority populations. • Build capacities of and fully resource community-led organizations to deliver on the 30-60-80 targets for HIV prevention, care, and support to key and priority populations.
<p>Promote key and priority populations' rights and dignity through enabling structural, legal, and policy frameworks that reduce stigma and discrimination.</p>	<ul style="list-style-type: none"> • Revise, adopt, and implement laws, policies, and programs that protect the rights of KPs and other priority populations, and promote their health and well-being. • Conduct and implement findings of stigma surveys and address stigma and discrimination using a human rights-based approach to Key and Priority Populations programming, including sensitization beyond HCWs (including sensitization of lawmakers and communities). • Invest in research and innovation to better understand the drivers of HIV transmission among KP and priority populations. • Build capacities of service providers in the delivery of non-discriminatory and non-judgmental services.
Expected Outcomes	
<ul style="list-style-type: none"> • 90% of key and priority populations access combination HIV prevention. • 95% of people at risk of HIV use combination prevention. • 95% of people most at risk of HIV access combination prevention services. 	

3.1.1.2. Combination Prevention for Adolescent Girls and Young Women

Context: Lesotho’s HIV program has made significant progress in addressing the high incidence rates of HIV among AGYW. However, HIV prevalence is still higher among women than men across all age groups, with AGYW aged 20-24 years being particularly vulnerable. In addition, VLS rates among young people remain below target. Closing these gaps requires optimal implementation and scale-up of evidence-based layered and targeted combination prevention approaches that address the specific needs of most at-risk AGYW, including access to comprehensive prevention, testing, and treatment services and addressing social and structural factors that increase their risk of infection. Challenges include harmful gender norms, limited comprehensive services, ineffective family planning in remote areas, poor attendance by male partners, limited infrastructure for adolescent-friendly health services, and comorbid mental illness among PLHIV associated with increased risk behavior and poor adherence among AGYW.

OBJECTIVE: To reduce new HIV infections among AGYW by 75% by 2028

Strategic Recommendations	Key Actions
<p>Optimally resource and rapidly scale-up access to combination HIV prevention for AGYW</p>	<ul style="list-style-type: none"> • Accelerate case finding and engage AGYW through community mapping and collaboration with other service providers. • Support integration of DREAMS into health center service delivery and prioritize implementation of DREAMS in the high-burden districts • Lower the coverage age for AGYW services from 15 to 10 years. • Collaborate with KP technical teams and CSOs for integrated programming interventions for AGYW. • Integrate PrEP in all AGYW service points and scale-up distribution beyond health facilities. • Capacity building of healthcare workers (including volunteer healthcare workers) through training to provide age-appropriate comprehensive care to AGYW. • Scale up user-friendly adolescent corners at every health facility and expand community-based service provision. • Provide human papilloma virus (HPV) vaccine and other SRH services, contraceptives, and commodities to AGYW. • Invest in increasing the availability and accessibility of condoms to AGYW at different venues. • Accelerate consistent use of condoms by at-risk AGYW groups using demand-generation approaches for new generations of young people. • Address drivers of GBV and HIV among AGYW and eliminate child marriage. • Economic and leadership empowerment of out-of-school girls and young women living in poverty. • Promote and ensure access to education for girls, focusing on keeping them in school, delaying sexual debut, and increasing access to comprehensive sexuality education. • Integrate screening for common mental disorders and link to pharmacological, psychosocial, and behavioral interventions for AGYW to treat comorbid mental illness and support ART adherence. • Integrate mental health and psychosocial support into AGYW services.

Strategic Recommendations	Key Actions
Provide combination prevention services to male sexual partners of AGYW	<ul style="list-style-type: none"> • Create demand for HIV prevention services among partners of AGYW, including through outreach programs that increase awareness and accessibility to prevention resources. • Increase access to index HIV testing and counseling services for male sexual partners of AGYW, including through community-based testing and counseling services and home-based testing. • Provide comprehensive HIV prevention services for male sexual partners of AGYW, including access to condoms, PrEP, VMMC, and TasP for those who are HIV-positive. • Strengthen referral linkages between HIV and other health and social services, including SRH services, mental health services, and substance abuse treatment. • Promote gender equity and positive masculinity among male sexual partners of AGYW through education and advocacy campaigns that challenge harmful gender norms and promote gender equality. • Develop strategies to address harmful social and structural barriers.
Expected Outcomes	
<ul style="list-style-type: none"> • Reduction in new HIV infections in AGYW by 75%. • 95% of women of reproductive age have their SRH needs met. • Increase the proportion of females 15 years and above with comprehensive knowledge of HIV and AIDS to 90%. • 75% reduction in the proportion of sexually active females aged 15 years and above involved in concurrent sexual partnerships. • 95% of girls and women most at risk access combination prevention services. • 75% increase in the proportion of young people and key and priority populations with comprehensive knowledge about HIV and AIDS. • 90% of boys and men in high-prevalence settings access combination HIV prevention. • 75% of young people and key and priority populations adopt safer sexual behavior. 	

3.1.1.3. Combination Prevention for Adolescent Boys and Young Men



Context:

Recent data shows that HIV incidence rates among young men increase between ages 20 and 30, partly due to traditional masculine values promoting risky sexual behavior. As a result, Lesotho has implemented a national VMMC strategy that involves task sharing, social mobilization, and outreach services. However, challenges include inadequate adolescent, boys and young men (ABYM)-responsive interventions, cultural barriers hindering VMMC uptake among older age groups, limited funding and outreach in hard-to-reach regions, and discrimination and stigma faced by ABYM engaging in same-sex behavior accessing HIV prevention and treatment services. Targeted interventions will aim to promote VMMC uptake and reduce HIV infection risk among boys and men, also reducing HIV infection risk for girls and women.

OBJECTIVE: To reduce new HIV infections among ABYM to 75% by 2028

Strategic Recommendations	Key Actions
Develop targeted programs to promote positive masculinity norms among ABYM	<ul style="list-style-type: none"> • HIV risk assessment and counselling. • Information and education on HIV transmission dynamics, risks of different sexual practices, and skills building on delayed sexual debut. • Use targeted media campaigns to provide information and education to discourage unprotected sex, scale up consistent and correct condom use, and reduce stigmatization of health services. • Male-centered demand creation to increase awareness, uptake and acceptability of relevant health services. • Differentiated service delivery (DSD) models to strengthen male-responsive prevention services in facilities, communities, workplaces, learning institutions, and other settings. • Provide information and education on gender equity, prevention of GBV, and reducing stigma, discrimination, and violence. • Build knowledge capacity of ABYM on prevention of HIV and GBV, including on CSE. • Address harmful norms through targeted programs. • Promote and ensure access to education for boys, with a focus on keeping them in school. • Create linkages between education and livelihoods/economic empowerment programs for ABYM. • Strengthen male engagement, involvement, and participation in HIV prevention programs.
Increase access to comprehensive SRH services.	<ul style="list-style-type: none"> • Develop and implement targeted programs to reach ABYM, such as outreach and peer-led initiatives. • Capacitate VMMC staff on PrEP service delivery and vice versa to enable the provision of comprehensive HIV prevention services • Provide comprehensive sexual health services that include HIV testing and counseling, STI screening and treatment, and access to PrEP. • Ensure the availability of condoms and lubricants, and promote their use through educational campaigns and distribution programs. • Implement a combination prevention package for adolescent boys and men.

Strategic Recommendations	Key Actions
New demand creation strategies for VMMC	<ul style="list-style-type: none"> • Increase male involvement in testing, condom use, and uptake of VMMC through Male Corners. • Undertake time-limited campaigns to address the seasonal nature of the demand for VMMC. • Scale holistic person-centered VMMC services that meet client needs, including after-hours services • Use program monitoring tools such as Geographic Information System (GIS) and site capacity and utilization to conduct community mapping, target community mobilization, monitor site productivity in real-time, and inform targeted demand creation among the age-pivot. • Leverage supporting performance-based small grants/incentives to local CBOs for demand creation and linkages. • Advocate for demand creation by the community, traditional government leadership, and peer approaches. • Promote VMMC as a wrap-around service for health, including SRH, PrEP, condom use, SGBV, and TB services. • Improve referral linkages of HIV-negative clients to VMMC (as well as for other HIV prevention services).
Address social and cultural factors	<ul style="list-style-type: none"> • Promote positive social norms that support ABYM's health and well-being. • Work with communities to challenge negative attitudes and beliefs about homosexuality and promote acceptance and tolerance. • Engage religious leaders and other influential figures to advocate for ABYM's rights and well-being. • Provide targeted programs to promote positive masculinity norms.
Strengthen linkages between traditional initiation schools and VMMC	<ul style="list-style-type: none"> • Educate traditional leaders and the general population on the benefits of VMMC. • Strategic engagement with traditional practitioners to support VMMC. • Counter anti-VMMC messaging with support from community gatekeepers and the media. • Support the provision of VMMC services in traditional initiation schools. • Scale-up re-usable VMMC kits as part of sustainability efforts
Strengthen Data Collection and Monitoring	<ul style="list-style-type: none"> • Collect data on HIV prevalence, incidence, and risk behaviors among ABYM to inform prevention and treatment efforts. • Monitor the uptake and effectiveness of prevention and treatment services among ABYM. • Use data to inform and evaluate the responsiveness of ABYM-focused HIV prevention and treatment programs.

Expected Outcomes
<ul style="list-style-type: none"> • Increase comprehensive knowledge of HIV and AIDS among males aged 15 years and above to 90%. • Reduce the proportion of sexually active males aged 15 years and above involved in concurrent sexual partnerships by 75%. • 95% of ABYM's most at-risk access combination HIV prevention. • 90% of ABYM have access to VMMC, integrated with a minimum package of services and multi-disease screening. • 95% of boys and men at higher risk use PrEP. • Reduce the proportion of men over 24 years old engaged in age-disparate sex by 75%. • Increase comprehensive knowledge about HIV and AIDS for AYP by 90%. • Increase CSE among adolescents and young people by 90%. • 90% of key and priority populations adopt safer sexual behavior.

3.1.1.4. Comprehensive Condom and Lubricants Programming



Context:

Lesotho's implementation of the Condom Strategy 2019-2022 has shown progress in education, distribution, usage, and disposal of condoms, as well as awareness campaigns and the introduction of related protective items. However, there are challenges and inequalities that hinder the strategy's success, including an inconsistent supply chain resulting in stock-outs, distribution limited to health facilities only, and cultural taboos that restrict open dialogue on sexual health and knowledge of lubricants among the population.

OBJECTIVE: To increase availability, access, and consistent use of condoms and lubricants among the general population and those at high risk of HIV infection by 2028

Strategic Recommendations	Key Actions
Decentralize the distribution of condoms and lubricants and accelerate the implementation of the Lesotho Condom Strategy to scale	<ul style="list-style-type: none"> • Map condom distribution to HIV case-based surveillance (CBS) and prioritize allocation to hotspots. • Joint packaging of condoms and lubricants. • Integrate condoms and lubricants distribution into other programs, including SRHR services. • Broaden community-based condoms and lubricants distribution using various strategies. • Establish monitoring and evaluation mechanisms for the distribution and use of condoms to track uptake. • Ensure fidelity to the Lesotho Condom Strategy, including quality standards and effective communication.
Scale up information dissemination on condoms and lubricants	<ul style="list-style-type: none"> • Review, update and strengthen national condom strategy. • Conduct outreach and education campaigns to increase awareness and demand for condoms and lubricants. • Develop targeted messaging and materials for key and priority populations • Establish partnerships for demand creation with community organizations and key influencers. • Train healthcare workers and other service providers on proper condom use and counseling techniques.
Expected Outcomes	
<ul style="list-style-type: none"> • 90% condom use during sexual activity with non-regular partners 	

3.1.1.5. Scaling Up Antiretroviral-Based Prevention



Context:

Lesotho has implemented oral PrEP as part of its combination prevention services for key and priority populations at high risk of HIV infection. However, interest in PrEP among HIV-negative individuals, uptake, and continued use remains sub-optimal, especially among AGYW. There is a need to up-scale simplified, differentiated, and digitalized services and rapid introduction of new technologies to increase equitable access, choice, and effective use of PrEP/PEP. Challenges include limited availability in rural areas, stigma and discrimination towards KPs, limited awareness and knowledge, and inadequate funding for ARV-based prevention programs.

OBJECTIVE: To increase access and utilization of PrEP and PEP for key and priority populations to 95% by 2028

Strategic Recommendations	Key Actions
Expand differentiated and decentralized PrEP and PEP service delivery.	<ul style="list-style-type: none"> • Develop a National PrEP Framework. • Develop a national acceleration plan to effectively roll out innovative new PrEP and PEP technologies (for example, Dapivirine ring, long-acting injectables, and event-driven PrEP).
Strengthen the integration of PrEP and PEP at all available entry points at the health unit.	<ul style="list-style-type: none"> • Develop national operational guidelines for integrating PrEP and PEP at all HIV and RMNCAH service delivery points. • Implement a unified approach to prevention, including status-neutral community-based HIV prevention approaches. • Task-shift PrEP maintenance visits to lay providers and other community- and facility-based models focusing on key and priority populations. • Screen and refer clients for treatment of mental health and substance use disorders
Increase awareness and access to PrEP and PEP.	<ul style="list-style-type: none"> • Develop targeted and community-wide campaigns to increase awareness of PrEP and PEP among high-risk populations. • Update and implement a healthcare provider training curriculum on PrEP and PEP, SBCC, guidelines, and human rights approaches. • Develop and implement innovative interventions, such as delivery applications, to ensure timely and equitable access to PrEP/PEP.
Address barriers to PrEP/PEP access and adherence.	<ul style="list-style-type: none"> • Develop and implement interventions to eliminate the stigma associated with PrEP/PEP use. • Utilize human-centered design approaches for decentralizing PrEP refills for AGYW within private pharmacies to expand access and adherence to PrEP/PEP • Implement community-wide awareness of PrEP and PEP. • Provide effective support and monitoring for individuals on PrEP/ PEP. • Undertake research and utilize user experiences to inform interventions.
Strengthen monitoring and evaluation of the PrEP/ PEP implementation.	<ul style="list-style-type: none"> • Track PrEP/PEP coverage, uptake, and adherence. • Collect and analyze data on PrEP/PEP outcomes and their impact on HIV incidence. • Use data to identify and address gaps and challenges in PrEP/ PEP program delivery and uptake. • Engage key stakeholders in ongoing program evaluation and improvement.
Expected outcomes	
<ul style="list-style-type: none"> • 95% of people at risk of HIV infection access and use appropriate, prioritized, person-centered, and effective combination prevention options. • 90% of AGYW 15-24 years old who are sexually active and at high risk receive PrEP. • 80% of HIV-negative partners in serodiscordant couples receive PrEP. • 50% of HIV-negative female sex workers (FSWs) and 20% of HIV-negative MSM receive PrEP 	

3.1.2 FOCUS AREA 1.2: Elimination of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B



Context:

Lesotho has made progress in reducing the MTCT of HIV by implementing the PMTCT program. However, challenges still exist, including low syphilis testing rates and high rates of women dropping out of the program. To reduce new HIV infections and achieve the global goal of ending the HIV epidemic by 2030, Lesotho must prioritize differentiated PMTCT services for AGYW and address social and economic barriers to care. Challenges include inadequate integration of PMTCT services, limited community engagement, gender power imbalance, stigma, and discrimination.

OBJECTIVE: To eliminate MTCT of HIV, syphilis, and Hepatitis B by 2028

Strategic Recommendations	Key Actions
Prong 1: Primary prevention of HIV infection among women of childbearing age	
Expand PrEP/PEP access for all pregnant and breastfeeding women (PBFW) at high risk of acquiring HIV.	<ul style="list-style-type: none"> • Strengthen SBCC on PrEP/PEP for PBFW and their partners. • Capacitate healthcare workers on initiating and managing PrEP/PEP for PBFW through structured training and mentorship. • Provide supportive supervision of PMTCT services, including PrEP/PEP. • Scale up facility-based PrEP/PEP provision for PBFW • Implement and monitor community-based platforms for stigma reduction, male engagement, and PrEP/PEP provision for PBFW.
Integrate PMTCT services into all RMNCAH service delivery points in the health system.	<ul style="list-style-type: none"> • Conduct a needs assessment to identify existing RMNCAH platforms and PMTCT service integration gaps. • Develop and implement comprehensive plans for integrating PMTCT services into existing RMNCAH platforms, considering the particular needs and preferences of AGYW. • Capacitate healthcare workers to provide adolescent and youth-responsive PMTCT services through structured training and mentorship. • Develop and implement strategies to improve the quality and accessibility of PMTCT services, such as reducing waiting times and ensuring PMTCT health products and technologies' security and availability. • CoHIV-exposednity outreach and education campaigns to raise awareness of PMTCT services and encourage uptake among AGYW. • Involve AGYW in the design and implementation of PMTCT services, including through the use of expert patients such as adolescent champions and youth-led advocacy groups.
Increase PrEP/ PEP service coverage for FSWs	<ul style="list-style-type: none"> • Scale up integrated mobile outreach services and drop-in centers (DICES) for FSWs • Train outreach workers and DICES staff on the initiation and management of PrEP for FSWs
Prong 2: Preventing unintended pregnancies among women living with HIV	
Expand access to effective modern dual contraceptive choices and support for pregnancy intentions.	<ul style="list-style-type: none"> • Build the capacity of HCWs on the use of long-acting reversible contraceptives (LARCs) • Procure and distribute adequate supplies of LARCs options to health facilities. • Conduct outreach activities to increase awareness and uptake of these contraceptive options among women living with HIV (WLHIV).
Strengthen the integration of HIV services into the broader RMNCAH service delivery platform.	<ul style="list-style-type: none"> • Provide training to healthcare workers on integrating HIV and family planning (FP) service delivery. • Revise client contact tools to include active assessment of contraceptive needs for WLHIV. • Increase availability and uptake of quality and comprehensive family planning services, especially for AGYW living with HIV.

Strengthen monitoring and evaluation activities to improve outcomes.	<ul style="list-style-type: none"> • Collect and analyze data on unmet needs for FP among WLHIV • Monitor progress towards the target of reducing the unmet need for FP among HIV-infected women to 10% or less • Conduct regular evaluations, including continuous quality improvement activities, to assess micro-interventions effectiveness and make the necessary data-driven adjustments.
Prong 3: Prevent vertical transmission of HIV	
Strengthen HIV testing services (HTS) for PBFW	<ul style="list-style-type: none"> • Optimize access to and utilization of HIV/Syphilis dual test kits and other multiplex testing platforms. • Integrate HTS into ANC services, labor and delivery, postnatal care (PNC), and mental health. • Test all pregnant women and their male partners for HIV, syphilis, and hepatitis B in the first trimester, with repeat testing for HIV-negative women in the third trimester. • Support supervision and mentorship to ensure fidelity to guidelines for HIV testing and counseling. • Capacitate healthcare workers through structured training and mentorship to carry out data analysis and track eMTCT indicators.
Enhance EID and institute timely treatment.	<ul style="list-style-type: none"> • Scale up integrated EID POC devices in health facilities to improve EID test result turnaround time and support birth testing of HIV exposed infants (HEI). • Conduct annual mother-infant pair cohort analyses to evaluate retention within the PMTCT program • Provide ART to all pregnant and breastfeeding WLHIV • Optimize and scale up testing of all HEI within two months of birth • Follow up and initiate ART for all HEI confirmed to be HIV-infected
Strengthen health systems for sustained PMTCT outcomes.	<ul style="list-style-type: none"> • Strengthen laboratory and diagnostic services for HIV and syphilis testing • Ensure adequate supply of essential health products and technologies to prevent vertical transmission of HIV • Provide supportive supervision and mentorship to healthcare workers to improve service quality • Establish strong referral and linkage systems between ANC, maternity, and PNC
Prong 4: Treatment, care, and support to mothers living with HIV, their children, and families	
Scale up implementation of a package of tailored and differentiated care and support interventions.	<ul style="list-style-type: none"> • Strengthen family-centered care aligned with the MNCH schedule of services for mother-infant pairs. • Develop guidelines for differentiated care for pregnant and lactating adolescents and other vulnerable groups. • Enhance bi-directional linkage to the orphans and vulnerable children (OVC) program. • Scale up community ART distribution groups for pregnant and breastfeeding adolescents and vulnerable groups. • Conduct home visits and one-to-one contacts with expert patients, such as mentor mothers, to provide care and support for pregnant and lactating adolescents and other vulnerable groups. • Scale-up case identification through index testing of siblings of CLHIV

<p>Optimize VL monitoring and treatment failure management for PBFW living with HIV.</p>	<ul style="list-style-type: none"> • Scale up the targeted installation of POC VL testing machines and ensure an adequate supply of testing commodities. • Capacitate healthcare workers to conduct routine point-of-care VL testing and use the results to enhance adherence counseling or switch women to a more efficacious regimen. • Scale-up VL monitoring in PBFW. • Establish multidisciplinary teams comprising nurses, counselors, mentor mothers, pharmacy personnel, and data clerks to review and re-engage patients and ensure optimal ART for successful patient return to care. • Engage CSO focal persons, mentor mothers, and VHVs to track PBFW with high VLs for appropriate management.
<p>Increase access to optimized ART regimen for PBFW living with HIV</p>	<ul style="list-style-type: none"> • Develop, review and disseminate updated PMTCT guidelines in line with global advancements in ART optimization. • Scale up the implementation of DSD models including peer-led approaches for pregnant and breastfeeding AGYW. • Support at-risk uninfected breastfeeding women to continue three-monthly HIVST or facility-based testing through three months after cessation of weaning. • Strengthen existing male-responsive facilities to support pregnant and breastfeeding women towards improving retention in care.

Expected Outcomes

- All PLWHIV receive ART for PMTCT.
- All HEI receive a virologic test by two months of age.
- 95% of PBFWs living with HIV have access to VL monitoring.
- 95% of AGYW living with HIV have access to comprehensive SRH services, including FP and cervical cancer screening.
- 95% of pregnant women and breastfeeding women access HIV, syphilis, and Hepatitis B testing
- Reduce MTCT of HIV to less than 2%.

3.1.3 FOCUS AREA 1.3: Integrated Services



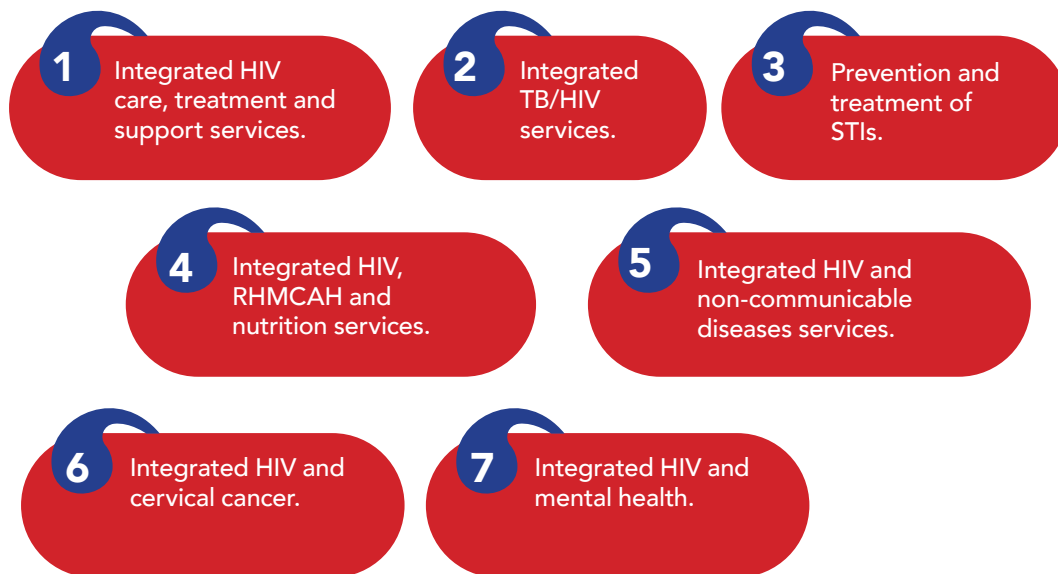
Context:

Integrating the HIV program with person-centered primary healthcare (PHC) provides opportunities to incorporate HIV services seamlessly into the broader health system, encompassing both healthcare facilities and community-based settings. This approach aligns with evolving government policy and aims to provide holistic care to individuals, regardless of their HIV status. By integrating HIV services, valuable lessons learned from the HIV response can be applied to a broader range of services, including non-communicable diseases (NCDs), sexual and reproductive health (SRH), and maternal, newborn, and child health (MNCH) services.

Integration of HIV services with PHC requires collaboration and partnerships across sectors to address the syndemic nature of HIV, sexually STIs, cervical cancer, viral hepatitis, substance use, mental health disorders and NCDs. Integrated services should encompass comprehensive HIV testing, prevention, care, treatment and supportive services, contributing to the overall health and well-being of the population.

Integration occurs at various levels, from policy development and operational guidelines to governance, capacity development of healthcare workers, infrastructure and communication. The LHSP 2023-2028 recognizes the importance of addressing barriers that hinder access and effective engagement in under-resourced areas and among specific populations. The plan outlines measures to overcome these barriers and ensure equitable access and engagement with programs and services throughout the country.

Key Interventions



3.1.3.1 Integrated HIV Care, Treatment, and Support Services



Context:

Lesotho faces challenges in addressing its HIV epidemic, particularly among young women aged 15-24 years, with a prevalence rate of more than double that of their male counterparts. Despite approximately 90% of Basotho knowing their HIV status, knowledge among men and boys aged 15-24 is significantly lower. To move the needle, the LHSP 2023-2028 proposes strengthening integrated HIV care and treatment services, expanding community-based HIV/STI testing and increasing TB case finding. However, challenges remain in providing access to services in remote areas, coordinating facility health services and promoting adherence to ART among migrant workers. In addition, there is a clear need to contextualize and scale up differentiated models of care, including community-based and mobile service delivery, in consideration of the urban and rural population disparities.

OBJECTIVE: To increase access to comprehensive, integrated and responsive HIV, TB and STIs care, treatment, and support services for children, adolescents, youth and adults living with HIV by 2028.

Strategic Recommendations	Key Actions
HIV Testing Services	
<p>Strengthen targeted peer-led demand creation and mobilization efforts to increase uptake.</p>	<ul style="list-style-type: none"> • Collaborate with CBOs to identify and train peer leaders. • Develop targeted messaging and campaigns to increase awareness and uptake through the use of innovative digital and social platforms. • Establish partnerships with employers, schools, and other community organizations to promote HIV testing. • Map recent infection hotspots using recency testing data to prioritize a comprehensive package of services, including HTS, PrEP, condoms, ART initiation, and other services.
<p>Expand the use of index testing and partner notification services, including using the social network strategy.</p>	<ul style="list-style-type: none"> • Scale up index testing and partner notification services. • Integrate HIV self-testing in all testing modalities, especially index testing to reach undiagnosed male sexual partners and CLHIV. • Strengthen the use of local community structures in HIVST distribution and contact tracing. • Use social networks to identify new seeds for testing and expand testing, especially for the AYP and men.
<p>Monitor and improve case identification in facilities</p>	<ul style="list-style-type: none"> • Strengthen and monitor the use of the risk screening tool to increase case identification in facilities. • Promote the use of e-Register to monitor re-testing of people previously on treatment and strengthen education for re-engagement in care. • Use site-level data to monitor yield and testing volumes for outpatient departments. • Use recency testing data to inform community outreaches, HIVST distribution, and integration into index testing efforts.
<p>Support and collaborate with key stakeholders to promote community education and Undetectable equals Untransmissible (U=U) messaging to increase acceptability for index testing and partner notification services.</p>	<ul style="list-style-type: none"> • Establish partnerships with CBOs, employers, schools, and other stakeholders to promote community education. • Provide education and training on U=U messaging to healthcare workers and community leaders. • Conduct targeted community testing, with emphasis on scaling up HIV ST distribution.
Pediatric Care, Treatment, and Support	
<p>Scale up DSD models for CLHIV and optimize Pediatric ART</p>	<ul style="list-style-type: none"> • Enroll stable children into MMD and transition them to adolescent care and treatment. • Roll-out VL dried blood spot (DBS) and point of care VL testing, including community-based VL DBS specimen collection • Transition eligible children to DTG-based regimen. • Community-based testing for HIV and TB for children in families with index cases. • Schedule regular meetings of caregivers and healthcare workers for treatment literacy and ART administration.

Strengthen pediatric psychosocial support groups.	<ul style="list-style-type: none"> Decentralize psychosocial services in all districts to local councils. Establish a community-based referral system for children in districts for OVC programs.
Enhance caregiver support	<ul style="list-style-type: none"> Revive the health center committees to provide linkages among traditional leaders, VHWs and caregivers. Build capacity among VHWs to support caregivers in disclosing HIV status to their children, treatment support and adherence. Create linkages for caregivers and community social services in all districts. Address potential challenges that come with age and lifelong treatment.
Adolescent, Youth and Adult Care, Treatment and Support	
Leadership, management and coordination, for care, treatment and support.	<p>Provide appropriate capacity building for workers and volunteers at all levels, including use of innovative methods for community-level training.</p> <p>Ensure availability of trained staff to support the HIV response, including pharmacy personnel at health centers.</p>
Optimization of care and treatment for adolescents and adults living with HIV, TB and STIs	<ul style="list-style-type: none"> Scale up community-based adolescent services to all districts and expand their scope to include care and treatment. Support health facilities in implementing the “Treat All” approach and scale up the transition to new efficacious treatment options. Strengthen facility- and community-based DSD models to improve continuity of treatment and prevent IIT. Provide tailored services for HIV services in consideration to their locality. Offer same-day or rapid ART initiation for all PLHIV at facility and community levels. Expand screening and POC diagnostic services for HIV/STIs and NCDs to the community level. Decentralize care and support to the community level. Strengthen accountability in the transition of adolescents from pediatric care to reduce LTFU. Develop minimum package of care for clients re-engaging in care
Provide intensified support to ensure adherence to the AHD package based on WHO and MOH AHD guidance.	<ul style="list-style-type: none"> Mentor healthcare workers in implementation of the AHD package as prescribed in the Lesotho/WHO AHD guidelines Disseminate AHD manuals and related job aides such as the algorithm for providing a package of care for people with AHD Expand AHD management package to additional lower health facilities using a hub spoke model Conduct CQI activities for AHD Screen for and treat all opportunistic infections like TB and cryptococcal meningitis Prevent opportunistic infections through provision of TB preventive therapy, fluconazole and cotrimoxazole for all eligible PLHIV.
Optimize ARVs for all the populations including second line ART regimens	<ul style="list-style-type: none"> Build capacity of HCWs in management of treatment failure. Provide age-appropriate counselling for those failing their first line ART regimen. Provide access to VL testing for those with confirmed treatment failure. Conduct drug resistance testing (DRT) for those on integrase strand transfer inhibitors (INSTIs) and protease inhibitors (PIs) regimen with confirmed failure Switch the viremias to their appropriate or desired second line in line with the guidelines and DRT results

<p>Scale up male-responsive services.</p>	<ul style="list-style-type: none"> • Develop and scale up comprehensive male-responsive HIV services at all levels. • Scale up integrated men's clinic model and workplace programs to improve men's retention in HIV prevention and treatment programs. • Facilitate the establishment of flexible operating hours and other DSD models to ensure accessibility and convenience for male patients. • Increase the availability and accessibility of HIVST services in community social settings to reach more men and encourage testing.
<p>Scale up use of CD4 for eligibility for cotrimoxazole preventive therapy (CPT) as well as screening for cryptococcal meningitis</p>	<ul style="list-style-type: none"> • Build the capacity of healthcare workers on use of CD4 tests to inform patient management through structured training, mentorship and institutionalization of quality improvement practices. • Ensure availability of laboratory reagents for CD4 and Crag tests. • Conduct CD4 testing as per the HIV Country Guidelines.

Treatment Monitoring and Drug Surveillance

<p>Promote the use of VL testing to guide treatment decisions</p>	<ul style="list-style-type: none"> • Scale up POC VL testing in the monitoring of HIV treatment as per National ART Guidelines. • Capacitate HCWs to interpret and use VL results to guide treatment decision-making through structured training, technical assistance and mentorship. • Develop real-time monitoring systems to ensure that patients are switched to efficacious regimens based on VL results.
<p>Strengthen data management and information systems.</p>	<ul style="list-style-type: none"> • Optimize systems for the timely and accurate reporting of VL and DRT results. • Adopt electronic data management systems to improve the efficiency of data collection, management and analysis. • Strengthen the capacity for data analysis and use it to inform programmatic decision-making.
<p>Engage communities in treatment monitoring and drug surveillance</p>	<ul style="list-style-type: none"> • Develop and implement community-based programs to increase awareness and knowledge of VL testing and drug resistance (DR) surveillance • Integrate treatment and VL literacy in all service outlets at facility and community levels to prevent IIT • Train community health workers (CHWs) in the proper collection of VL and DR specimens • Develop systems to ensure that community-based programs are integrated with the broader healthcare system and that data is shared and used to inform decision-making.

Expected Outcomes

- 95% of PLHIV know their status and are linked to appropriate prevention, treatment and care services.
- 95% of PLHIV who are on ART have achieved VLS.
- 75% of children, adolescents, youth, and adults living with HIV have access to age-responsive integrated prevention, treatment and care services.

3.1.3.2. Integrated TB/HIV Services



Context:

Although TB incidence declined between 2010 and 2014, it has increased since then, with the rural districts having a higher incidence rate than the urban setting. PLHIV, miners, healthcare workers, inmates, contacts of TB patients and children are at a high risk of TB and hence the need for TB preventive therapy (TPT). TPT uptake scale up was hindered by lack of isoniazid preventive therapy (IPT) commodities in the previous years. There is a challenge in early TB detection and the treatment success rate for TB patients is below the WHO-recommended target. Rural and highland districts are disproportionately affected by poor access to TB services, poor contact tracing and a lack of active case-finding strategies. Lesotho has prioritized addressing these challenges to reduce new TB infections and achieve the global goal of ending the TB epidemic by 2030.

OBJECTIVE: To reduce TB-related morbidity and mortality among PLHIV by 75% by 2028.

Strategic Recommendations	Key Activities
High level policy engagement and advocacy for policy level TB/HIV integration and support.	<ul style="list-style-type: none"> Facilitate the setting up of a TB/HIV parliamentary committee Ensure facilitation of broad-based parliamentary advocacy, debate and discussions. Formulate, oversee and monitor policy and legislation on integrated TB/HIV. Prepare and table periodic reports before the House. Facilitate establishment of a parliament TB caucus to coordinate national, regional and global agenda of TB. Advocate to parliament that NAC be mandated to co-opt TB under its national coordination bodies as part of Multi Sectoral Accountability Framework to accelerate progress towards ending TB (MAF-TB).
Strengthen community and facility-based prevention, screening, and management of TB/HIV	<ul style="list-style-type: none"> Develop and implement an integrated TB/HIV national operational guideline for community prevention, screening and referral for general, key and priority populations. Develop and disseminate a comprehensive package for TB/HIV care. Mobilize resources for development and implementation of the integrated TB/HIV national operational guideline for community prevention, screening and referral for general, key and priority populations. Build partnerships with community leaders to promote behavior change in health-seeking behavior and address some of the determinants of the diseases within the communities. Address stigma and discrimination associated with TB. Utilize innovations such as, mobile TB screening units, in hard-to-reach areas and one-stop shops in TB and HIV service points.
Strengthen community-led monitoring	<ul style="list-style-type: none"> Develop mechanisms for community structures to provide data and reports at local and national level Develop capacity of and incentivize CHWs and traditional healers to monitor and report on integrated TB/HIV services. Establish a system for feedback and reporting to the MoH and NAC.
Strengthen capacity of HIV and TB positive patients and their families on TB treatment and TPT	<ul style="list-style-type: none"> Develop and implement operational guidelines to engage and build capacity of PLHIV on TB prevention and treatment. Develop the capacity of service providers to inform and educate PLHIV on the benefits and adverse effects of TB treatment and TPT. Develop capacity of service providers on correct prescribing of TPT and monitoring of TB treatment.
Strengthen laboratory services and diagnosis of TB	<ul style="list-style-type: none"> Ensure availability of quality-assured diagnostic tools, such as GeneXpert machines, urine-based TB-LAM and other technologies for all health facilities Train laboratory staff on TB diagnosis, including interpretation of GeneXpert, urine TB-LAM results Conduct regular monitoring and supervision of TB laboratory services Scale-up mechanisms for prompt detection and management of Rifampicin-resistant TB cases
Ensure TPT and laboratory commodity availability in all service delivery points	<ul style="list-style-type: none"> Prepare commodity forecasting based on data. Monitor commodity stockout regularly. Make timely orders for preventive, treatment, and laboratory commodities.

Ensure accurate and timely data on TB/HIV co-infection

- Establish and ensure the functioning of point of care electronic medical records (EMR) system and linked to national health information system (HIS) for rapid data analysis of and decision-making on TB/HIV.
- Provide for mandatory reporting of TPT and TB treatment related adverse effects.
- Provide for service integration data treatment-related hearing for coordinated response and decision-making at the national and local levels.

Expected Outcomes

- 75% reduction in TB morbidity and mortality among PLHIV.
- 75% increase in TB case finding and treatment among PLHIV.
- All TB/HIV co-infected persons are started on ART

3.1.3.3. Prevention & Treatment of STIs



Context:

Lesotho faces a significant public health challenge with high prevalence rates of sexually transmitted infections (STIs), particularly among KPs such as FSWs, MSM and PWID. Addressing the STI burden requires a comprehensive and integrated approach to STI prevention, diagnosis and treatment, with targeted interventions for key and general populations. However, challenges exist, including limited access to STI screening and treatment services for key and priority populations, inadequate integration of STI services into broader healthcare services and inadequate engagement of men in STI prevention and treatment efforts.

OBJECTIVE: To optimize the diagnosis, treatment and prevention of STIs for the general population, PLHIV, and key and priority populations by 2028

Strategic Recommendations	Key Actions
Strengthen the integration of HIV/STI services at all service delivery points	<ul style="list-style-type: none"> Review and implement National Guidelines for Integrated HIV/STI Services. Train healthcare workers on integrated service delivery. Develop integrated monitoring and evaluation systems.
Increase access to HIV/STI testing and counseling	<ul style="list-style-type: none"> Expand community-based HIV/STI testing services, including mobile and outreach testing. Ensure the availability of rapid diagnostic tests for STIs in all healthcare facilities. Promote regular HIV/STI testing, including viral hepatitis, among key and priority populations.
Expand treatment and management of STIs	<ul style="list-style-type: none"> Map and link services across facilities for seamless access to STI services. Increase the availability of antibiotics and other medications for STI treatment in all healthcare facilities. Capacitate healthcare workers on STI and viral hepatitis management and treatment protocols through structured trainings. Promote partner notification and treatment for STIs and viral hepatitis.
Strengthen prevention of STIs	<ul style="list-style-type: none"> Adapt and adopt the HIV prevention services. Increase the availability and distribution of condoms and other barrier methods. Provide PrEP for key and priority populations at high risk for HIV/STIs and viral hepatitis. Promote behavioral interventions for STI and viral hepatitis prevention among key and priority populations.
Address social and structural barriers to accessing HIV/STI services	<ul style="list-style-type: none"> Address stigma and discrimination against key and priority populations in healthcare settings. Increase awareness of HIV/STI and viral hepatitis services and reduce barriers to accessing them, including transportation and financial barriers. Engage with CBOs, CSOs, and key and priority population networks to increase awareness of integrated HIV/STI services and viral hepatitis. Establish STI program or technical working groups (TWGs) to integrate within the HIV program in line with WHO guidelines.
Expected Outcomes	
<ul style="list-style-type: none"> Increase in STI/viral hepatitis screening to 75% at all levels of care Availability of STI/viral hepatitis drugs in all health facilities 	

3.1.3.4. Integrated HIV and Non-communicable Diseases Services

**Context:**

In Lesotho, NCDs are increasingly becoming a significant cause of morbidity and mortality among PLHIV. Factors such as demographic transitions, changes in lifestyle and dietary patterns, co-infections with HIV and other infections, and an aging HIV-infected population have contributed to this burden. However, access to early diagnosis and treatment of NCDs among PLHIV remains a significant challenge, with limited awareness and inequalities in healthcare access. The lack of integration between HIV and NCD services has also resulted in missed opportunities for early diagnosis and management of NCDs among PLHIV.

OBJECTIVE: To ensure all PLHIV have access to early diagnosis and treatment of defined NCDs by 2028

Strategic Recommendations	Key Actions
Strengthen health systems to integrate HIV and NCD services	<ul style="list-style-type: none"> • Map existing health systems to identify opportunities for integration. • Develop and implement standardized training programs for healthcare workers on integrated HIV/NCD services. • Establish data systems that allow for tracking of integrated service delivery and outcomes.
Implement and scale up integrated screening and management of HIV and NCDs	<ul style="list-style-type: none"> • Develop integrated screening and management guidelines that include both HIV and NCDs. • Provide regular screening for both HIV and NCDs at health facilities. • Develop referral systems for patients requiring specialized care.
Promote community awareness and involvement in integrated HIV/NCD services	<ul style="list-style-type: none"> • Develop and implement community education programs on the benefits of integrated HIV/NCD services. • Engage community leaders and stakeholders in the development and implementation of integrated services. • Develop community-led support groups for patients with HIV and NCDs.
Ensure the availability of essential health products and technologies for integrated services.	<ul style="list-style-type: none"> • Procure essential medicines and diagnostic technologies for integrated services. • Ensure health facilities have the necessary equipment and infrastructure for integrated service delivery. • Establish supply chain management systems to enhance adequate and timely delivery of integrated services.
Conduct research and monitor the progress of integrated HIV/NCD services	<ul style="list-style-type: none"> • Conduct operational research to identify best practices for integrated service delivery. • Develop and implement monitoring and evaluation frameworks for integrated services. • Regularly review and update guidelines and protocols for integrated service delivery based on new evidence and emerging best practices.
Expected Outcomes	
<ul style="list-style-type: none"> • 90% of all PLHIV have access to early diagnosis and treatment of defined NCDs 	

3.1.3.5. Integrated HIV, RMNCAH and Nutrition Services



Context

Lesotho has a high prevalence of HIV, particularly among women and girls, with low contraceptive use and high rates of unintended pregnancies. To address these challenges, the LHSP 2023-2028 has identified the integration of HIV into RMNCAH and nutrition services as a critical strategy. However, limited access to quality health services, contraceptive methods, inadequate funding and sub-optimal awareness among healthcare workers and the general population remain significant challenges.

OBJECTIVE: Increase access to integrated HIV, RMNCAH and nutrition services for all women in Lesotho to 95% by 2028

Strategic Recommendations	Key Actions
Enhance the capacity of healthcare workers to deliver integrated HIV, RMNCAH and nutrition services.	<ul style="list-style-type: none"> • Conduct training and mentorship programs to build the skills of healthcare workers in integrated service delivery. • Develop guidelines and standard operating procedures for integrated service delivery. • Establish supportive supervision mechanisms to ensure quality service delivery.
Integration of HIV, RMNCAH and nutrition services at the facility level	<ul style="list-style-type: none"> • Ensure the availability of necessary commodities, equipment and supplies to deliver integrated services. • Provide a conducive environment for integrated service delivery, including private and confidential spaces for service provision. • Develop and implement client-centered approaches to service delivery, including using electronic medical records to track client care.
Community-based service delivery and engagement	<ul style="list-style-type: none"> • Engage with communities to increase awareness and demand for integrated services. • Establish community-based service delivery points like mobile clinics and utilization of CHWs. • Build community capacity to support service delivery, including community-based adherence support and peer support groups.
Collection and analysis of data for monitoring, evaluation and decision making	<ul style="list-style-type: none"> • Develop and implement a comprehensive monitoring and evaluation plan for integrated service delivery. • Collect and analyze data on service utilization, quality of care, and health outcomes. • Use data to inform program planning, identify gaps and improve service delivery.
Strengthen partnerships and collaboration	<ul style="list-style-type: none"> • Foster partnerships and collaboration between health facilities, CBOs and other stakeholders to promote integrated service delivery. • Engage with donors and development partners to mobilize resources for integrated service delivery. • Build networks and coalitions to advocate for policies and programs that support integrated service delivery.
Expected Outcomes	
<ul style="list-style-type: none"> • 95% of women, including WLHIV, receive integrated HIV, RMNCAH and nutrition services 	

3.1.3.6. Integrated HIV and Cervical Cancer Services



Context

In Lesotho, the risk of cervical cancer among women up to 74 years of age is significant, particularly for those living with HIV. Studies have shown that HIV-positive women contribute to a higher burden of cervical cancer in the region. Cervical cancer accounted for a small percentage of female deaths in Lesotho in 2019, but the screening program was not reaching an optimal number of eligible women. It is crucial to educate both HIV-negative women and WLHIV about preventive measures, screen them, and provide treatment for cervical cancer as part of the routine HIV prevention, care and treatment package.

OBJECTIVE: To ensure 90% of WLHIV and key and priority populations have access to information on prevention, early diagnosis and treatment of cervical cancer.

Strategic Recommendations	Key Actions
Strengthen health systems to integrate HIV and cervical cancer services	<ul style="list-style-type: none"> • Map existing health systems to identify opportunities for integration of cervical cancer into HIV prevention and treatment. • Develop and implement standardized training programs for healthcare workers on integrated HIV/cervical cancer prevention, diagnosis and treatment services. • Establish data systems that allow for tracking of integrated service delivery and outcomes.
Implement and scale up integrated screening and management of cervical cancer	<ul style="list-style-type: none"> • Develop integrated screening and management guidelines that include HIV/cervical cancer. • Provide regular screening for cervical cancer in HIV service delivery points in health facilities. • Develop referral systems for patients requiring specialized care • Integrate HPV testing into existing GeneXpert platforms.
Promote community awareness and involvement in integrated HIV/Cervical cancer services	<ul style="list-style-type: none"> • Develop and implement community education programs on the benefits of early screening and treatment of cervical cancer among PLHIV. • Engage men, community leaders and stakeholders in the development and implementation of integrated services. • Develop community-led support groups for patients with HIV and cervical cancer.
Ensure the availability of essential health products and technologies for integrated services.	<ul style="list-style-type: none"> • Ensure health facilities have the necessary equipment and infrastructure for screening and treatment of early (non-invasive) cervical cancer. • Provide HPV vaccination of WLHIV • Establish supply chain management systems to enhance adequate and timely delivery of integrated HIV/Cervical cancer services.
Conduct research and monitor the progress of integrated HIV/ NCD services	<ul style="list-style-type: none"> • Conduct operational research to identify best practices for HIV/cervical cancer integrated service delivery • Develop and implement monitoring and evaluation frameworks for HIV/ cervical cancer integration. • Regularly review and update guidelines and protocols for integrated service delivery to match new evidence and emerging best practices on cervical cancer among WLHIV.

Expected Outcomes

- 90% of all girls receive HPV vaccination by the age of 15 years.
- 70% of all WLHIV are screened with a high-performance test by the age of 35 years, and again at 45 years.
- 90% of all women diagnosed with cervical cancer receive treatment

3.1.3.7. Integrated HIV and Mental Health

Context

Mental health issues are more prevalent among PLHIV, key and priority populations, and those affected by HIV than the general population. This association manifests in various ways, including a higher likelihood of engaging in risky behavior, difficulties in accessing and adhering to treatment and prevention interventions, and increased AIDS-related mortality among individuals with mental health problems. Therefore, when integrating mental health into HIV service delivery, it is crucial to prioritize principles such as human rights, multisectoral collaboration, person-centered care, quality services and support, a life-course approach, empowerment and gender equality.

OBJECTIVE: To ensure all PLHIV and key and priority population have access to early and person-centered integrated HIV/mental health services by 2028

Strategic Recommendations	Key Actions
Strengthen health systems to integrate HIV and mental health services	<ul style="list-style-type: none"> Map existing health systems to identify opportunities for integration of mental health into HIV prevention, diagnosis and treatment packages. Develop and implement standardized training programs for healthcare workers on integrated HIV/mental health and psychosocial support services. Establish data systems that track HIV/mental health integrated service delivery and outcomes.
Implement and scale up integrated screening and management of HIV and mental health	<ul style="list-style-type: none"> Develop and disseminate prevention, identification and management of mental health among PLHIV and key and priority populations. Provide regular screening for integrated HIV/mental health in the community, single-facility and multi-facility service delivery points. Develop and implement referral systems for patients requiring specialized care.
Promote community awareness and involvement in integrated HIV/mental health services	<ul style="list-style-type: none"> Develop and implement community (peer-led, primary health care worker-led or mental health worker-led) education on and referral for integrated HIV/mental health and psychosocial support services. Engage the patient and vulnerable groups, community leaders and stakeholders in developing and implementing integrated HIV/mental health/psychosocial support services. Develop community-led support groups for PLHIV and those with mental health problems (including substance use).
Ensure the availability of essential health products and technologies for integrated HIV/mental health services.	<ul style="list-style-type: none"> Procure essential prevention, medicines and diagnostic commodities and technologies for HIV/mental health integrated services. Ensure health facilities and communities have the necessary prevention, diagnostic, treatment and referral tools and infrastructure for HIV/mental health integrated service delivery. Establish supply chain management systems to enhance adequate and timely delivery of HIV/mental health integrated services.
Conduct research and monitor the progress of integrated HIV/mental health services	<ul style="list-style-type: none"> Conduct operational research to identify best practices for HIV/mental health integrated service delivery. Develop and implement monitoring and evaluation frameworks for HIV/mental health integrated services. Regularly review and update guidelines and protocols for integrated service delivery to match new evidence and emerging best practices on mental health among PLHIV and key and priority populations.
Expected Outcomes	
<ul style="list-style-type: none"> All PLHIV and key and priority population have access to early and person-centered integrated HIV/mental health services. 	

3.1.4 FOCUS AREA 1.4. Social and Behavior Change Communication



Context

Lesotho's national strategy to address the HIV epidemic includes SBCC, which targets key and priority populations, including AYPs. SBCC activities are implemented through various platforms, including life LSBE, peer education models and awareness campaigns. While there is progress in improving HIV, TB and STIs knowledge, continued efforts are necessary to address cultural and social norms that perpetuate the epidemic. Challenges include misconceptions around HIV, TB and STIs as well as mental health, inadequate implementation of LSBE in schools, limited access to information in rural and hard-to-reach areas, suboptimal engagement of young people in youth programs, and comorbid mental illness and drug use among AYPs.

OBJECTIVE: Develop and disseminate targeted and age-specific social and behavior change messages

Strategic Recommendations	Key Actions
Implement an SBCC advocacy strategy and costed action plan linked to expected outcomes.	<ul style="list-style-type: none"> • Develop a differentiated and evidence-informed SBCC and advocacy strategy with a costed action plan linked to expected outcomes under each result area. • Undertake audience segmentation to ensure appropriately tailored messaging and approaches. • Use mutually reinforcing multi-media channels appropriately for different populations. • Ensure logical links between expected outcomes, defined monitoring and evaluation framework, costing and funding source. • Synchronize SBCC and advocacy with community service delivery. • Engage men to promote gender-equitable attitudes and enhance their health-seeking behavior. • Conduct community surveys to improve case finding and retention of AYP in HIV programs.
Capacitate implementers at all levels	<ul style="list-style-type: none"> • Build capacity for well-informed SBCC at national, district and community levels, and in all settings. • Engage trained beneficiaries from all population groups in SBCC design, implementation, monitoring and evaluation. • Actively involve key and priority populations in SBCC approaches. • Harmonize SBCC approaches with differentiated service scale-up and comprehensive messaging for HIV prevention and SRHR. • Include specific campaigns to address low demand and unmet need for health services, especially for hard-to-reach populations • Explore public-private partnerships for SBCC, advocacy and related service provision • Utilize existing structures, such as initiation schools for SBCC implementation • Identify and support community-specific champions for HIV prevention to engage in communications for awareness and advocacy • Continuously capacity build of educators for effective implementation of LBSE • Comprehensive training of peer facilitators for effective SBCC delivery
Strengthen male involvement in all areas of HIV prevention and treatment access and more comprehensive health-seeking behavior.	<ul style="list-style-type: none"> • Scale up local best practice behavior change interventions and programs with successful outcomes. • Develop a continuous national mass media campaign with a specific theme to increase male involvement and uptake of HIV prevention and treatment, promote rights protection, reduce SGBV and mitigate products and services, to saturate knowledge and influence public perceptions. • Promote HIV prevention, treatment and rights protection among men. • Encourage men to seek health services and support.
Establish programs to transform harmful social norms and cultural practices with community participation, curricula and gender-transformative approaches	<ul style="list-style-type: none"> • Sensitize communities, community leaders, traditional healers and multisectoral players to help AGYW realize their rights and transform harmful practices. • Develop well-defined curricula with gender-transformative approaches that address norms, gender roles, sexual orientation, gender identity and power imbalances to prevent SGBV and reinforce HIV and SRHR knowledge and risk perception.

Improve access to mental health and substance abuse services for AYPs in Lesotho to reduce their risk behaviors and vulnerability to HIV.

- Increase awareness towards prevention of stigma and discrimination for patients with mental health issues
- Expand the availability and accessibility of mental health and substance abuse services for AYPs.
- Improve awareness and education among AYPs and their communities about the link between mental health, substance abuse and HIV risk.
- Integrate mental health and substance abuse screening and treatment into existing HIV prevention and treatment programs for AYPs

Expected Outcomes

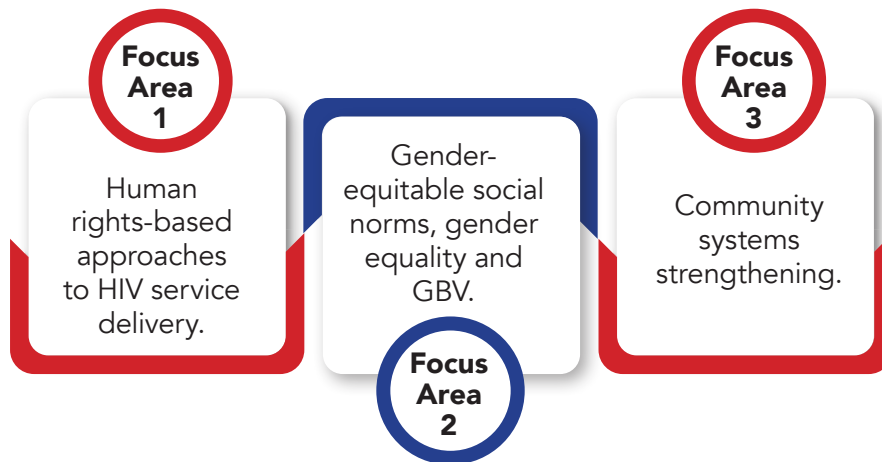
- 75% of adults 15 years and older have comprehensive knowledge of HIV
- 90% of girls/women have comprehensive knowledge of HIV
- 80% of boys/men aged 15-24 years have comprehensive knowledge have comprehensive knowledge of HIV
- 75% decrease in the number of males and females, 15-24 years old who have sex before the age of 15 years
- 75% increase in the number of males 15-24 years old who use condoms when having sex with non-marital, non-cohabiting partners
- 75% increase in the number of females 15-24 years old who use condoms when having sex with non-marital, non-cohabiting partners



3.2 Goal 2: Break down structural and social barriers to achieving optimal outcomes in HIV prevention and management

Breaking down structural and social barriers is crucial to achieving optimal outcomes in HIV, TB and STI prevention, treatment and care. Structural and social barriers can prevent individuals and communities from accessing and engaging with health services and adhering to treatment regimens. This priority area addresses the root causes of structural and social barriers and promotes equity, inclusion and social justice in Lesotho's HIV, TB and STI response.

Focus Areas



3.2.1 FOCUS AREA 2.1. Human Rights-Based Approaches To HIV Service Delivery.



Context

Despite progress made in the past seven years, stigma and discrimination towards PLHIV persist, particularly among KPs. This hinders their access to essential health services and contributes to the ongoing HIV epidemic. While there has been an overall decline in stigma, the prevalence of verbal discrimination, discrimination by family members and internalized stigma remains. These lead to negative consequences such as difficulties in disclosing one's HIV status and maintaining consistent treatment. In order to uphold human rights and preserve the dignity of all individuals, it is crucial to address the underlying causes of stigma, including cultural and social norms, misconceptions and criminalization. Inadequate protection of human rights and limited legal and policy frameworks pose additional challenges. To overcome these barriers, comprehensive and rights-based approaches are needed, focusing on addressing the social, economic and political determinants of health. By promoting social justice and equity, universal access to essential health services that are free from stigma and discrimination can be achieved.

OBJECTIVE: To reduce stigma and discrimination and promote human rights, equality and dignity for all PLHIV, key and priority populations, and people at risk of HIV, TB and STIs.

Strategic Recommendations	Key Actions
<p>Develop and implement comprehensive programs and interventions to raise awareness and reduce stigma and discrimination at all levels of society.</p>	<ul style="list-style-type: none"> • Conduct research to identify stigma and discrimination associated with HIV and intersectional stigma and discrimination. • Develop and implement national and community-based programs to raise awareness and reduce stigma and discrimination related to HIV and KPs. • Develop and implement context specific/localized communication and media campaigns that promote HIV-related knowledge, awareness and positive attitudes toward PLHIV and KPs. • Reduce HIV-related stigma and discrimination in health care, institutions, workplaces and FBOs settings • Strengthen and resource peer support networks including virtual approaches for PLHIV and KPs through community-led monitoring targeting stigma, discrimination and rights violations.
<p>Promote community-led initiatives that encourage engagement, empowerment and meaningful involvement of PLHIV, key and priority populations, and people at risk of HIV in decision-making processes.</p>	<ul style="list-style-type: none"> • Support capacity building and leadership development of PLHIV and KPs to actively participate in decision-making processes. • Strengthen CBOs and networks to promote meaningful engagement, empowerment, and involvement of PLHIV and KPs in decision-making processes. • Promote community-driven research to inform HIV policies and programs. • Develop and support community-based monitoring and evaluation systems to ensure accountability and impact of HIV programs.
<p>Enforce policies and regulations prioritizing human rights and dignity, and ensure access to essential health services free from stigma and discrimination.</p>	<ul style="list-style-type: none"> • Scale up implementation of policies and regulations that ensure quality and non-discriminatory HIV services. • Develop and enforce laws and policies that protect the human rights of PLHIV and KPs, including privacy, confidentiality and non-discrimination, and routinely sensitize duty bearers. • Regularly monitor and evaluate HIV programs to ensure they are rights-based and non-discriminatory.
<p>Increase the accessibility, availability, and utilization of HIV-related legal services and support to protect the rights of PLHIV, key and priority populations, and people at risk of HIV, TB and STIs</p>	<ul style="list-style-type: none"> • Implement policies and programs to provide legal support and services to PLHIV and KPs. • Scale up legal aid clinics and mobile legal services to support and assist PLHIV and KPs in remote and underserved areas. • Promote access to justice for populations left behind including PLHIV, KPs, people in prisons, migrants, and women and girls, particularly AGYW • Develop and implement strategies to reduce the criminalization of HIV transmission and KPs, and advocate for removing discriminatory laws and policies. • Regularly monitor and evaluate legal aid services to ensure they are effective and accessible. • Advocate for establishment of a Human Rights Commission.

Strengthen capacity-building and sensitization of healthcare workers and other service providers to provide services without discrimination or prejudice and to promote human rights

- Develop and implement comprehensive capacity-building programs for health-care workers and other service providers on HIV, human rights, gender equality and non-discrimination.
- Conduct regular sensitization and awareness-raising activities to reduce stigma and discrimination among healthcare workers and other service providers.
- Work with professional associations to ensure HIV-related competencies are included in the curricula and certification processes.
- Develop and implement guidelines and protocols for non-discriminatory service provision and addressing GBV and discrimination.
- Regularly monitor and evaluate capacity-building and sensitization programs to ensure they are effective and sustainable.
- Promote access to justice against HIV-related and intersectional stigma, discrimination, GBV and other human rights violations.

Expected Outcomes

- More than 90% of PLHIV and KPs have access to legal services.
- More than 90% of PLHIV who experience rights abuses seek redress.
- Less than 10% of PLHIV and KPs experience stigma and discrimination.
- Existence of policies and regulations prioritizing human rights, dignity, and access to essential health services, including legal services.

3.2.2 FOCUS AREA 2.2: Gender-equitable Social Norms, Gender Equality and Gender-based Violence



Context

GBV and harmful social norms are significant drivers of the HIV epidemic in Lesotho, particularly for women and girls. These, therefore, require a multifaceted approach that promotes gender equity and equality, empowers women and girls, engages men and boys, and addresses the underlying social norms that perpetuate gender imbalances, including harmful traditional practices. Women and girls in humanitarian settings, marginalized and rural communities face additional barriers in accessing comprehensive HIV services due to inequities in the availability of these services. There's limited capacity and efforts for engaging men and boys in gender-transformative programming, and weak multi-sectoral linkages for GBV prevention and response.

OBJECTIVE: To promote gender equity and equality, address GBV and mitigate the risk and impact of HIV, TB and STIs on all genders

Strategic Recommendations	Key Actions
<p>Implement a gender-responsive strategy to improve the integration of HIV and SGBV programs</p>	<ul style="list-style-type: none"> • Document gender inequalities in communities, institutions, policies, and programs that drive GBV and HIV. • Strengthen leadership, coordination, and accountability for integrating HIV/SGBV programming at national and district levels. • Develop and implement a person-centered essential services package to respond to GBV and establish referral pathways in health, social services, police and justice sectors, including information and communication technologies (ICT). • Conduct research to identify and address gaps in multisectoral integration of GBV and HIV programs. • Include HIV multi-sectoral gender-responsive strategies and plans. • Implement evidence-based, gender-responsive HIV prevention and treatment programs, including PMTCT, for women and girls, men and boys, and communities. • Strengthen the capacity of partners, including communities, to integrate HIV and gender equality and GBV programming. • Establish an accountability framework to monitor the commitment to eliminate gender equality and all forms of GBV • Scale up the dissemination of information to improve awareness and education on GBV and HIV
<p>Implement and monitor a gender-responsive strategy to address and prevent GBV, promote gender equality and mitigate their impact on HIV, while strengthening community-led efforts.</p>	<ul style="list-style-type: none"> • Engage key stakeholders, including government, civil society, the private sector and the media, to advocate for the promotion of gender equality and the elimination of GBV and gender discrimination • Strengthen the capacity of HIV implementing partners and communities, to address and prevent GBV and promote gender equality and equitable social norms • Conduct regular assessments of the impact of the comprehensive gender-responsive strategy on GBV, gender inequalities, and their impact on the HIV response. • Engage men with evidence-based interventions and peer approaches in their safe spaces such as Lebollo, Khotla, and Man engage and caring fathers. • Empower community leaders on gender equality so that they may drive the localized fight to end SGBV and HIV.
<p>Mainstream gender equality and equitable social norms across all HIV policies and programming.</p>	<ul style="list-style-type: none"> • Strengthen the capacity of partners, including communities, to address and prevent GBV, intimate partner violence (IPV) and promote gender equality and equitable social norms through training and capacity-building activities. • Integrate GBV into nationally representative surveys such as the Demographic and Health Survey to address the country's lack of data on GBV. • Ensure adequate resources are allocated to integrated HIV/GBV interventions • Address gender equality in HIV plans and policies including M&E frameworks

Expected Outcomes
<ul style="list-style-type: none"> • Less than 10% of women, girls, PLHIV and key and priority populations experience gender inequality and violence • 75% of OVC receive comprehensive HIV program services

3.2.3 FOCUS AREA 2.3: Community Systems Strengthening



Context

Effective community systems are integral to successful HIV responses, particularly in serving those most affected. Building resilient and sustainable community systems is paramount, as it enables meaningful engagement and empowerment of vulnerable groups in planning and delivering interventions. To facilitate a more effective community-led HIV response in Lesotho, investment in community-led organizations and systems is necessary. This requires strengthening governance structures, increasing technical capacity, and promoting community ownership and sustainability. Significant challenges to this approach include inadequate financing and training for networks of PLHIV and vulnerable groups and limited integration and capacity within existing community systems.

OBJECTIVE: To strengthen community systems for sustainable and transformative HIV, TB, and STI programs that prioritize the needs of vulnerable groups and address social and structural barriers.

Strategic Recommendations	Key Actions
Strengthen community systems for efficient community-led HIV responses	<ul style="list-style-type: none"> Identify and capacitate community systems and community-led organizations on effective HIV prevention, treatment, care, and support programs through structured training, technical assistance, and mentorship. Build the capacity of community systems and community-led organizations to engage in policy dialogue, advocacy, and implementation. Establish and strengthen partnerships between community-led organizations and community systems and health facilities to ensure better service delivery, linkage and follow-up of clients. Greater involvement of KPs and adolescents living with HIV in capacity building of other adolescents on sexuality education and HIV prevention. Greater participation of PLHIV, KPs, vulnerable groups, and Women and Adolescent Networks in community meetings, participatory assessments, and program and survey designs. Strengthen networks of organizations advocating for rights of and delivering services to key and priority populations Support, adapt and scale up community-led innovations.
Ensure sustainable financing for community systems.	<ul style="list-style-type: none"> Advocate for increased and ring-fenced budget allocations for community-led responses Build the capacity of community systems and community-led organizations to mobilize resources and diversify funding sources. Support the establishment of social enterprises by community systems and community-led organizations to generate income and sustain their activities. Operationalize social contracting. Build capacities of community-led organizations to strengthen accountability
Promote social and legal empowerment of communities affected by HIV.	<ul style="list-style-type: none"> Integrate paralegal services into community health systems. Strengthen the capacity of community-led organizations to provide psychosocial support.
Integrate and strengthen community health information systems	<ul style="list-style-type: none"> Enhance integrated reporting between community and government structures. Update DHIS2 to include community and key and priority population indicators. Real-time monitoring of compliance in the form of accuracy, consistency and timeliness. Periodic structured support of community health organizations through joint monitoring and evaluation strengthening activities. Standardize and digitize (computerize) the Lesotho Output Monitoring System for HIV and AIDS (LOMSHA) and Health Management Information Systems (HMIS) to ensure communication between the community and the tertiary hospital level information systems. Build the capacity of the community health system (such as CSOs, FBOs, CBOs, CHW, PLHIV networks and KP networks) in data collection and performance review Conduct regular evaluations of community-led responses to HIV to measure impact and identify areas for improvement. Fully operationalize and resource community-led monitoring and research, and ensure data utilization to improve programs.

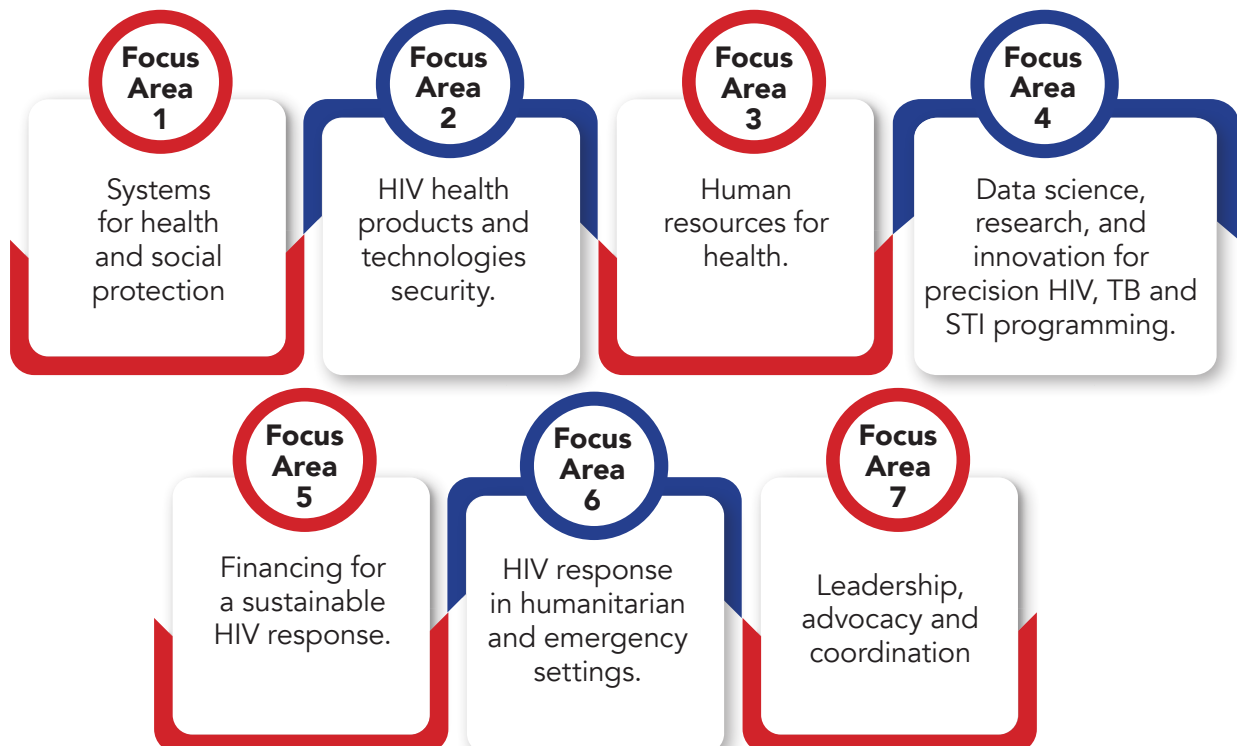
Expected Outcomes
<ul style="list-style-type: none"> 30% of testing and treatment services are delivered by community-led organizations. 90% of service delivery for HIV prevention programs for key and priority populations are delivered by community-led organizations. 80% of services for women are delivered by community-led organizations that are women-led. Increase in the proportion of community health data collected, analyzed, and used for decision-making



3.3 Goal 3: To have a fully resourced, sustainable, and efficient HIV response integrated into systems for health, social protection and pandemic settings.

The success of Lesotho’s HIV response relies on a fully resourced, sustainable and efficient HIV program that is integrated into broader health and social protection systems. The effects of the COVID-19 pandemic, ongoing challenges of low-resource availability and difficulty with access to services continue to impact health outcomes for the Basotho. This requires a comprehensive approach that prioritizes investments in the health sector, strengthens health systems, and fosters multisectoral partnerships to address health’s social and economic determinants. Additionally, ensuring the availability and accessibility of essential medicines and commodities is crucial for effectively delivering HIV services. By focusing on these critical areas, the LHSP 2023-2028 builds a robust and sustainable HIV response that meets the needs of all affected populations and helps to improve the overall health and well-being of all Basotho.

Focus Areas



3.3.1 FOCUS AREA 3.1: Systems for Health and social protection.



While significant progress has been made in the fight against HIV and AIDS in Lesotho, many PLHIV and key and priority populations still face significant barriers to accessing essential health and social protection services, due to poverty, stigma, and discrimination among other barriers. Establishing a comprehensive health and social protection system is necessary to ensure access to these essential services, reduce inequalities and enhance the quality of life for those living with, at risk of, or affected by HIV. Challenges such as inadequate funding, coordination and attention to social determinants of health hinder progress.

OBJECTIVE: To strengthen systems for health and social protection schemes to reduce inequalities and improve access to essential services for people living with, at risk of, or affected by HIV, TB and STIs.

Strategic Recommendations	Key Actions
Strengthen coordination and integration of HIV and social protection services for PLHIV and priority populations	<ul style="list-style-type: none"> • Establish a system for coordinating and integrating HIV and social protection services, including developing a referral system between HIV and social protection services. • Strengthen complimentary community social protection interventions to widen social security coverage for PLHIV • Increase awareness of and access to social protection services including cash plus options for PLHIV. • Foster partnerships between government, CSOs and the private sector to support the implementation of social protection programs for PLHIV and priority populations. • Develop livelihood skills of vulnerable children and young people for example those living with HIV and disabilities. • Support vulnerable children and their families plan for livelihood support post-graduation/exit from the programs. • Evaluate and monitor the effectiveness of the social protection programs for PLHIV, key and priority populations, and make necessary adjustments to achieve HIV outcomes.
Improve access and quality of social protection services for PLHIV and other affected populations.	<ul style="list-style-type: none"> • Expand access to social protection services to reach more people living with, at risk of, or affected by HIV, especially in rural areas, urban poor and other underserved communities. • Strengthen the capacity of social protection providers to integrate the needs of PLHIV and those most at risk. • Monitor, evaluate and conduct research on the impact of the social protection program on reducing inequalities and improving the well-being of PLHIV.
Include social protection in sustainability plans for the HIV response	<ul style="list-style-type: none"> • Foster sustainability through increased domestic ownership and accountability by involving stakeholders, including PLHIV, in the program's planning, implementation, monitoring and evaluation. • Advocate for HIV-sensitive social protection policies and plans

Expected Outcomes

- At least 75% of PLHIV, and those at risk of and affected by HIV benefit from HIV-sensitive social protection services
- Increase the number of PLHIV enrolled in social protection programs (such as health insurance and cash transfers) by 2028.
- Improved coordination between health and social protection systems to better address the needs of vulnerable populations

3.3.2 FOCUS AREA 3.2: HIV Health Products and Technologies Security



Context

The health system in Lesotho faces challenges in ensuring uninterrupted supply of HIV and AIDS commodities, and getting them to those who need them when they need them. Challenges include limited access to prevention and treatment services in remote areas, and limited availability of pediatric formulations and diagnostic tests. Therefore, it is essential to strengthen the supply chain management of health products and technologies, and build the capacity of the health workforce to ensure timely and reliable delivery of critical health products and technologies, particularly for marginalized populations.

OBJECTIVE: To improve supply chain management to ensure the availability, access and security of HIV commodities.

Strategic Recommendations	Key Actions
<p>Strengthen supply chain and workforce capacity for managing HIV commodities, products and technologies.</p>	<ul style="list-style-type: none"> • Conduct and implement A National Supply Chain Assessment to assess the supply chain’s maturity, capabilities and performance for sustaining epidemic control • Develop and implement a comprehensive health products and technologies logistics information management to streamline forecasting, quantification, storage and distribution. • Build in a monitoring and evaluation module into the electronic Logistics Management Information System to generate data for decision making. • Develop the capacity of health workforce to manage and utilize the commodity logistics management information system. • Optimize the diagnostic network to support integrated and multi-disease testing platforms • Ensure coordination between health facilities and the supply chain management system. • Advocate for sustainable financing for health products and technology security.
<p>Strengthen governance and accountability for health products and technologies, including promoting digital solutions.</p>	<ul style="list-style-type: none"> • Monitor and evaluate the health products and technologies security strategy implementation and distribution and delivery system. • Strengthen data management systems to track the availability and use of health products and technologies using innovative emerging digital platforms. • Foster research and innovation to support the development of health products and technologies • Establish the Lesotho Medicine Regulatory Authority to sustainably strengthen medical product quality assurance/quality improvement systems.
<p>Expected Outcomes</p>	
<ul style="list-style-type: none"> • Strengthened supply chain of HIV commodities, products and technologies. • Improved governance and accountability for health products and technologies, including stronger regulatory systems and mechanisms for reporting and addressing shortages or stock outs. • Increase in use of digital technologies to improve supply chain management, enhance efficiency and accountability, and improve access to health products and technologies for populations. 	

3.3.3 FOCUS AREA 3.3: Human Resources for Health



Context

Lesotho faces several health workforce challenges, including high staff turnover, poor supervision and mentorship, and shortages of skilled workers. Comprehensive strategies should address these gaps by recruiting and retaining health workers. Effective training, mentorship, and strong governance and management systems should be established to support comprehensive HIV services. Limited access to services and insufficient data in remote areas make it difficult to identify gaps and plan targeted human resources for health (HRH) strategies. Building and sustaining a well-trained, motivated and supported health workforce is a long-term investment that will ultimately improve health outcomes and strengthen the broader health system.

OBJECTIVE: To build and retain a capable and competent HRH workforce that can provide quality services to support the national HIV, TB and STI response.

Strategic Recommendations	Key Actions
<p>Develop and implement a partnership-driven training program to strengthen HRH capacity for HIV, TB and STI services.</p>	<ul style="list-style-type: none"> Review current HRH capacity and identify knowledge and skills gaps in providing quality HIV, TB and STI services. Develop and implement in-service training programs, including training in the latest evidence-based approaches and technologies for HIV, TB and STI care and treatment. Foster partnerships with organizations and institutions to support HRH development and capacity-building, such as professional associations, academic institutions and international organizations
<p>Continuous evaluation and improvement of HIV, TB and STI training programs for comprehensive HRH development and capacity-building, including targeted initiatives for retention and burnout reduction</p>	<ul style="list-style-type: none"> Strengthen the Performance Management System to enhance staff performance and accountability across program areas. Develop and implement initiatives to reduce HRH burnout and enhance retention, such as professional development opportunities, flexible work arrangements and improved working conditions. Engage with healthcare workers to identify their training needs and incorporate their feedback into training programs. Develop and implement a comprehensive HRH development and capacity-building plan to ensure the long-term sustainability of HRH capacity, considering current and future needs. Establish mentorship and leadership programs to support the development of future HRH leaders, including mentoring relationships between experienced and new HRH. Monitor and evaluate the impact of training programs on healthcare worker knowledge, skills and performance. Use the results of evaluations to continuously improve the quality of the training program.
<p>Strengthen HRH through planning and management, promote and support the development of specialized HIV HRH, and foster continuous learning and professional development.</p>	<ul style="list-style-type: none"> Develop a comprehensive HRH strategy and workforce development plan. Incorporate HRH development and capacity-building into the broader health systems strengthening agenda to ensure sustained capacity for quality integrated HIV, TB, and STI services. Ensure the HRH plan aligns with national and regional health workforce priorities and strategies. Implement HRH policies and systems to attract, retain, and motivate healthcare workers, especially in underserved and remote areas. Strengthen human resource information systems to improve data collection, analysis and reporting on HRH.

Expected Outcomes

- Increase in the number of skilled healthcare workers providing HIV/AIDS services in rural and underserved areas by 2028
- Strengthened HRH policies for and governance of the health work force.
- Strengthened partnerships for HRH capacity building and development

3.3.4 FOCUS AREA 3.4: Data Science, Research and Innovation for Precision HIV, TB and STI Programming



Context

Despite government efforts to combat the HIV epidemic, the lack of accurate and timely data poses a significant obstacle in developing targeted interventions. In addition, there is a need to invest in research and innovation to identify new prevention strategies and treatments, and to develop innovative approaches for improving service delivery. This focus area aims to enhance the precision and impact of the national HIV response through better data management, evidence-based programming, and increased investment in research and innovation.

OBJECTIVE: To use data science, research and innovation to inform HIV, TB and STI programming, and ensure evidence-based and adaptive responses.

Strategic Recommendations	Key Actions
Strengthen data quality assurance.	<ul style="list-style-type: none"> Assess HIV data systems to identify gaps and actions for improvement. Develop a data collection, management and analysis plan. Train and supervise healthcare workers and stakeholders in collecting, managing and using data for decision-making. Conduct data quality assessment and specific data quality audits. Collaborate with stakeholders to harmonize data collection and reporting standards.
Utilize technology and innovation (such as mHealth technologies, EMR, GIS, and data visualization tools) to improve HIV data collection, management and analysis.	<ul style="list-style-type: none"> Implement data-driven approaches to improve the quality and accuracy of data. Establish partnerships with organizations and academic institutions to develop innovative data collection and analysis methods. Provide training to stakeholders on using technology and innovation in data management. Encourage stakeholder collaboration to share data and information to support evidence-based decision-making. Develop an interoperable HIV case-based surveillance system by integrating a unique identifier system for the current eRegister, and link it with the national civil registration and vital statistics to a central national data warehouse.
Enhance the utility of data science in HIV, TB and STI programming	<ul style="list-style-type: none"> Build stakeholder capacity in data science through training and provision of resources to effectively use HIV, TB and STI data. Conduct accurate, complete, timely data collection activities on HIV, TB and STIs. Utilize modern data science tools to analyze and interpret HIV, TB and STI trends and patterns. Visualize data clearly and understandably for a wide range of stakeholders. Share HIV, TB and STI data securely while protecting patient privacy.
Develop and implement an HIV research and innovation agenda	<ul style="list-style-type: none"> Coordinate and streamline ongoing HIV-related research to identify gaps and opportunities for further research. Establish a national research agenda, with input from stakeholders, to guide the development of HIV research and innovation initiatives. Foster partnerships and collaborations between stakeholders to support the implementation of the research agenda. Support the development of new technologies and innovative approaches to address HIV-related challenges. Promote sharing of research findings and best practices among stakeholders to support evidence-based decision-making in Lesotho's HIV program.

Expected Outcomes

- Improved data collection, analysis, and use for HIV monitoring and evaluation, including disaggregated data on key and priority populations and service coverage.
- Increased use of evidence-based programming and innovative approaches in HIV program design and implementation.
- Enhanced capacity for research and innovation to identify and address gaps in the HIV response, and to inform program design and implementation.
- Improved coordination and partnerships among stakeholders in the collection and use of data, science, research and innovation to ensure a comprehensive and adaptive response to the HIV epidemic.

3.3.5 Focus Area 3.5: Financing for a Sustainable HIV Response



Context

Lesotho requires LSL 13 billion to fully fund its HIV, TB and STI response for the next five years, with a funding gap of LSL 1.2 billion based on current trends. The costing figures do not include detailed interventions to trace and treat TB patients but only cover the management of co-infections. The financing plan aligns with national and global frameworks and commitments, aiming to sustain progress made in the response while expanding the resource base and ensuring efficient use of available grants and domestic resources. The cost of the response has reduced when compared to the previous plan courtesy of a decline in the cost of ART. The cost of social enablers remains high and is a shared cost with the rest of the health response. The total resource needs estimate by LHSP priority investment areas are presented in Table 3.2.

Table 3.2: Total Resource Needs Estimate (LSL 13 billion) by LHSP Priority Investment Areas (Source: RNM Costing Model)

Priority Investment Areas	2023/4	2023/5	2025/6	2026/7	2027/8
	LSL m	LSL m	LSL m	LSL m	LSL m
Prevention of new HIV, TB and STIs	464.58	409.61	434.23	461.81	489.50
Treatment, care and support for HIV, TB and STIs	953.33	928.87	909.50	902.05	882.85
Resilient sustainable systems for HIV, TB and STIs	510.45	481.85	483.74	490.99	494.05
Strengthening strategic information, Research and Innovation	163.06	153.93	154.53	156.84	157.82
Rights-based approach to HIV response	411.86	404.23	405.25	407.43	407.89
Sustainable financing for the HIV, TB and STI response	21.27	20.08	20.16	20.46	20.59
Communication and advocacy for HIV, TB and STIs	14.18	13.38	13.44	13.64	13.72
Leadership and accountability for Delivery of LHSP results	141.79	133.85	134.37	136.39	137.23
Total Resource Needs Estimate	2,680.52	2,545.80	2,555.22	2,589.61	2,603.65

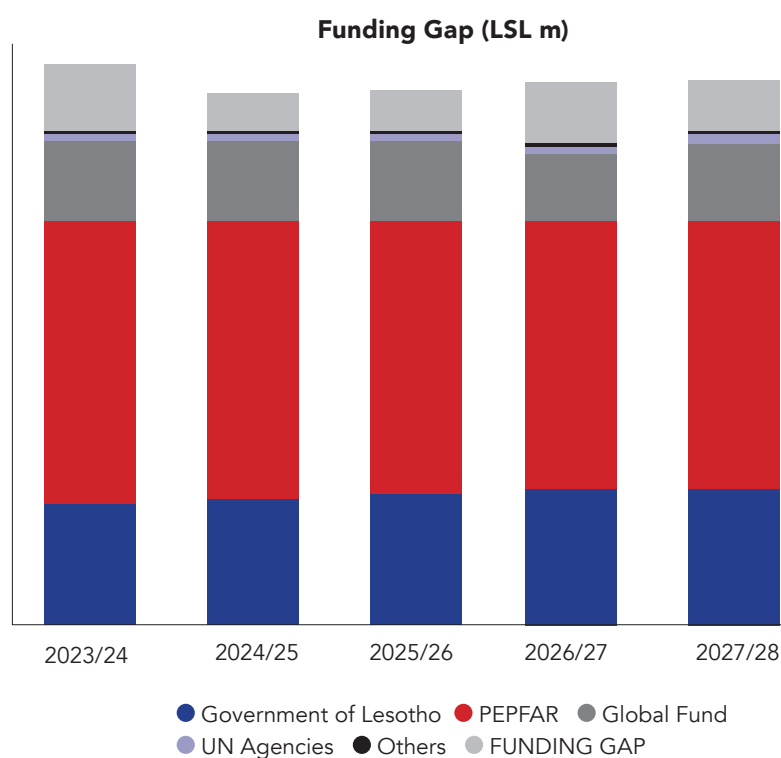
**Figure 3.2 Projected Contributions by Funding Source (LSL m) and expected funding gap for each year of the Lesotho HIV Strategic Plan 2023-2028 (Source: Key Informant Interviews and Estimates)**

Figure 3.2 shows the estimated contribution by source and the expected funding gap for each year of the LHSP. The projected funding is derived based on the following assumptions:

All USD commitments have been converted to LSL using a rate of \$: LSL18 across all five years.

The breakdown of the contribution from the GoL is derived from the National Aids Spending Assessment conducted in 2020 with figures for the five years of this plan being estimated. The forward-looking numbers have been derived from adjusting the budget amount by the overall year-on-year adjustment of the MoH allocation.

The President’s Emergency Plan for AIDS Relief (PEPFAR) contribution is based on confirmed funding for the first three years and a year-on-year reduction of 2% for the last two years based on key

informant interviews with PEPFAR representatives. Country Operational Plan financial year cycles (October to September) have been ignored and assumed to align with the LHSP financial calendar (Apr to Mar).

The Global Fund allocation is based on the confirmed New Funding Model 3 allocation (first year of this plan), and the amount communicated in the allocation letter for Grant Cycle 7. The final year is an estimate assuming the same levels of funding are maintained.

Lesotho heavily relies on external funding sources and needs to bridge the funding gap to achieve its goal of ending the HIV epidemic by 2030. The LHSP 2023-2028 includes initiatives to mobilize resources, involve the private sector, improve financial management, and harmonize resource mobilization, utilization and tracking.

OBJECTIVE: To secure sufficient, sustainable, and predictable financing to support the implementation of the LHSP 2023-2028.

Lesotho heavily relies on external funding sources and needs to bridge the funding gap to achieve its goal of ending the HIV epidemic by 2030. The LHSP 2023-2028 includes initiatives to mobilize resources, involve the private sector, improve financial management, and harmonize resource mobilization, utilization and tracking.



Strategic Recommendations	Key Actions
Increase domestic financing for a sustained HIV response	<ul style="list-style-type: none"> • Map the current government allocation for the national HIV response, and identify gaps and advocacy agendas. • Review and implement policies for line ministries' allocations toward the HIV response. • Strengthen the private sector and CSOs' accountability for HIV resources. • Ensure sustained political commitment to the HIV response • Conduct investment cases for financing the HIV response in the context of universal healthcare.
Develop and implement innovative financing mechanisms and achieve resource efficiencies.	<ul style="list-style-type: none"> • Conduct a feasibility study on innovative financing mechanisms such as social impact bonds, development impact bonds and other alternative financing mechanisms. • Develop and implement a comprehensive financial management framework incorporating financial planning, budgeting, accounting and reporting. • Continuously track the cost of healthcare services and seek to achieve efficiency and optimize spending. • Maintain an updated national repository of reliable per unit costs data for key interventions. • Advocate for integrated programming and service delivery to benefit from economies of scale and reduced shared costs. • Ensure regular internal and external audits to monitor resource utilization and identify areas for improvement. • Participate in regional and continental initiatives to reduce the cost of drugs and commodities. • Enhance digitalization of financial reporting mechanisms • Make expenditure data by partner and investment categories publicly available. • Create an accountability framework for all partners involved in the HIV response including periodic reporting of various partners' contributions.
Develop, implement and monitor a national HIV sustainability plan that includes transition from donor funding	<ul style="list-style-type: none"> • Convene and coordinate a national multisector structure on sustainability planning. • Develop and implement a sustainability framework supported by realistic plans. • Support the implementation of the Decentralization Bill. • Align existing programs and their cost structures to ensure they remain viable and sustainable when transferred to the government. • Undertake regular and ongoing sustainability assessments, using pre-determined agreed indicators, to ensure a resilient HIV response. • Ring-fence resources earmarked for health in emergent humanitarian responses.
Provide an enabling environment for private investment in HIV programs and harness the role of the private sector in domestic resource mobilization for HIV response	<ul style="list-style-type: none"> • Develop a comprehensive advocacy and communication strategy to educate, sensitize and adequately engage private sector entities on the benefits of investing in HIV response. • Introduce pro-health taxes to generate revenue for healthcare and HIV spending. • Develop a platform for regular dialogue between public health agencies and private sector entities to facilitate collaboration and partnership in HIV response.
Engage the private sector towards achieving efficiency and effectiveness in resource utilization.	<ul style="list-style-type: none"> • Develop monitoring and evaluation systems to track the impact of private sector investments in HIV response. • Provide technical assistance and capacity building to private sector entities on effective resource utilization in HIV response. • Encourage private sector entities to adopt best practices in HIV response to improve efficiency and effectiveness in resource utilization.
Play the role of "matchmaker" by introducing public health agencies to potential investors and lenders.	<p>Develop a database of potential investors and lenders interested in HIV response. Facilitate meetings and networking events between public health agencies, potential investors and lenders.</p> <p>Provide technical assistance to public health agencies in engaging with potential investors and lenders.</p>

Expected Outcomes

Increase in domestic financing for HIV response by 30% within the next five years.
Diversification of funding sources for HIV response, including innovative financing mechanisms and partnerships with the private sector.
Improved efficiency and effectiveness of HIV funding through strengthened financial management and accountability systems.

3.3.6 FOCUS AREA 3.6: HIV Response in Humanitarian and Emergency Settings



Context

Lesotho's response to emergencies and disasters, including the COVID-19 pandemic, has been challenged by disrupted access to healthcare, including HIV prevention and continuity of care. Climate change exacerbates vulnerabilities and inequalities, impacting the effectiveness of HIV treatment and increasing the risk of transmission. There is a need for a coordinated and comprehensive approach to emergencies that prioritizes the needs of affected vulnerable populations, including key and priority populations, and ensures inclusiveness and equity. The country lacks a national emergency preparedness, response and recovery plan specific to the HIV response.

OBJECTIVE: To ensure access to HIV prevention, testing, treatment, care, and support services for people living with or at risk of HIV during humanitarian crises and emergencies

Strategic Recommendations	Key Actions
Strengthen coordination and partnerships for HIV response in emergencies and humanitarian crises.	<ul style="list-style-type: none"> • Incorporate HIV in the national disaster preparedness, response and recovery plans. • Strengthen coordination between humanitarian organizations, government agencies and other relevant stakeholders to ensure a comprehensive and effective HIV response in emergencies and humanitarian crises.
Sustained continuity of HIV services in emergencies and humanitarian crises	<ul style="list-style-type: none"> • Assign and re-assign HRH for continuity of HIV services, to reduce HIV risk in humanitarian and emergency settings. • Develop a package of HIV care in emergencies and humanitarian crises • Strengthen community capacities to support HIV continuity of care during emergencies and humanitarian crises • Develop a communication and community engagement plan for HIV in humanitarian emergencies • Develop technology-driven mechanisms for early warning, information dissemination, and enhanced HIV response during emergencies and humanitarian crises.
Expected Outcomes	
<ul style="list-style-type: none"> • Improved access to HIV prevention and treatment services in emergency and humanitarian settings. • Enhanced leadership and coordination to address HIV programs during emergencies. • Existence of a national emergency preparedness, response and recovery plan specific to the HIV response 	

3.3.7 FOCUS AREA 3.7: Leadership, Advocacy and Coordination



Context

A comprehensive and collaborative approach is essential for an effective HIV response in Lesotho, requiring strong leadership and coordination among multiple sectors and stakeholders. This strategic plan aims to enhance multi-sectoral cooperation, thereby maximizing the efforts to end HIV and reinforce the NAC's responsibility to coordinate the country's multi-sector response to HIV, TB and STIs. HIV stakeholders, and their roles and responsibilities are presented in Table 3.3.

Table 3.3: Stakeholder Analysis

Stakeholder	Roles and Responsibilities
Public Sector Coordination and Roles of Government Ministries	
National AIDS Commission	<ul style="list-style-type: none"> • Coordinate and prioritize HIV prevention care and treatment interventions with various ministries and sector leads. • Ensure adequate domestic resource mobilization by working with the cabinet subcommittee on AIDS and the Ministry of Finance. • Regulate, monitor, and oversee the implementation of all aspects of LHSP using the results framework as a principal guide. • Provide neutral leadership for civil society response to HIV and AIDS. • Collaborate with local and international agencies working on HIV and AIDS in the country. • Revitalize through staffing at the national level, financial resource mobilization, management capacity, information system and research management.
Ministry of Health	<ul style="list-style-type: none"> • Regulation, formulation, and review of health sector policies and guidelines on HIV prevention, treatment, and care. • Strengthening, availing and quality assurance of the health system, including infrastructure and equipment, and human resources at and linked to health facilities. • Procurement and supply chain management of pharmaceuticals, vaccines, health equipment and other technologies. • Adequate budget allocation for HIV within the health sector. • Ensuring strong laboratory systems and managing the health information management system. • Ensuring access to services by the general population, PLHIV, people affected by TB, and key and priority populations.
Ministry of Education and Training	<ul style="list-style-type: none"> • Facilitating HIV and AIDS mainstreaming in learning institutions. • Prevention among children and young people, including through CSE delivery. • Promotion of HIV prevention and treatment services and product uptake. • Social protection, for example, through the school feeding program and provision of menstrual hygiene kits. • Identification of SGBV survivors and other children in need of legal protection.
Ministry of Gender, Youth, Sports, Arts, Culture and Social Development	<ul style="list-style-type: none"> • Coordinate provision of social assistance to indigent PLHIV, AGYW, OVC, elderly and child-headed households. • Identify individuals qualifying for social protection provided by other ministries/sectors to alleviate the social and economic impacts of HIV and AIDS. • Collaborate with NAC to coordinate the identification and targeting of vulnerable individuals through National Information System for Social Assistance and other means.
Ministry of Labor and Employment	<ul style="list-style-type: none"> • Integrate all HIV programs and policies in the workplace and surrounding communities. • Provide social security to vulnerable individuals in collaboration with Ministry of Social Development (MoSD) and other implementers. • Diversify strategies for creating jobs and employment to mitigate the effects of low socio-economic status, which is associated with risky behaviors
Ministry of Finance and Development Planning	<ul style="list-style-type: none"> • In collaboration with NAC, enforce the requirement for the contribution of 2% of budgets by other ministries to HIV through various methods to increase HIV financing.

Ministry of Justice, Human Rights and Correctional Services	<ul style="list-style-type: none"> • Implement HIV services in collaboration with relevant ministries and stakeholders among people in correctional facilities, linking those living with HIV to MoH, MoSD and local government structures.
Ministry of Agriculture, Food Security and Nutrition	<ul style="list-style-type: none"> • Train PLHIV, AGYW, and other vulnerable groups and communities to promote food security. • Provide nutritional counseling and measure nutritional status. • Provide seeds to the most vulnerable, continue supporting feeding programs and conduct positive deviance studies to improve food security. • Avail/second its human resources to promote nutrition and provide arbitrary assistance
Ministry of Local Government and Chieftainship, Home Affairs, and Police	<ul style="list-style-type: none"> • Coordinate district and community-based HIV and AIDS interventions on behalf of the government • Develop the Essential Services Package and oversee DACs and coordinators at the community level. • Strengthen District and Community AIDS Committees to more efficiently coordinate the response on behalf of the government and other sectors.
Policy, Governance, Advocacy, and Resource Mobilization Structures	
Office of the Prime Minister	<ul style="list-style-type: none"> • Provide political leadership in the national multi-sectoral HIV and AIDS response. • Advocate for improved political commitment and sustainability of the response. • Ensure sustainable financing for the response. • Promote national and community ownership of the response. • Ensure an enabling social, policy and legal environment for the response.
Cabinet Sub-Committee on HIV/AIDS	<ul style="list-style-type: none"> • Review programmatic and management policy documents and proposals by NAC • Advise the Prime Minister on HIV and AIDS response progress and challenges. • Advocate for continued prioritization of HIV and AIDS response on the national social, economic and political agenda • Oversee NACs compliance with the stipulations of the LHSP, NAC Act, National HIV and AIDS Policy, and other relevant policies and laws • Advocate for sustainable financing of the national multi-sectoral response with government and development partners.

NAC provides effective mechanisms for coordination and advocacy efforts directed towards critical decision-makers and the general public. At the district level, coordination is overseen by the Ministry of Local Government and Chieftainship and the MoH, and at the community level, by Community Councils AIDS Committees. In addition, technical coordination is achieved through TWGs. However, lack of political goodwill to address the HIV epidemic effectively and limited capacity for coordination and leadership, as well as inadequate domestic funding and resource mobilization for the HIV response, pose significant challenges.

Implementing the LHSP 2023-2028 will require enhanced good governance practices and accountability mechanisms by using an outcome-oriented implementation approach, performance monitoring and evaluation, stakeholder engagement, transparency, and accountability. In addition, adopting accountability instruments such as the (MAF-TB) will elevate the TB response and draw the all-important political commitment toward prevention of TB/HIV-related morbidity and mortality.

OBJECTIVE: To strengthen effective and efficient leadership, coordination and advocacy for a sustainable response to end HIV as a public health threat in Lesotho by 2030.

Strategic Recommendations	Key Actions
Operationalize NAC under the Office of the Prime Minister for overall coordination of the national response to HIV	<ul style="list-style-type: none"> • Ensure NAC exercises its mandate in partnership with other stakeholders through a multisectoral and decentralized framework. • Review of the NAC Act and mandate (to incorporate HIV, TB and STI control and management). • Central and decentralized coordination of HIV and TB funding. • Leverage high-level authorities such as parliament, senate, and public sector structures with newly revised and updated terms of reference and provision of capacities. • Coordinate and manage multi-sectoral participation within the existing National Coordination Framework premised on the Three One's principles. • Advocate for the establishment of NAC levy to contribute towards domestic funding. • Increase development partners' support towards the coordinating role of NAC.
Implement the results framework for effective monitoring and implementation of LHSP 2023-2028	<ul style="list-style-type: none"> • Ensure interventions outlined in the LHSP are implemented through the Program Results Framework to standardize reporting, enforce accountability, and share tasks, risks, results, and challenges with other stakeholders. • Designate sector leads for oversight and implementation of each LHSP goal, including working with civil society and other sectors to build capacity towards achieving LHSP outcomes.
Strengthen collaboration with technical and development partners, CSOs, and District Authorities.	<ul style="list-style-type: none"> • Ensure the participation of subject matter experts in the different program areas from the technical and development partners in the TWGs and Committees of Experts. • Improve coordination of a multi-stakeholder response to ensure that the allocation and utilization of resources are aligned with the LHSP priorities. • Enhance technical collaboration with national and international agencies. • Improve the engagement of local leadership to increase buy-in for the implementation of the LHSP. • Develop a private sector engagement framework in line with the LHSP, better defining the role of the private sector in the response.

Expected Outcomes

- Improved multisectoral coordination and collaboration for a more integrated and coherent HIV response
- Strengthened institutional capacity and human resources for effective leadership, coordination and advocacy at all levels.
- Increased participation of PLHIV and key and priority populations in leadership, coordination and advocacy structures
- Strengthened and adequately resourced multisectoral structures that efficiently coordinate management, implementation, reporting and resource mobilization for the HIV response.
- Existence of complementary community, civil society, key and priority populations, and PLHIV collaboration structures at national, district, and community levels.
- Enhanced advocacy and communication for increased political will, resource mobilization and community engagement

ANNEX 1: RESULTS FRAMEWORK

The impact level targets of the LHSP 2023 to 2028 are, by 2028:
 Reduce new HIV, TB and STIs by 75%.
 Reduce AIDS-related deaths by 75%.
 Eliminate mother-to-child transmission of HIV, Syphilis and Hepatitis B.
 Reduce all forms of inequalities at all levels
 Attain sustainability of the national HIV response

Goal 1: Deliver equitable access to evidence-based, people-centered HIV services

Focus Area 1.1: Prevent New HIV, TB and STIs

Key Intervention 1.1.1: Combination Prevention and Harm Reduction for Key and Priority Populations

Results Level	Indicators	Disaggregation	Baseline	Data Source	Target 2023/24	Target 2024/25	Target 2025/26	Target 2026/27	Target 2027/28
Outcome									
90% of key and priority populations access combination HIV prevention	% of key and priority populations who access combination HIV prevention ¹	MSM, SW, PWID, TG, Closed setting	17.3%	IBBS	50%	70%	90%	90%	90%
95% of people at risk of HIV use combination prevention	% of people at risk of HIV use combination prevention	All	TBD	TBD	65%	85%	95%	95%	95%
95% of people most at risk of HIV access combination prevention services	% of people most at risk of HIV will have access to combination prevention services ²	All	TBD	TBD	65%	85%	95%	95%	95%

1 Global HIV Prevention 2020 Roadmap

2 Global HIV targets I Be in the KNOW

90% of key and priority populations adopt safer sexual behavior									
Key Intervention 1.1.4: Comprehensive Condom and Lubricants Programming									
Outcome									
90% condom use during sexual activity with non-regular partners	% of condom use with client or non-regular partners during most recent sexual activity	All	69.4%	LePHIA (UNAIDS 2021)	70%	80%	90%	90%	90%
Output									
30 million male condoms distributed annually	Number of male condoms and female condoms and water-based lubricants distributed in a year	Males	207 2000 90 000	MTR Jan-June 2021 DHIS2 LOMSHA	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000
Two million female condoms distributed annually	Number of female condoms distributed in a year	Females			2,000,000	2,000,000	2,000,000	2,000,000	2,000,000
TBD	Number of water-based lubricants distributed in a year	Males, Females							
Focus Area 1.1.5: Scaling Up Antiretroviral- Based Prevention									
Outcome									
95% of people at risk of HIV infection access and use appropriate, prioritized, person-centred and effective combination prevention options	% of people at risk of HIV infection who have access to and use appropriate, prioritized, person-centered and effective combination prevention options. ³	All	TBD	TBD	65%	85%	95%	95%	95%
	Percentage of all individuals at risk of HIV provided with PrEP	All	TBD	DHIS2	85%	90%	90%	90%	90%

3 UNAIDS. Global AIDS Strategy 2021–2026 End Inequalities. End AIDs.

90% of AGYW 15-24 years old who are sexually active and at high risk receive PrEP	% of KPs who have access to PrEP	All KPs	TBD	TBD	TBD	TBD	TBD	TBD	90%
	% of sexually active and at high risk of HIV AGYW, 15-24 years old, who receive PrEP	AGYW	TBD	DHIS	70%	80%	90%	90%	90%
80% of HIV-negative partners in sero-discordant couples receive PrEP	% of HIV-negative partners in sero-discordant couples who receive PrEP	Discordant couples	TBD	DHIS	80%	80%	80%	80%	80%
	CSE provided in all schools in rural areas	All children	TBD	Ministry of Education and Training	TBD	TBD	TBD	TBD	90%
	% of eligible population covered by national social protection programs	Sex, Age and type	TBD	Ministry of Social Welfare	TBD	TBD	TBD	TBD	TBD
50% of HIV-negative FSWs and 20% of HIV-negative MSM receive PrEP									

Focus Area 1.2: Elimination of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B

Outcome									
All pregnant WLHIV receive ART for PMTCT	% of pregnant WLHIV who receive ART for PMTCT	All Women	89%	Spectrum	90%	90%	95%	95%	95%
All HEI infants receive a virological test by two months of age	% of HEI infants who receive a virological test by two months of age	All (Males and Females)	TBD	DHIS2	100%	100%	100%	100%	100%
95% of PBFW living with HIV have access to VL monitoring	% of PBFW living with HIV who have documented VL	All Women	TBD	DHIS2	90%	95%	95%	95%	95%

95% of AGYW living with HIV have access to comprehensive SRH services, including FP and cervical cancer screening	% of AGYW living with HIV who have access to comprehensive SRH services, including FP and cervical cancer screening	AGYW	TBD	TBD	95%	95%	95%	95%	95%
95% of pregnant women and breastfeeding women access HIV, syphilis and hepatitis B testing	% of pregnant women and breastfeeding women tested for HIV, syphilis and hepatitis B testing	All ages	TBD	TBD	TBD	TBD	95%	95%	95%
Reduce MTCT of HIV to less than 2%	% HEI who test HIV-positive	Infants	TBD	TBD	TBD	TBD	TBD	TBD	TBD

Focus Area 1.3 Integrated Services

Key Intervention 1.3:1 Integrated HIV Care, Treatment, And Support Services

Outcome									
95% of PLHIV know their status and are linked to appropriate prevention, treatment and care services	% of PLHIV who know their status and are linked to appropriate prevention, treatment and care services	All	90%	LePHIA	90%	93%	95%	95%	95%
95% of PLHIV who are on ART have achieved VLS	% of PLHIV who are on ART and have documented viral load status	All	91%	PEPFAR Panorama Spotlight 2022	95%	95%	95%	95%	95%
	% of PLHIV who are on ART have achieved VLS	All	97%	LePHIA	95%	95%	95%	95%	95%

75% of children, adolescents, youth and adults living with HIV have access to age-responsive integrated prevention, treatment and care services	% of PLHIV and those at risk linked to people-centred and context specific integrated services	All	TBD	TBD	90%	90%	90%	90%	90%
	% of children, adolescents, youth, and adults living with HIV who have access to age-responsive integrated prevention, treatment and care services	Children and Adolescents	TBD	TBD	55%	65%	75%	75%	75%

Key Intervention 1.3.2 Integration of TB/HIV Services

Outcome									
75% reduction in TB morbidity and mortality among PLHIV	TB mortality and morbidity rates among PLHIV	ALL	4.08%	TB Audit Report	50%	60%	75%	75%	75%
75% increase in TB case finding and treatment among PLHIV	TB case finding rates among PLHIV	ALL	TBD	DHIS2	TBD	TBD	TBD	TBD	TBD
	% PLHIV with TB who receive treatment for TB	ALL	TBD	DHIS2	TBD	TBD	TBD	TBD	TBD
All TB/HIV co-infected people are started on ART	% of people with TB/HIV co-infection started on ART	ALL	TBD	DHIS2	100%	100%	100%	100%	100%

Key Intervention 1.3.3 Prevention and Treatment of STIs

Outcome									
Increase in STI/viral hepatitis screening to 75% at all levels of care	% of STI/viral hepatitis screening	All	TBD	TBD	TBD	TBD	75%	75%	75%
Availability of STI/viral hepatitis drugs in all health facilities	% of health facilities with adequate supply of STI/viral hepatitis drugs	All	TBD	TBD	TBD	TBD	100%	100%	100%

Focus Area 1.4 Social and Behavior Change Communication

Outcome									
75% of adults 15 years and older have comprehensive knowledge of HIV	% of adults 15 years and older with comprehensive knowledge about HIV and AIDS	All	TBD	TBD	40%	50%	60%	70%	75%
90% of girls/women aged 15-24 years have comprehensive knowledge of HIV	% of girls/women aged 15-24 years with comprehensive knowledge of HIV	Girls/Young women	30.7% (2016/17)	LePHIA	50%	60%	70%	80%	90%
80% of boys/men aged 15-24 years have comprehensive knowledge of HIV	% of boys/men aged 15-24 years with comprehensive knowledge of HIV	Boys/Young men	26% (2016/17)	LePHIA	30%	40%	50%	60%	80%
75% decrease in the number of males and females, 15-24 years old who have sex before the age of 15 years	% of males 15-24 years who had sex before the age of 15	Males	20.6%	LePHIA	20%	15%	10%	10%	10%
	% of females 15-24 years who had sex before the age of 15	Females	4.7%	LePHIA	3%	2%	1%	1%	1%
75% increase in the number of males 15-24 years old who use condoms when having sex with non-marital, non-cohabiting partners	% of males 15-24 years old who report using a condom the last time they had sex with a non-marital, non-cohabiting partner	ALL	79.9	LeP-HIA2020	80%	83%	85%	90%	95%
75% increase in the number of females 15-24 years old who use condoms when having sex with non-marital, non-cohabiting partners	% of females 15-24 years old who report using a condom the last time they had sex with a non-marital, non-cohabiting partner	Females	71.9%	LeP-HIA2020	80%	85%	90%	93%	95%

	Proportion of women and girls, men and boys who have access to GBV prevention and response services, including legal and psychosocial support	All	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Proportion of women and girls, men and boys who participate in community-led efforts to promote gender equality, GBV prevention, and HIV mitigation, including through advocacy, social mobilization, and peer education	All	TBD	TBD	TBD	TBD	TBD	TBD	TBD
75% of OVC receive comprehensive HIV program services	Percentage of OVC served with a comprehensive program	All	TBD	TBD	40%	50%	60%	70%	75%

Focus Area 2.3: Community Systems Strengthening

Outcome									
30% of testing and treatment services are delivered by community-led organizations	% of testing and treatment services delivered by community-led organizations	District/Community		Epi Analysis	10%	20%	30%	30%	30%
90% of service delivery for HIV prevention programs for key and priority populations	% of service delivery for HIV prevention programs for key and vulnerable populations delivered by community-led organizations	Key and Vulnerable populations		UNAIDS Annual Report	70%	80%	90%	90%	90%
	% of societal enabler programs delivered by community-led organizations	Community organizations	TBD	TBD	40%	50%	60%	60%	60%

Focus Area 3.3: Human Resources for Health

Outcome									
Increase in number of skilled healthcare workers providing HIV/AIDS services in rural and underserved areas by 2028	Number of skilled health-care workers in rural and underserved areas for HIV/AIDS services	All	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Quality of training programs for necessary skills and competencies for HRH	All	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Strengthened HRH policies for and governance of health workforce	TBD	At All levels	TBD	TBD	TBD	TBD	TBD	TBD	TBD
	Extent to which digital technologies and innovative approaches are used in HRH management	All	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Strengthened partnerships for HRH capacity building and development	Number of partnerships established for HRH capacity building and development	All	TBD	TBD	TBD	TBD	TBD	TBD	TBD

Focus Area 3.4: Data Science, Research and Innovation for Precision HIV Programming

Outcome									
Improved data collection, analysis, and use for monitoring and evaluating the HIV response, including disaggregated data on key populations and service coverage.	TBD	All	TBD	LOMSHA DHIS2	TBD	TBD	TBD	TBD	TBD

ANNEX 2: MINIMUM PACKAGE OF CARE FOR DIFFERENT POPULATION GROUPS

General population

- Promotion and provision of condoms and lubricants
- Screening, testing and treatment, and adherence and retention support for HIV, TB, STIs and cervical cancer
- Accessible PMTCT, VMMC, PrEP/PEP services
- Comprehensive integrated SRH and nutrition services
- Screening, treatment, and psychosocial support for mental health disorders
- Prevention, support and redress for human rights violations including gender norms and equality, and access to justice for SGBV
- Targeted SBCC messaging

Key and other priority populations (including SWs, MSM, PWID and LGBTQI+)

- Condom and lubricant promotion and provision
- Screening, testing and treatment, and adherence and retention support for HIV, TB and STIs including contact tracing and partner notification services
- PrEP, PEP and other tailored high-impact prevention options
- DSD in non-traditional settings, including after-hours and weekend services
- Tailored integrated SRH services including screening and management of cervical cancer
- Intensified mental health screening and psychosocial support, and referral to harm reduction services
- Screening for SGBV and referral to psychosocial and other support services for human rights violations
- Access to PEP, safe abortion and post-sexual assault support
- Targeted SBCC
- Prevention, support and redress for human rights violations including gender norms and equality, and access to justice

Children (both in and out of school)

- Age-appropriate CSE in school and non-school and child-friendly environments
 - Gender norms education, including risk reduction in sexual relationships
 - Nutritional and social protection support
 - Comprehensive mental health services and access to psychosocial support
 - Programs for promoting school retention and completion
 - Child- and youth-responsive SRH services in school and community settings:
 - HPV vaccination
 - Sanitary towels / dignity packs
 - Protection against all forms of child abuse
-

Adolescents and young people (both in and out of school)

- Comprehensive youth-responsive SRH services in the school and community settings:
- PrEP and PEP
- STI services including complete doses of the HPV vaccine
- PMTCT Services
- Family planning services including
- Access to safe abortion
- Modern hormonal contraceptive methods
- Male and female condoms and lubricants in schools and tertiary institutions
- Sanitary towels / dignity packs
- Age-appropriate disclosure and adherence support for young KPs and AYP living with HIV
- Community level demand creation and promotion of SRH services for young KPs
- Programmes to keep girls in schools, including:
- Support for pregnant learners
- Access to parenting programmes and peer groups and clubs
- Access to further education and mentorship/ internship opportunities
- Linkages to social protection and economic empowerment programmes

People with disabilities

- Accessible comprehensive prevention services
- Peer-led or peer-supported integrated outreach services
- Targeted health education regarding risk and vulnerability to HIV, TB and STIs
- Accelerated nutritional and social protection support
- CSE accessible to learners with disabilities
- Intensive psychosocial support mechanisms
- Intensified TB screening, treatment and care

Migrant and mobile populations

- Intensified psychosocial support services
- Cross-border collaboration on HIV, TB and STIs policy and programming
- Demand creation and promotion of available services using informal networks
- Provision of health services along the highways and transport corridors
- Flexible DSD options including provision of condoms, HIV testing services, and MMD of ARVs and anti-TB treatment
- Tailored prevention messages and SBCC to address specific challenges e.g., SGBV, harmful drug and alcohol use and access to SRH services and rights.
- Strategies for social protection to mitigate the impact of HIV, TB and STIs

ARVs – Antiretrovirals; AYP – Adolescents and young persons; CSE – Comprehensive sexuality education; DSD – Differentiated service delivery; HIV – Human immunodeficiency virus; KPs – Key populations; MMD – Multi-month dispensing; MSM – Men who have sex with men; PEP – Post exposure prophylaxis; PMTCT – Prevention of mother-to-child transmission; PrEP – Pre-exposure prophylaxis; PWID – People who inject drugs; SBCC – Social and behavior change communication; SGBV – Sexual and gender-based violence; SRH – Sexual and reproductive health; STIs – Sexually transmitted infections; SWs – Sex workers; TB – Tuberculosis; VMMC – Voluntary medical male circumcision.

ANNEX 3: HIV PREVENTION PILLARS, EXISTING BARRIERS/INEQUALITIES AND RECOMMENDED PREVENTION PACKAGES

Barriers / Inequalities	Recommended Prevention Packages
Pillar 1: Key Populations: (SWs, gay men and other MSM, PWID, Trans-gender people, Prisoners)	
Stigma and discrimination	<ul style="list-style-type: none"> • Community-level interventions to reduce stigma and promote inclusion of KPs • Sensitization and training for healthcare workers to provide non-judgmental care • Advocacy and legal support to protect the human rights of KPs, including access to healthcare and justice system without discrimination. • Media campaigns and social mobilization to raise awareness and educate the public about the rights and needs of KPs, combat harmful stereotypes and myths, and promote social inclusion. • Capacity building and leadership development of KP-led organizations to empower them to engage in advocacy and service delivery, build social networks and resilience, and provide peer support and education.
Limited access to healthcare services	<ul style="list-style-type: none"> • Establish community-based facilities that provide KP-responsive services • Incentivise healthcare workers to offer services to KPs • Advocate for demand-side interventions (for example, provision of transport vouchers or stipends) • Provision of telemedicine services to KPs
Criminalization of key population behaviors	<ul style="list-style-type: none"> • Develop and implement targeted public awareness campaigns to reduce stigmatization towards KPs • Formation of strategic partnerships with legal and human rights organizations to provide legal support to KPs • Promotion of community-led initiatives aimed at educating and sensitizing the general public on the rights of KPs • Provision of training and capacity building for law enforcement officers to reduce discriminatory behavior and improve understanding of KPs • Advocacy for increased political will and support for KP-focused interventions
Substance abuse and mental health issues	<ul style="list-style-type: none"> • Integration of mental health and substance abuse services into HIV prevention and treatment programs • Provision of counseling and peer support services to address mental health and substance abuse issues among key populations • Develop and implement community-based harm reduction interventions, including peer-led interventions and drug substitution therapies • Capacitate healthcare workers to manage substance abuse and mental health disorders among KPs • Implement evidence-based behavioral interventions to reduce substance abuse and improve mental health among KPs

Limited access to HIV prevention and treatment	<ul style="list-style-type: none"> • Provision of financial incentives to encourage HIV testing and treatment uptake among KPs • Develop targeted SBCC awareness campaigns for HIV prevention and treatment services • Implement community-based distribution programs for condoms, PrEP, and other prevention tools • Provision of differentiated care models, including community-based adherence support and peer navigation services, to address barriers to HIV treatment adherence and retention • Integrate HIV services for KPs into the broader SRH platform
Limited data on HIV burden among KPs	<ul style="list-style-type: none"> • Establish surveillance systems to monitor HIV incidence and prevalence among KPs • Conduct of periodic population size estimation and mapping exercises to inform program planning and implementation • Provide training to KP-led organizations to support data collection, analysis, and dissemination • Implement innovative data collection methods, including the use of mobile technology, to increase data quality and reduce reporting bias • Promote data use at all levels to inform program planning, advocacy, and resource allocation

Pillar 2: Adolescent Girls and Young Women

Gender inequalities and social norms (inadequate access to education and employment opportunities, GBV, SAE, and cultural beliefs and practices such as early marriage and transactional sex)	<ul style="list-style-type: none"> • CSE, life skills training, and economic empowerment programs targeting AGYW • Community mobilization and engagement with traditional and religious leaders to challenge harmful gender norms • Enforce laws and policies to protect AGYW from GBV and discrimination
Limited access to SRH services	<ul style="list-style-type: none"> • Strengthen healthcare systems to provide integrated SRH services, including HIV prevention and treatment, to AGYW • Capacitate healthcare workers to deliver non-judgmental and youth-friendly services • Provision of HIV self-testing and PrEP to AGYW
Poverty and economic inequalities (lack of access to resources to facilitate access healthcare services, limited employment opportunities and economic empowerment)	<ul style="list-style-type: none"> • Implement social protection programs, such as cash transfers and school feeding programs, targeting AGYW and their families • Provide transportation subsidies to facilitate access to healthcare services • Implement economic empowerment programs targeting AGYW, including vocational training and entrepreneurship programs
Marginalization, including stigma and discrimination against sex workers and inadequate access to tailored HIV prevention and treatment services	<ul style="list-style-type: none"> • Scale up targeted HIV prevention and treatment services for KPs, including SW-friendly clinics and transgender health clinics • Community-led approaches to reach and engage KPs in HIV prevention and treatment services • Advocacy and policy reform to address stigma and discrimination against KPs
Inadequacies in data and evidence-based HIV programming among AGYW	<ul style="list-style-type: none"> • Strengthen monitoring and evaluation systems to collect and analyze data on the HIV epidemic among AGYW • Conduct research to generate evidence on effective HIV prevention and treatment interventions for AGYW • Use data and evidence to inform policy and programming for HIV prevention and treatment among AGYW

Pillar 3: Adolescent Boys and Young Men	
Limited engagement of adolescent boys and young men in HIV prevention and treatment programs	<ul style="list-style-type: none"> • Implement gender-sensitive programs that engage ABYM in HIV prevention and treatment. • Train healthcare workers to provide gender-sensitive services to ABYM. • Promote male involvement in SRHR education and HIV prevention and treatment programs.
Stigma and discrimination related to their HIV status, sexual orientation, and gender identity	<ul style="list-style-type: none"> • Implement HIV-related stigma reduction programs. • Conduct community mobilization campaigns to increase awareness about the negative effects of stigma and discrimination. • Provide CSE that addresses SRHR, including HIV prevention and treatment.
Poverty and marginalization	<ul style="list-style-type: none"> • Implement economic empowerment programs that target ABYM living in poverty or marginalized communities. • Provide educational opportunities to improve knowledge and skills among ABYM. • Expand access to healthcare services in marginalized communities. • Increase community mobilization efforts to address poverty and marginalization.
Cultural and gender norms that reinforce harmful practices (early sexual debut, multiple sexual partners, and GBV)	<ul style="list-style-type: none"> • Implement culturally sensitive and gender-transformative programs to challenge harmful gender norms and practices. • Engage men and boys in programs that promote gender equality and positive masculinities. • Increase the involvement of parents and guardians in programs to promote healthy behaviors among ABYM.
Limited access to HIV prevention, testing, treatment and care services due to a lack of knowledge and awareness about available services and their rights.	<ul style="list-style-type: none"> • Expand youth-responsive HTS in health facilities. • Train healthcare workers to provide youth-responsive services. • Increase community outreach programs to reach more ABYM. • Provide SRHR education to increase knowledge about available services.
Pillar 4: Condom Programming	
Limited access to condoms, lubricants, and guidelines for their use, particularly for youth and key and vulnerable populations.	<ul style="list-style-type: none"> • Increase access to condoms, lubricants, and guidelines through community outlets, schools and youth-friendly health services. • Develop targeted awareness campaigns to reach key and vulnerable populations. • Conduct research on the specific needs of these populations and adapt condom programming accordingly
Restricted access to condoms at Catholic-run hospitals and facilities within CHAL catchment areas.	<ul style="list-style-type: none"> • Distribute condoms at multiple community sites within CHAL catchment areas. • Engage with CHAL and other religious organizations to increase their support for condom programming.
Poor monitoring and management of the condom supply chain, leading to stockouts and quality assurance issues	<ul style="list-style-type: none"> • Improve monitoring and management of the condom supply chain, including forecasting, stockpiling, tracking, and quality assurance. • Increase in-country quality assurance for condoms through regular testing and inspection. • Implement a distribution system that ensures condoms are available at all times.
Low demand for condoms, particularly female condoms, due to cultural barriers and insufficient promotion efforts	<ul style="list-style-type: none"> • Increase demand for condoms through targeted awareness campaigns and social marketing. • Improve promotion of female condoms by addressing cultural barriers and branding issues. • Increase availability of female condoms in community outlets and health facilities.

Inadequate provision of condoms after risk assessment, with insufficient counselling and education on condom use	<ul style="list-style-type: none"> • Provide condoms routinely after risk assessment, with adequate counselling and education on condom use. • Train health care workers on effective counselling and education techniques. • Increase awareness of the importance of consistent and correct condom use.
Limited quality assurance for condoms within the country, leading to storage and transportation issues	<ul style="list-style-type: none"> • Increase quality assurance for condoms within the country through regular testing and inspection. • Implement measures to ensure proper storage and transportation of condoms. • Partner with international organizations to improve quality assurance of imported condoms.
Insufficient condom social marketing and market analysis, leading to a lack of awareness and demand for condoms.	<ul style="list-style-type: none"> • Increase condom social marketing to increase awareness and demand for condoms. • Conduct market analysis to identify gaps and opportunities in condom programming. • Collaborate with private sector partners to increase distribution and promotion of condoms.
Pillar 5: ARV-based Prevention	
Lack of awareness and access to ARV-based prevention among key and vulnerable populations	<ul style="list-style-type: none"> • Comprehensive HIV education and awareness campaigns targeted at key and vulnerable populations. • Outreach programs to reach those who may not have access to health-care facilities. • Strengthening and expanding HTS to identify those who could benefit from ARV-based prevention.
Stigma and discrimination against PLHIV, key and vulnerable populations, and those who use ARV-based prevention	<ul style="list-style-type: none"> • Community-based advocacy and sensitization programs to address stigma and discrimination. • Capacitate healthcare workers to provide non-judgmental and culturally sensitive services. • Enforce laws and policies that protect the rights of key and vulnerable populations.
Limited availability and accessibility of ARV-based prevention interventions	<ul style="list-style-type: none"> • Increase funding for ARV-based prevention interventions. • Scale up access to ARV-based prevention interventions through the integration of HIV prevention and treatment services • Strengthen supply chain management systems to ensure consistent availability of ARV-based prevention interventions. • Strengthen partnerships with the private sector to improve the distribution of ARV-based prevention interventions.
Poor adherence to ARV-based prevention interventions	<ul style="list-style-type: none"> • Comprehensive adherence counselling for those on ARV-based prevention interventions. • Use of reminder systems such as text messaging and pill boxes. • Provision of peer support structures and counselling services to encourage adherence.

ABYM – Adolescent boys and young men; AGYW – Adolescent girls and young women; ARV – Antiretroviral; CHAL – Christian Health Association of Lesotho; CSE – Comprehensive sexuality education; GBV – Gender based violence; HIV – Human immunodeficiency virus; HTS – HIV testing services; KPs – Key populations; MSM – Men who have sex with men; PrEP – Pre-exposure prophylaxis; PWID – People who inject drugs; SAE – Sexual abuse and exploitation; SBCC – Social and behavior change communication; SRH – Sexual and reproductive health; SRHR – Sexual and reproductive health rights; SWs – Sex workers.

ANNEX 4: LIST OF CONTRIBUTORS

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Baylor	ICAP Head Office
Baylor / Karabo-Ea-Bophelo	Informative
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CDC/PEPFAR	LCCM
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Correctional Services Mohale's Hoek	LENASO Head Office
CRS	LENASO Mafeteng
CSOs	LENASO Mohale's Hoek
CW-Lesotho	LENASO Qacha's Nek
DHMT Berea	LENASO Thaba-Tseka
DHMT Butha-Buthe	LENEPWHA
DHMT Leribe	LENEPWHA Berea
DHMT Mafeteng	LENEPWHA Mafeteng
DHMT Maseru	LENEPWHA Maseru
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District AIDS Committee Qacha's Nek	Lesotho-Red-cross
District AIDS Committee Quthing	LPPA
EGPAF	M&E Point of Contact Consultations
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EGPAF Leribe	Mantsopa Institute
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Ministry of Finance	South Region
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Ministry of Health	Team
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