

**Kingdom of Lesotho**

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# **National HIV & AIDS Strategic Plan 2018/19 – 2022/23**

**Ending AIDS by 2030**

## ABBREVIATIONS AND ACRONYMS

ADR	Acquired Drug Resistance
AGYW	Adolescent Girls and Young Women
AMR	Analytical Measurement Range
ART	Anti-retroviral Therapy
BCC	Behaviour Change Communication
BeMONC	Basic Emergency Obstetric and New-born Care
CAGs	Community Antiretroviral Groups
CBO	Community Based Organizations
CHAL	Christian Health Association of Lesotho
CHEAL	Comprehensive HIV Epidemic Analysis Study for Lesotho
CSO	Civil Society Organization
CSS	Community Systems Strengthening
DBS	Dry Blood Sample
DHIS 2	District Health Information System 2
DRS	Drug Resistant-TB Survey
DSD	Differentiated Service Delivery
EID	Early Infant Diagnosis
EMR	Electronic Medical Records
EWS	Early Warning Systems
FBC	Full Blood Count
FSW	Female Sex Workers
GHO	Global Health Observatory
GOL	Government of Lesotho
HCW	Health Care Worker
HIVDR	HIV Drug Resistance
HRH	Human Resources for Health
HTS	HIV Testing Services
IMR	Incidence Mortality Ratio
INH	Isoniazid
IPC	Infection Prevention and Control
IPM	Incidence Pattern Model
IPT	Intermittent Preventive Therapy
LAM	Lipoarabinomannan Assay
LDHS	Lesotho Demographic Health Survey
LePHIA	Lesotho Population-based HIV Impact Assessment
LOMSHA	Lesotho Output Monitoring System for HIV and AIDS
LF	Lumefantrine
LF-LAM	Lateral Flow Urine Lipoarabinomannan Assay
LMPS	Lesotho Mounted Police Service
LRF	Lab Request Form
LTFU	Lost to Follow Up
M&E	Monitoring and Evaluation
MDR-TB	Multi-Drug Resistant Tuberculosis
MOA	Ministry of Agriculture and Food Security
MOE	Ministry of Education and Training
MOF	Ministry of Finance
MOH	Ministry of Health
MOPS	Ministry of Public Service

MOSD	Ministry of Social Development
MoT	Modes of Transmission
MSM	Men Having Sex with Men
MTCT	Mother to Child Transmission
MMG	Mother to Mother Support Groups
NAC	National AIDS Commission
NDSO	National Drug Service Organization
NISSA	National Information System for Social Assistance
NPT	New Prevention Technologies
NRL	National Reference Laboratories
NSP	National Strategic Plan
NTP	National Tuberculosis Programme
PCR	Polymerase Chain Reaction
PDR	Pre-treatment Drug Resistance
PEPFAR	Presidents Emergency Fund for AIDS Relief
PHC	Primary Health Care
PI	Protease Inhibitor-based antiretroviral therapy
PLHIV	People Living with HIV
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People who Inject Drugs
QA	Quality Assurance
RSSH	Resilient and Sustainable Systems for Health
SBCC	Social and Behaviour Change Communication
SCMD	Supply Chain Management Directorate
SGBV	Sexual and Gender Based Violence
SRHR	Sexual and Reproductive Health Rights
SOPs	Standard Operating Procedures
SRMNCAHN	Sexual, Reproductive, Maternal, Neonatal, Child and Adolescent Health and Nutrition
TAT	Turnaround Times
TLD	Tenofovir/ lamivudine/ dolutegravir
TLE	Tenofovir/ lamivudine/ efavirenz
TOR	Terms of Reference
UNAIDS	Joint United Nations Program on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VDRL	Venereal Disease Research Laboratory test
VLS	Viral Load Suppression
VMMC	Voluntary Medical Male Circumcision
WDI	World Development Indicators
WHO	World Health Organization

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## Definition of Key Terms

95-95-95	Diagnose 95% of all people living with HIV, provide antiretroviral therapy (ART) for 95% of those diagnosed, and achieve viral suppression in 95% of people on treatment
Behavioural Change	Adoption and maintenance of healthy behaviour (with respect to practices) that reduce the chances of acquiring HIV.
Comprehensive Sexuality Education	An age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic and non-judgmental information
Concurrent sexual partnerships	People involved in overlapping sexual partnerships where intercourse with one partner occurs between two acts of intercourse with another partner (within the last six or twelve months).
Elimination	Stopping the transmission of HIV in a specific geographic area or countrywide
Epidemic Control	The point when new HIV infections decrease and fall below the total number of deaths among people living with HIV
Eradication	The permanent eradication of a disease to zero cases
HIV-Specific Social protection	Programmes that focus exclusively on HIV and people living with and affected by HIV. Under HIV-specific programmes, HIV services are provided for free, and financial incentives are offered to encourage access to them. Examples of these might include cash refunds to address the opportunity costs of accessing services and free food and nutrition for people living with HIV on antiretroviral therapy or tuberculosis treatment to encourage adherence to treatment. Lesotho Government has a framework for social protection that, by default, may be considered HIV sensitive, is the revitalization of HIV-specific social protection aimed at the most vulnerable or at risk of HIV and AIDS.
Hyperendemic disease	A constantly present disease, at high incidence or prevalence.
Incidence Mortality Ratio	Ratio of total number of new HIV infections [per year] to the total number of deaths from all causes among HIV-infected individuals [per year]- a measure of epidemic control, when incidence falls below mortality
Sexual Exploitation	Any actual or attempted abuse of position of vulnerability, differential power or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Involvement of children/ minors in the exchange of goods or money for sexual services is considered sexual exploitation.
Sex Workers	Consenting female, male and transgender adults—including young people over the age of 18 years—who <b>regularly or occasionally</b> receive money or goods in exchange for sexual services.
Social and behaviour change communication	Multi-faceted communication interventions that seek to transform risky behaviours and harmful socio-cultural norms, beliefs, values and practices, and to increase demand for services
Treatment Cascade	The chain of events that are involved in an HIV -positive person receiving treatment until his or her viral load is suppressed to undetectable levels. Stages of the HIV treatment cascade are as follows: the number of people living with HIV; the number who are linked to medical care; the number who start HIV treatment; the number who adhere to their treatment regimen; and, finally, the number who suppress HIV to undetectable levels in their blood.

# 1. CONTEXT AND RATIONALE FOR A NEW STRATEGIC PLAN

## 1.1 Introduction and Rationale

Nearly five decades into the AIDS response, growing global confidence in countries' ability to end the epidemic has culminated in a vision set at the United Nations General Assembly Political Declaration on HIV and AIDS in June 2016, which reaffirmed Member States' commitment to the 2030 Agenda for Sustainable Development, including the resolve to fast track and end the AIDS epidemic by 2030 and implement the Agenda on Financing for Development.<sup>1</sup> In aligning its 2016-2021 Strategy to the new global vision, UNAIDS identified Lesotho as a 'Fast Track Country' with a severe epidemic. The Lesotho Population-Based HIV Impact Assessment (LePHIA, 2017), a nationwide cross-sectional household survey, estimated HIV prevalence among adults aged 15 to 59 years at 25.6% (30.4% females and 20.8% males); and as high as 49.9% among women aged 35-39. More than 330,000 people live with HIV. Incidence remains high at 1.47% in adults 15 to 59 years, 1.74% in females and 1.22% in males, with more than 13000 new adult infections annually. Population-level viral load suppression (VLS) rates were at 67.6%. Estimated at 2.1%, paediatric HIV prevalence is among the highest in the world. Surveys of key and vulnerable populations estimated prevalence at 71.9% among female sex workers, 43.3% among Factory Workers, 32.9% for MSM and 31% among prisoners.

The previous National HIV/AIDS Strategic Plan 2011-2016 was extended to 2018 to align with the National Strategic Development Plan and respond to the UN Political Declaration on HIV and AIDS of 2016. It outlined interventions for HIV prevention; treatment care and support; impact mitigation; response coordination and management towards halving new infections and AIDS and TB-related deaths by 2018; eliminating mother to child transmission and improving efficiency and effectiveness of national response planning, coordination and service delivery. The strategy also sought to fast track the response in alignment to global commitments and 90-90-90<sup>2</sup> targets and was synchronized with the national Tuberculosis strategy. The 2017 LePHIA findings imply that the country is on track to achieve 90-90-90 targets by about 2020. Nonetheless, incidence and mortality reduction remain major goals since the country is still one of the world's most severely affected by the HIV and TB epidemics. This new strategic plan has been designed to accelerate and recalibrate the response to the epidemic.

## 1.2 How this Plan was Developed

Relying on a rich array of evidence, this National HIV and AIDS Strategic Plan 2018/19 – 2022/23 has been consultatively developed to guide Lesotho towards epidemic control and build an enabling environment that will support eventual elimination. The plan is informed by the National Strategic Development Plan and Health Sector Strategic Plan, as well as global guidelines, Africa Union and SADC commitments. Several analytical studies investigated the epidemic and reasons for slower reduction in incidence, gaps, constraints and barriers to implementation progress, and challenges. Key among these were:

- The Lesotho Population-Based HIV Impact Assessment (LePHIA), performed between 2016 and 2017, which estimated HIV prevalence, incidence and viral load suppression;
- A 2017 prevention assessment and gap analysis which provided insights into programmatic limitations and proffered remedies for the country's prevention response;
- The Comprehensive HIV Epidemic Analysis for Lesotho (CHEAL), which assessed HIV trends and underlying sub-population level causalities, building on the Incidence Pattern Model;

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<sup>1</sup> UNGA Seventieth Session Agenda item 11: Implementation of the Declaration of Commitment on HIV/AIDS and the political declarations on HIV/AIDS; Addis Ababa Action Agenda of the Third International Conference on Financing for Development.<sup>1</sup>

<sup>2</sup> Where 90% of people living with HIV know their status, 90% of people who know their status are accessing treatment and 90% of people on treatment are virally suppressed

- An external Joint TB/HIV (and Viral Hepatitis) Program Review analysed progress, challenges and made recommendations to strengthen each intervention;
- The Spectrum suite of tools, which uses HIV prevalence and incidence from population surveys including LDHS and LePHIA to model the HIV epidemic, provide estimates and project key indicators such as number of new infections, number of people living with HIV, mother-to-child transmission rate, mortality and others;
- Customized transmission-probability models to prioritize target populations and interventions (programmatic scope) and determine the optimal program coverage (scale) required to achieve the desired impact on the epidemic;

A systematic consultative multi-stakeholder dialogue guided development of the new strategy. A series of consultations and reviews by people living with HIV and / or TB, National AIDS Commission, Ministry of Health and other line ministries, United Nations System, PEPFAR, Global Fund, broad Civil Society (and private sector) and others delved into programmatic and operational level specificities, relying on available evidence to make more granular, corrective recommendations for strategies, interventions and activities. An analysis of all the above evidence by implementers and policymakers determined common reasons for lower coverage and impact.

National AIDS Commission coordinated the development of this plan through a multisectoral steering committee, task teams and technical working groups consisting of government, development partners, civil society including networks of People Living with HIV, representatives of Key Populations and private sector groups, and technical assistance; prior to international peer reviews, district and national level reviews and validation.

### **What is New in This Plan**

- Adoption of results-based planning language and accountability framework (Strategic Results, or Goals; Program Results; Result Areas, and Outcome Results cascading into output level results at the operational planning level)
- A shift from intervention-focus to a people-centred response. Examples include differentiated service delivery (DSD) for ART such as Community ART Groups (CAGs) and ART Refills Groups
- Strengthened focus on gender
- Alignment to the 95-95-95 Targets
- Differentiated Combination Prevention
- Innovations in interventions, products, activities and delivery models: differentiated HTS; self-testing; PrEP; male corners providing comprehensive health services for men; unique identifier EMR/ options for blockchain technologies for patient identification and tracking; Index testing; dually qualified VMMC nurse initiates (professional and cultural qualifications to expand VMMC service delivery and acceptability); TLD and TLE combinations; shorter coursed regimen; LF-LAM for severely immunocompromised; technologies to reduce viral load and EID TATs; accelerate essential drug distribution in hard-to-reach areas, among others.
- Revamped and costed Multisectoral Coordination Framework; new HIV and TB coordination structure; and a collaborative implementation framework
- Standardization of DHIS 2: Integration of LOMSHA; EMR; Key Populations and partner reporting; extension of computerization of DHIS 2 to primary level;
- Review of service delivery models and response/ allocation prioritization criteria (From geography to sources and drivers of the epidemic); and
- Advancing the Global Fast Track Vision from control to elimination.

### **1.3 Operational and Socioeconomic Context**

The Kingdom of Lesotho's 2,007,201 population (Bureau of Statistics, 2016) lives within a high-altitude network of rivers, valleys descending to 1400m above sea level and mountains peaking at 3,482m. The country's 30,355 km<sup>2</sup> is completely encircled by the Republic of South Africa. The western half of the country, encompassing the capital

Maseru, Mafeteng, Leribe, Teyateyaneng and other towns, is more densely populated. An estimated 57.8 % of the population lives below the poverty line (World Bank, 2016). Maternal, infant and child mortality have been on a downward trend since the 1960s but remain relatively high.

**Economic Context:** Lesotho is a lower middle-income economy with GDP per capita of USD 1020. The economy is based on agriculture, livestock, manufacturing and mining industries, with workers' remittances from South Africa another major source of inflows. Services comprise 60% of the country's GDP, while industry (mining, manufacturing, construction, energy production) comprise 34.6% and agriculture 5.3% (World Bank 2017 estimates). Most formal employees are women working in the garments sector, while men are mostly migrant labourers in South African mines, working under inadequate health conditions and away from their families for up to three quarters of the year. The Government of Lesotho (GoL) is another significant employer. Still, unemployment remains high, at 28%, coupled with high inequality and poverty. Youth and some elderly populations are net dependents, while the Gini-coefficient shows a sizable gap between the rich and poor. The economic growth rate between 2011 and 2015 averaged 4.5%, but slowed to 2.3% by 2017. Economic growth prospects will be boosted by expected increases in mining and construction activity during this plan period (World Bank, 2017), increasing internal migration which is among the HIV epidemic drivers.

**Table 1.1 : Summary of Critical Demographic, Health and Economic Indicators**

PARAMETER	VALUE	YEAR (DATA SOURCE)
Population	2,007,201	BoS (2016)
Urban Population	31.7%	BoS (2016)
Popn. In extreme poverty	57.8%	World Bank, 2017
GDP Per Capita (PPP \$)	\$1020	World Bank, 2017
Life Expectancy at Birth	53.6 Years (F 56; M 51.6)	WDI (2015)
Maternal Mortality	1024/ 100000 live births	LDHS (2014)
Under-5 Mortality	80.4 /1000 live births	WDI (2016)
Stunting Prevalence	33%	UNICEF/ LDHS (2014)
Vaccination coverage	68 %	BoS (2016)
Number of Orphans	210 712 (27% of Children)	BoS (2016)
Health Budget as % Total	15%	MOF, 2017
Health Expenditure % GDP	10.6%	World Bank (2015)
Public Health Expenditure	76%	World Bank (2015)
Out of Pocket Expenditure	16.5 %	World Bank (2015)
Physicians Density	Below 0.1 per 1000 population	WHO, WDI
Nurses Density	0.6 per 1000 population	WHO, WDI
Adult Literacy Rate	85% (94.5% for female)	WHO, WDI

### Demographic Context

The 2016 household census enumerated the total population of Lesotho as 2,007,201 distributed as follows. 38% of the population is youthful (that is, falling between the age ranges 15-34 years), at a time when youth unemployment, another driver of the epidemic, remains high. At least 42% of the population is aged 0-19. On average, 51% of the population is female. Population varies across the 10 administrative districts of Maseru (the Capital City); Leribe, Berea, Mafeteng, Mohale's Hoek, Thaba-Tseka, Botha-Bothe, Quthing, Mokhotlong and Qacha's Nek. The highest population was in Maseru with 519,186 people, while the lowest in Qacha's Nek (74,566) people. Household shocks, including death, job loss, or crop failure are the main "push" factors contributing to general, and especially female migration in Lesotho, with 43% of families reporting at least one member living away from home (Botea et al. 2017). Children (0-17 years) comprise 38.1% of the total population (BOS, 2016)- 38.1%. About 18% of those aged 3-17 are not in school (10.1% are males and 7.9% are females). Only about half (54%) of Lesotho's children live with their parents. Up to



48% of orphans live with their grand-parents, while 12% live in child headed households. 24 % of girls get married before they attain 18 years of age while the likelihood of getting pregnant for orphan girls is twice as high as that of girls with both parents. 33% of children were stunted, while 3% were wasted by 2014 (LDHS). Of the more than 200,000 orphans, significantly more are paternal rather than maternal or double orphans.

## 1.4 Health Systems

**Health Infrastructure:** By the end of 2017, there were at least 236 health facilities in the country, including one referral hospital, two specialized hospitals, 18 general hospitals, four primary hospitals, four filter clinics and 207 health centres (MOH, 2017), Forty percent (40%) of the health centres and 58% of hospitals are MOH-owned. Thirty Eight percent (38%) of health centres and the same proportion (38%) of hospitals are owned by Civil Society. Health centres are the first point of care for HIV and other diseases. Nine out of 10 private for-profit health facilities are situated in urban areas within western districts of Maseru, Berea, Mafeteng, and Leribe. Some non-governmental organizations (NGOs) complement service delivery to a significant proportion of the population. About 80% of the population accesses improved water sources, while only 30% has improved sanitation - critical indicators in mother and child health (WHO, 2015). The proportion of facilities providing basic emergency services are limited (UNICEF, 2015).

**Human Resources:** Overall, Lesotho's health system suffers an acute shortage of human resources. There are only six nurses, one physician and a pharmacist for every 10000 people. One doctor and three nurses serve about 1000 people living with HIV or TB. The Annual Joint Review report of FY 2015/16 found that about 50 percent of the health centres run by the government and civil society were staffed according to minimum staffing requirements. The overall vacancy rate was 22% in 2015/16, a significant improvement from 43% reported the previous year. Nearly 5000 community/ village health workers, traditional birth attendants, distribution agents and water minders complement service delivery at community level, critical in ensuring reduction in some disease burden including polio, waterborne diseases and delivery of HIV interventions within the prevention, test and treat continuum. Still, the ratio of community or household level health workers to PLHIV and TB clients is still below the WHO recommended threshold and this is evident in high rates of Loss to Follow Up. The Health Sector Strategy prioritizes community level service delivery as central to health service promotion; hence strengthening it to efficiently support the achievement of 95-95-95 targets will be a critical Program Result.

**Medicines, medical devices and medical technologies (health commodities) Procurement and Supply Chain Management:** The procurement and supply chain in Lesotho is coordinated by Supply Chain Management Directorate (SCMD) of MOH, with development partners playing critical supportive roles in financing, while some assist with procurement and quality assurance. SCMD also participates in selection of products by MOH programs. The system can ensure health commodity security. Storage warehousing and distribution through to community level is coordinated mainly through NDSO, an agency of MOH. The system for stock monitoring and reporting at facility level has improved due to the rollout of informed push reporting and requesting tool. Forecasting has been improved, but challenges remain in budgeting when some programs fail to use forecasted results to inform their budgets. Disbursement of funds from MOF is done on a quarterly basis and this affects procurement and supply of health commodities. Current regulations do not allow pre-financing/ prepayment of orders as required by suppliers, occasioning long lead times, with a limited pool of local suppliers at country level. Gazettement of SCMD has been delayed hence budget size and staffing is limited while the sustainability of activities is at risk. This is a critical risk in the context of the global fast track targets envisioned in this strategy, and in the United Nations declaration.

**Pharmaceutical Services:** Lack of a fully functional national drug regulatory agency has led to gaps in registration and product quality monitoring within the country. ARVs procurements in Lesotho are made from WHO prequalified suppliers, while that of TB commodities is done under the Global Drug Facility (GDF) mechanism. Patient data reported

from health facilities has been of poor quality, characterized by under-reporting, inaccuracies and limited disaggregation of data.

**Strategic Information:** MOH and partners have made major advances in deploying systems and tools to generate and manage strategic information. The country introduced a revamped version of the electronic District Health Information System (DHIS2); deployed and trained human resources in M&E. Obtaining reliable and high-quality data for decision-making is still a challenge owing to marked discrepancies between routine and survey data, inadequate human resource (as evidenced by a 65% M&E human resource gap) and nascent unique patient identification and tracking systems. EPI, HIV and TB data systems are yet to be merged while segmented deployment by the Global Fund and better funded PEPFAR implementers have led to an unbalanced HMIS system. Communication between the HMIS unit and programs has been poor over the years; with limited sharing of information. DHIS 2, the community information system (LOMSHA), financial and human resources information systems are yet to be merged as recommended globally; while key population; unique patient identification, and social assistance information data is not integrated in DHIS 2 leading to potential duplication and some inefficiencies in program design and implementation.

## 1.5 Human Rights, Law and Gender Context

Harmful laws, policies and practices; inadequate legal literacy and limited access to legal services continue to affect the implementation environment and achievement of results. *A Report on the Assessment of the legal environment for HIV and AIDS in Lesotho* (2016) underscores lack of awareness of laws among people living with or affected by HIV in Lesotho. Several HIV related laws need review, simplification or wider dissemination. The Sexual Offences Act (2003) and Legal Capacity of Married Persons Act (2006), Gender and Development Policy; National HIV and AIDS Policy (2006 and the AIDS Bill are not yet updated to fully meet the rights and needs of PLHIV and vulnerable groups. The Children's Protection and Welfare Act 2011 and the Legal Capacity of Married Persons Act 2006 do not provide for child marriage as a punishable offence. Laws requiring updates to better mitigate against the effects of HIV include the Elderly Act, Children's Welfare Act, the Labour law and the Disability Equity Bill.

Gender inequality, gender-based violence and many forms of human rights violations significantly influence the twin HIV and TB epidemics in Lesotho<sup>3</sup>. These include sexual and gender-based violence, harmful cultural norms and practices related to gender such as early marriage, persisting stigma, discrimination, inadequate access to health services, and unsafe working conditions. According to LePHIA (2017), 10% of women and girls have been forced to have sex, while the Gender Links Report (2014), states that 62% of Basotho women have experienced intimate partner violence over their lifetime, and 86% had experienced gender-based violence. More than a third of men (37%) reported perpetrating, intimate partner violence, with 16% of men admitting to having committed rape. Stigma and discriminatory attitudes deter uptake of health services: The Lesotho Stigma index (2013) reported stigma and discriminatory practices in social service facilities, including stigma by duty bearers within and outside the healthcare setting.<sup>4</sup> Many groups face exploitative and poor working conditions including miners in neighbouring South Africa who suffer high rates of TB/HIV incidence; Women, children and adolescents who engage in sex work or exploitative relationships and some factory workers, especially women in the garment industry who continue to earn low wages, and remain classified among the working poor.

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<sup>3</sup> LepHIA (2017); Legal Environment Assessment (2016)

<sup>4</sup> The People Living with HIV Stigma Index (2013); UNAIDS, GNP+, ICW Global.

## 2. EPIDEMIOLOGICAL TRENDS AND RESPONSE ANALYSIS

The HIV epidemic in Lesotho is generalized and hyperendemic, with HIV prevalence highest in female sex workers, men having sex with men, factory workers and prison populations. Though the main mode of transmission is heterosexual contact, the root causes driving the epidemic are socio-cultural and economic in nature. HIV is the main driver of Lesotho's twin epidemic of Tuberculosis, while TB is a leading cause of comorbidity and deaths among people living with HIV. The country ranks high in TB-HIV comorbidity with a co-infection rate of 72%, the world's second highest HIV prevalence and fourth highest severity of TB burden (incidence per capita).

### 2.1 Epidemiological Trends

**2.1.1 Trends in incidence:** The Lesotho Population Based HIV Impact Assessment (LePHIA 2017) estimated annual incidence among people aged 15 to 59 at 1.47 in 2016. Incidence is higher in females (1.74%), than in males (1.22%). This corresponds to at least 13,000 new adult HIV infections annually. Between the ages 15-49, incidence is 1.55 (1.81 female and 1.33 male).

Adult HIV Incidence peaked at 2.27% per 100 person-years (PY) in 1997, steadily decreasing to 1.55 [0.98, 2.11] new infections 2017 (CHEAL 2017). During the last ten years however, the HIV epidemic has stabilized. Comparative analysis using the 15-49 age group shows that the number of new infections has declined from an estimated 18,870 new infections in 2007 to 14,706 in 2017 (Spectrum Estimates, 2018), representing a drop of only 22% during the last decade.

Understanding where and why new infections are occurring is the most important factor for appropriately targeting HIV prevention responses. In 2017 an analysis was undertaken using the Incidence Patterns Model (Avenir Health, 2018) and working with DHS 2014 data. The model estimated that the great majority of new infections occur in the general population, with over 68% of all new infections occurring in never married females, never married uncircumcised males, and sero-discordant couples with the male as the HIV positive partner. Only a small percentage (7%) of new infections were estimated to occur in female sex workers and men having sex with men because of the relatively small size of these populations, although their HIV prevalence is higher than that in the general population.

**2.1.2 HIV Prevalence:** Prevalence of HIV among adults ages 15 to 59 years in Lesotho is 25.6%: 30.4% among females and 20.8% among males (LePHIA, 2017). This corresponds to approximately 306,000 people living with HIV (PLHIV) aged 15 to 59 years. Prevalence among children ages 0 to 14 years is 2.1%: 2.6% among females and 1.5% among males. This corresponds to approximately 13,000 children living with HIV (CLHIV) aged 0-14 years (LePHIA, 2017). The highest HIV prevalence in all ages and both sexes is 49.9% in females aged 35 to 39 compared to 46.9% in males aged 40-44 years. Variances in prevalence between males and females are most marked between 20 to 24-year-olds, over four times as high in females (16.7%) than in males (4.0%). All 10 districts of Lesotho have high HIV prevalence, ranging from 17.8% to 29.3% adult prevalence, with five lower lying districts with higher population density and stronger economic activities accounting for an estimated 75% of all people living with HIV (PLHIV).

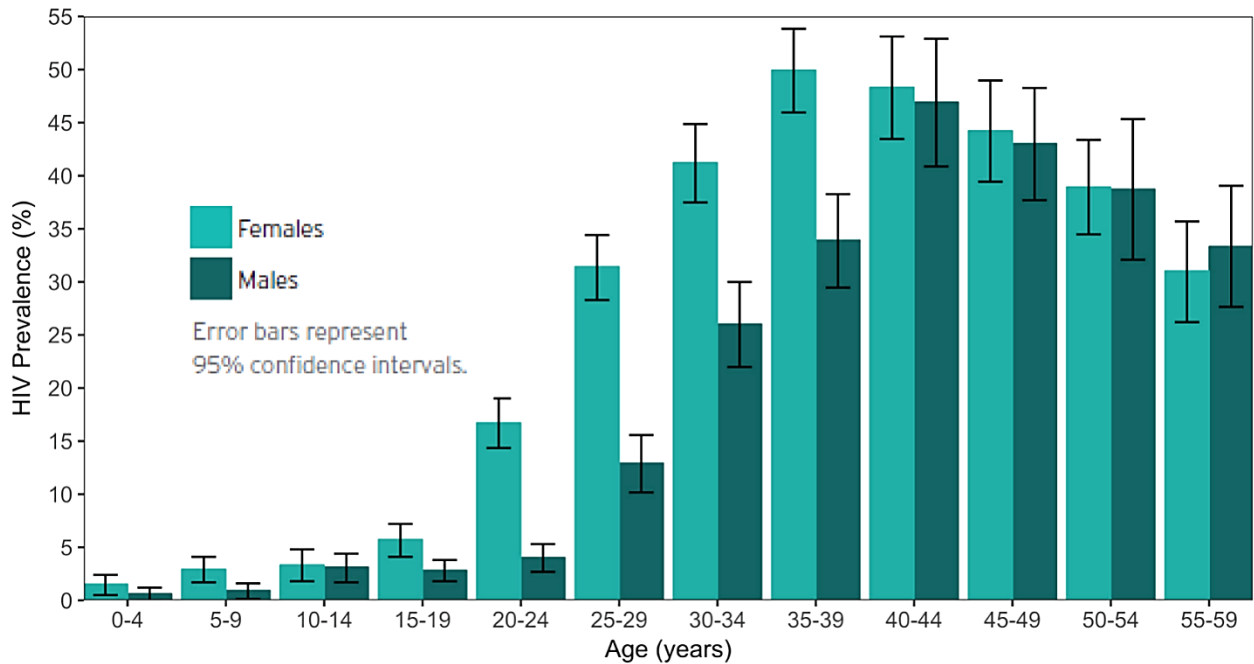


Figure : HIV Prevalence by Age and Sex (LePHIA 2017)

### 2.1.3 Heterogeneity of the epidemic:

The HIV epidemic is hyperendemic with geographical and population-based variations (gender, age, social and individual behavioural differences). Spatial and temporal variances in prevalence and incidence have been witnessed in the whole country. By geographical area, prevalence varies by district from a low of 17.8% in Butha Buthe to a high of 29.3% in Maseru. Viral load suppression rates are highest in Berea at 71.7% and lowest in Mokhotlong at 58.8%.

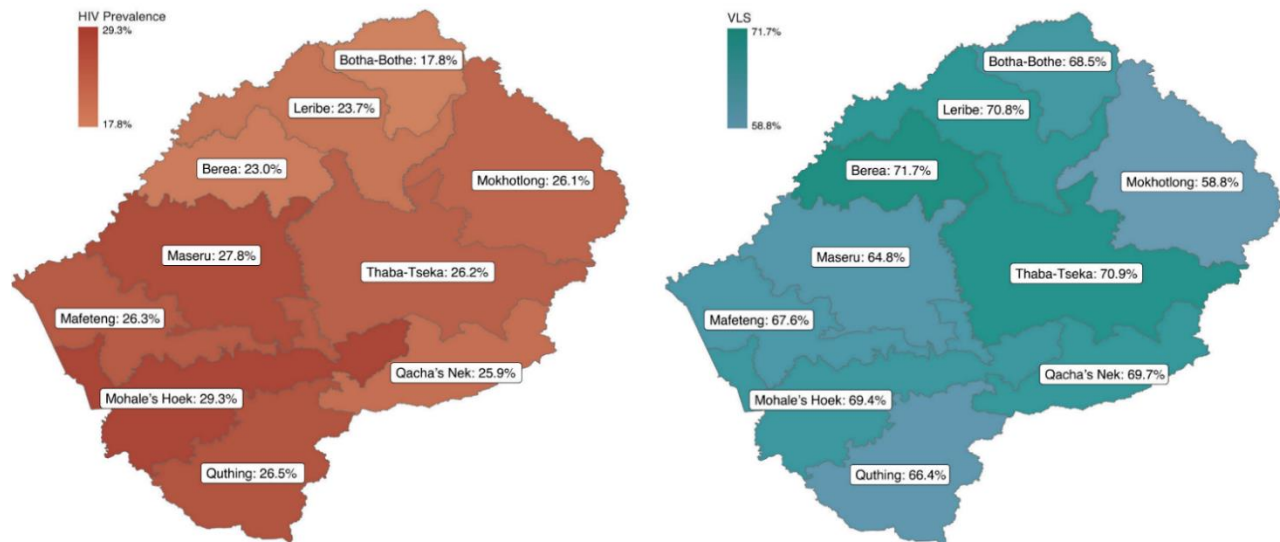


Figure: Variances in HIV Prevalence and Viral Load Suppression Rates Across Districts. (LePHIA 2016-17)

**Trends over time:** Trends in the HIV epidemic over time show that it has persisted at high prevalence across all districts. In 2004, HIV prevalence in excess of 20% in Leribe (29.7%), Maseru (25.5%) and Berea (24%) and others were possibly associated with increased population of women working in garment factories in these districts. In 2017 the highest prevalence districts became Maseru (27.8%), Berea (29.3%) and Leribe (29.3%). The prevalence across districts and in different years have overlapping confidence intervals- hence may not imply any major differences. The studies however confirm urbanization and labour migration as significant drivers of the HIV epidemic, though also emphasizing the need for a comprehensive HIV response across the whole country.

Heterogeneity of the epidemic is also observed along socioeconomic and geographic strata. A review of HIV prevalence across urban and rural areas, while checking for employment types found that HIV prevalence is consistently higher in urban areas and among the employed. For employed adults, prevalence is higher among the unskilled, self-employed or those in low-skilled jobs than among the professional, technical or managerial cadres (CHEAL, 2017).

Men with no education are increasingly more likely to be HIV-positive than their counterparts with some level of secondary or tertiary education. On the other hand, women with some primary level education are more likely to be infected with HIV than their counterparts with no education, secondary or tertiary level education. (LDHS, 2004, 2009 and 2014.)

**2.1.4 Viral load suppression (VLS) rates:** Among HIV-positive adults ages 15 to 59 years viral load suppression (VLS) rates have risen from less than 45% in 2011 to 67.6%: 70.5% among females and 63.4% among males. Prevalence of VLS among people living with HIV is highest among older people ages 45 to 59 years: 80.3% among HIV-positive females and 81.4% among HIV-positive males. In contrast, prevalence of VLS is distinctly lower among younger adults: 50.9% among HIV-positive females ages 15 to 24 years and 46.1% among HIV-positive males ages 25 to 34 years. (LePHIA, 2017)

**2.1.5 Morbidity and mortality:** Scale up of ART and increasing VLS has halved AIDS related mortality from 10,345 in 2007 to 4,908 in 2017 (HIV Estimates and Projections 2018). Key drivers of HIV morbidity are Tuberculosis, Viral Hepatitis, pulmonary and a range of neonatal and child infections related to lack of access to clean water, sanitation and hygiene, among others (WHO/ World Bank Global Health Observatory) More men than women die of HIV-related causes, primarily due to poor health-seeking behaviour, translating to lower HTS uptake or access; and lower ART enrolment and retention in care.

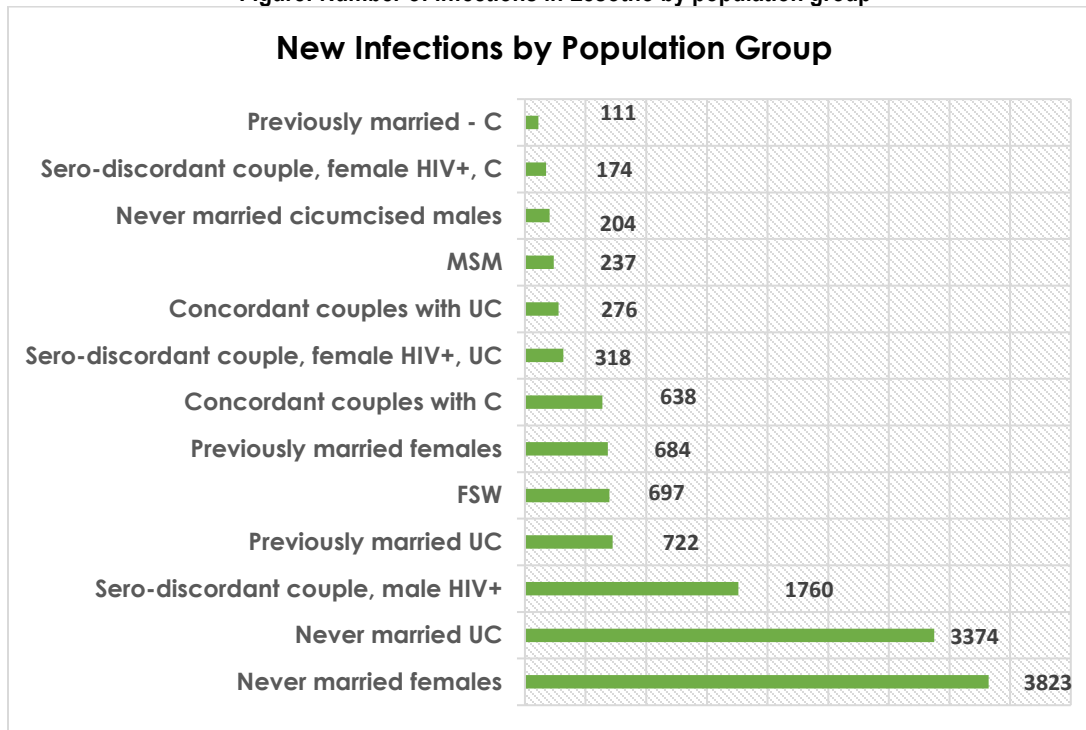
## **2.2 Sources of New Infections and Drivers of the Epidemic**

### **2.2.1 Sources of New Infections by Population Characteristics**

A comprehensive analysis of the distribution of new infections according to easily identifiable characteristics, through the Incidence Patterns Model, validated by previously known information from the Lesotho Demographic Health Surveys of 2014; BSS 2012 and compared to LePHIA 2017, show that most new infections in 2017 were among women compared to men, and outside of stable relationships. However, uncircumcised men never married females and sero-discordant couples (where male partner was HIV positive) constituted a sizable proportion of new infections. The graph below reflects the Incidence Patterns Model estimates (CHEAL, 2017) In this model, the number of new infections in a population group depends on the group's size and its disease incidence. The largest number of new infections was estimated to occur among women who had never married - mostly young women before marriage (3,823; 29.4%); uncircumcised men who had never married (3,374; 25.9%), and sero-discordant couples with the male partner HIV+ (1,760, 13.5%) – all of whom contributed 69% of new infections. Other new infections were among previously married and uncircumcised men (722, 5.5%), female sex workers (697, 5.4%), previously married females (684, 5.3%), and concordant couples with male circumcised (638, 4.9%). Remaining groups made up less than 8% of new infections. Key populations (FSW, MSM) are estimated to account for only about 7.2% of new infections despite FSW and MSM

exhibiting high prevalence. The relative contribution of new infections among these two key populations was low because of their lower absolute population size, since MSM and FSW comprise only 1.5% and 1.1% of the active population respectively. In addition, majority of FSW (72%) and about a third (33%) of the MSM population are living with HIV. However, key populations tend to have large sexual networks and therefore play a significant role in HIV transmission within the networks.

Figure: Number of infections in Lesotho by population group



**Key**

MSM = Men who have sex with men  
 FSW = Female sex workers  
 C/UC = Circumcised/ Uncircumcised Male

While other risk behaviors cannot be overlooked, lack of circumcision is a cross-cutting driver of new infections among males, accounting for 4,414 (86%) of new infections in male groups, including never married & uncircumcised males (66%), previously married & uncircumcised males (14%) and serodiscordant couples with female HIV+ & male uncircumcised (6%). Nearly half of all women and girls who get infected are single (49%), while 22% are in discordant relationships with a HIV positive partner. An additional 9% of infections among women and girls occur from sex work. These three groups contribute 80% of new infections among females. Other infections among females occur in concordant couples (HIV negative) with circumcised males (9%; previously married females (8%) and concordant couples (HIV negative) with uncircumcised males (3%). The latter type of couples is thought to be lower in population size than the former, hence the lower number of infections.

**2.2.2 Drivers of the Epidemic**

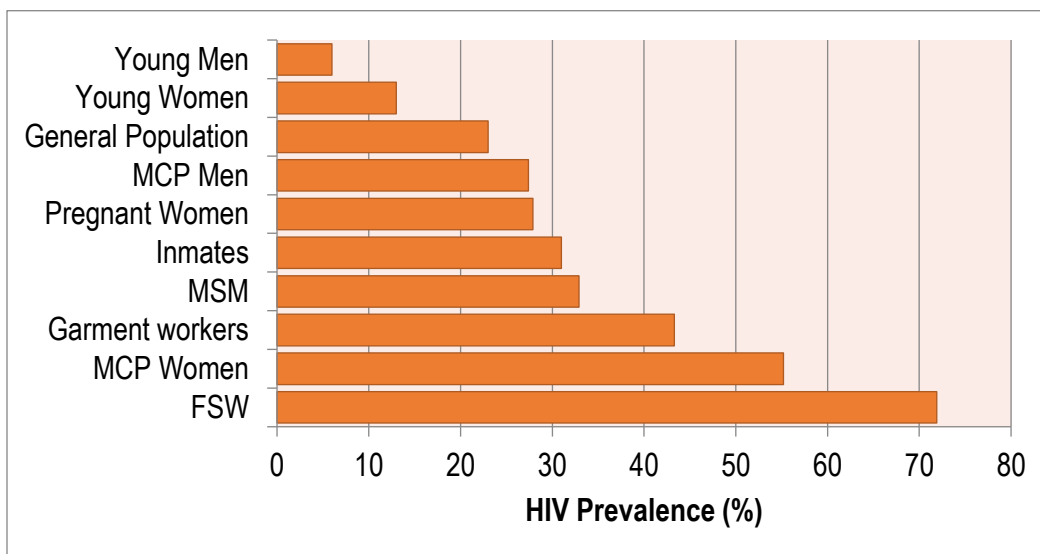
**2.2.2.1 Behavioural and Biological Drivers of the Epidemic**

Individual risk behaviours arise from structural and socio-cultural factors and personal motivation. Risk behaviours also result from lack of knowledge and low risk perception with limited agency and opportunity to make safer choices. Structural and socio-cultural factors include high levels of mobility and migrancy, wealth disparity (including between

men and women), unemployment, gender inequality, and stigma and discrimination. Adolescent girls and women may be drawn into sex work or transactional sex, and the 2013 situation analysis of adolescent girls (Bophelo Ba Rona) highlighted multiple risk factors and barriers regarding their SRHR. High risk behaviours in Lesotho (as in many countries with generalised HIV epidemics) include:

- Early sexual debut in girls and boys
- Concurrent sexual partnerships
- Sex work (full or part time) driving the epidemic among sex workers and their clients and stable partners of both FSW and clients. Impoverished women and some men migrants and their stable partners, AGYW and extremely poor adolescent and orphaned girls are more likely to sell sex to survive, and various forms of transactional sex may be widely adopted.
- Anal sex drives the epidemic among gay men and other MSM such as male prisoners, in herd boys and some sex workers. Anal sex in the general population and AGYW has not been quantified but may also be a contributing factor placing them at risk
- Low uptake of medical male circumcision
- Age-disparate sex affecting adolescent and young women, older men and young male partners of AGYW
- Stable discordant couples place the HIV negative partner at significant risk unless the HIV positive partner is virally suppressed
- Inadequate condom use across all ages and groupings
- Low comprehensive knowledge of HIV.

The graph below depicts Lesotho’s comparatively high HIV prevalence in different populations.



Data sources are primarily LePHIA (2017) and CHEAL (2017)

**Sex Work and sexual exploitation:** HIV prevalence among sex workers is estimated at 71.9%, while the sex industry is growing. The number of people who buy sexual services increased from 7% (LDHS 2009) to over 10% (LDHS 2014); now estimated at over 100,000 people annually (LDHS). About 700 sex workers acquire HIV infection annually and majority maintain concurrent sexual relationships (Incidence Patterns Model, CHEAL, 2017). Ten percent of sex workers do not use condoms with paying customers, while 52% do not use condoms with their regular, non-paying partners.

**Low rates of VMMC:** The proportion of men undergoing VMMC (23% of 15-49 years and 13.8% of 50-59 years) remains too low to have population-level impact on reduction of incidence. Majority of new infections (more than 4400 annually) occur among non-circumcised males.

**Early Sexual Debut:** 67% of girls and 48% of boys in Lesotho debut sex before attaining 18 years. Twenty-three percent (23%) of girls and 5% of boys debut sex aged 15 and below. Less than one third of them access combination prevention services despite evidence of a significant number of pregnancies. This constitutes a major programmatic gap. The UNFPA population dashboard (2006 – 2015) reports an adolescent birth rate of 94 for every 1,000. Of these, 5500 girls have pregnancies before they attain 18 years of age, while 27% of ANC attendants of all ages test HIV positive, implying that delayed sexual debut would avert a significant number of new infections.

**Inadequate levels of condom use:** CHEAL (2017) found that close to 30% of men had concurrent sexual partners with limited consistent condom use. Only about half of women 15-49 (54%) used condoms, while 65% of men reported using a condom. Condom use was slightly higher among adolescents and young people 15-24, with 60% of women and 72% of men reporting condom use. In 2014 reported condom use by male clients at last paid sex was the highest, at 89.9%, and the lowest current use was reported by married women at 16.9%.

**Men who have sex with men:** HIV prevalence among men who have sex with men is higher than that of men in the general population, although only an estimated 24.5% of MSM have ever tested for HIV. Despite higher HIV transmissibility through anal sex, at least 23% of MSM in Lesotho do not use condoms, while only 14.5% know that anal sex is risky. Self and external stigma and discrimination including by health providers and duty bearers such as police expose MSM to further abuse and makes some hide their sexual orientation, thereby missing critical knowledge and service packages.

**Concurrent sexual partnerships:** HIV prevalence among women within the general / vulnerable population in concurrent sexual partnerships (55%) is nearly twice that of men.

**Inadequate knowledge for behaviour change:** Comprehensive HIV knowledge is low among young people (31% of men and 38% of women). Additionally, most programs have been rolled out without sufficient attention to the need to increase knowledge and enhance demand, including for VMMC, condoms, Test and Treat (Joint TB/HIV Review, 2017). This gap needs to be addressed, with demand creation rolled out in synchrony with increased supply.

**Age-disparate sex:** Adolescent girls and young women aged 15-24 who have sex with partners 10 or more years older are at increased risk because the older the man the higher the likelihood he is HIV positive. Variances in prevalence between males and females are most marked between 20 to 24-year-olds - over four times as high in females (16.7%) than in males (4.0%). HIV prevalence has been rising for young women but remained stable for young men. Incidence among women (1.81%) is nearly double that of men (0.93%). Prevalence patterns show a likelihood of relationships between girls aged 15 to 24 with older men. There are heightened challenges for girls and women in these relationships regarding condom use, negotiation of safer sex and overall power dynamics in age-disparate relationships, and for FSW.

**Discordancy:** In discordant couples the HIV negative partner is at high long-term risk of acquiring HIV unless the partner is virally suppressed, and/or the couple use condoms consistently (CHEAL, 2017) or takes pre-exposure prophylaxis.

**High prevalence among women of childbearing age:** ANC data show 27% HIV prevalence in pregnant women attending ANC services, indicating an urgent need to ensure that pregnant adolescent girls and women attend ANC services and access HIV treatment and care for their own health and also to protect their unborn child. Women are more highly motivated to adhere to ART to protect their child than themselves, as shown by poor adherence data postnatally.



**High TB/HIV Comorbidity:** The high percentage (72%) of TB patients who are living with HIV (National Tuberculosis Program, 2017), is driven by Lesotho’s HIV epidemic. TB prevalence peaks among the modal HIV incidence age groups of 25 to 34 and 35 to 44. Incidence of smear positive sputum is 281 per 100 000, among 24 to 35-year olds, intersecting with the modal HIV incidence age ranges. This makes a strong case for prioritization of integrated HIV and TB screening, treatment and prevention especially within these age groups. Annual TB incidence is estimated at 788 per 100 000, with a high mortality rate of 55 per 100 000. Case notification has declined from 9,555 cases in 2013 to 7,513 in 2016, with higher male notification rates.

### 2.2.2.2 Structural and Sociocultural Drivers of the Epidemic:

**Poverty, unemployment, high levels of dependency:** These structural drivers of the epidemic render sex workers, factory workers, migrants, adolescent girls and young women, adult individuals of all ages, other population groups, and orphans more vulnerable both to infection and to the effects of HIV and AIDS.

**Migration and mobility:** Migrant men in technical, artisanal, construction, and transport sub industries, including drivers, vehicle mechanics; and vocational or domestic workers, painting, carpentry, masonry and industrial jobs in urban centres are the main clients of female sex workers; in addition, unskilled labourers are more likely to be HIV infected than their skilled counterparts. Urban migrants are either self-employed (22.4%), engaged in manufacturing (15.7%) and work in private households (10.4%) (BOS, 2016).-

**Negative effects of urbanization:** Regression analysis on districts with net migration and prevalence during 10 years between 2004 and 2014 shows that increased urbanization tends to have a net positive correlation with HIV incidence – effectively promoting or sustaining new infections among urban migrants (Regression on LDHS 2004,2009,2014 outcomes; CHEASL 2017). Lesotho is still merely 31.7% urbanized (BOS, 2016); meaning that increasing urbanization is still a factor to consider in HIV prevention and mitigation.

**Sexual and Gender-Based Violence (SGBV):** SGBV drives the epidemic among women and girls, orphans, and key populations. HIV prevalence is 58% higher among adolescent girls and young women who report having been forced to have sex than among their counterparts who have not. Within the broader 15-59 population, this difference is 26% (denominator sizes differ since roughly 10% report having been raped). Among women 25-59, HIV prevalence is 47.2% for those forced to have sex, and 39.1% for those not forced to have sex (LePHIA, 2017). 10% of sampled women reported having been raped.

Characteristics	Females	
	Percentage HIV Positive	Number
<b>Ever physically forced to have sex</b>		
<b>15-24</b>		
No	11.9	1,337
Yes	18.6	154
<b>25-59</b>		
No	39.1	3,112
Yes	47.2	368
<b>15-59</b>		
No	30.9	4,449
Yes	39.1	522

**Gender inequality, harmful cultural norms and practices related to gender:** Lesotho ranks a low 132 out of 188 countries in the Gender Inequality Index (UNDP 2017) due to economic inequity and disparities, harmful gender and cultural norms and inadequate access to reproductive health services. One out of five adolescent girls give birth between the ages of 15 and 19 (LDHS, 2014). 59% of women participate in the labour force compared to 73% of men in both informal and formal sectors. Socio-cultural gender norms and beliefs regarding masculinity and femininity fuel stigma, discrimination and violence, compelling FSW and MSM to conceal their sexual behaviours and identities- and dissuading them from accessing HIV prevention and treatment services.

**Legal, socio-cultural and policy barriers:** While the environment for key populations is gradually improving because of advocacy efforts at multiple levels, including by local CSOs, customary laws (Leruthuli laws) continue to contradict

statutory laws – key among them are laws addressing gender-based violence, protecting individual rights and the strategy to combat child marriage – that are not adequately understood by community leaders, women and girls. The Criminal Procedures Act, criminalising sodomy between men (though not between men and women), is contradicted by the more recent Sexual Offences Act of 2003, that endorses sexual activity between consenting adults. Access to legal services for key populations remains insufficient. The National Human Rights Commission is still not instituted. Few CSOs are adequately funded to fill these gaps or coordinate adequately with others delivering prevention and treatment services, while their capacity needs building. Correctional facilities have internal health posts, but few offer comprehensive HIV and TB services, and challenges persist in tracing ex-prisoners on ART, once they are released. Effective provision of HIV-sensitive social protection is similarly hindered by inadequacies in a raft of laws (see Program Result 5, Section 3 of this plan), and policy formulation and coordination mismatches between the HIV, Social Development, Finance, Education, Gender, Local Government, Law and other sectors.

## 2.3 Response Analysis – Review of Progress, Challenges and Opportunities from NSP 2011-2018

### 2.3.1 Progress against Program Goals and 90-90-90 Targets

Lesotho adopted the 90–90–90 targets; aiming that by 2020, 90% of all people living with HIV would know their status; 90% of all people with diagnosed HIV infection would receive sustained antiretroviral therapy (ART); and 90% of all people receiving ART would have viral suppression. Following is a highlight of results measured through the LePHIA survey by the end of 2017.

**Diagnosis:** 77.2% of people living with HIV between ages 15 to 59 years report knowing their HIV status. These comprise 81.5% of HIV-positive females and 71.0% of HIV-positive males.

**Treatment:** 90.2% of people living with HIV between ages 15 to 59 years who know their HIV status, report current use of ART. These comprise 90.6% of HIV-positive females and 89.4% of HIV-positive males.

**Viral Suppression:** 88.2% of people living with HIV between ages 15 to 59 who report current use of ART are virally suppressed. These comprise 88.3% of HIV-positive females and 88.4% of HIV-positive males. This translates to 67.6% of people living with HIV having suppressed viral load.

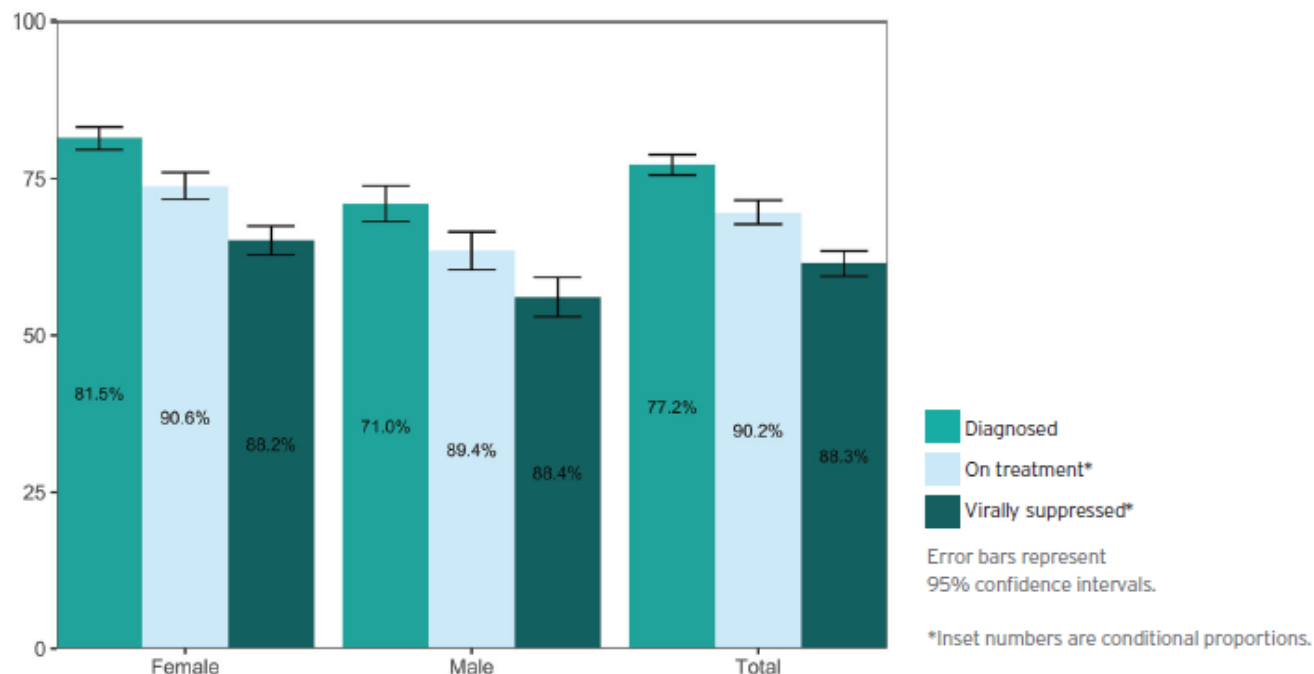
The latest Spectrum Estimates (2018) indicate that incidence and mortality reduction targets are within reach for Lesotho. Lesotho halved the number of AIDS and TB related deaths between 2007 and 2017 and surpassed the annual AIDS deaths-to-treatment ratio.

Against a target of 50%, HIV incidence reduced by 22%, from 18,870 in 2007 to 14,706 in 2017, while AIDS related deaths reduced from 11854 to 4908 while initiating more than 10,000 on ART in 2016/17. Both these tipping points will be achieved, since the country plans to enrol over 11,000 additional individuals on treatment, annually, between 2018 and 2020.<sup>5</sup>

The data show that while within reach, current trends will not meet fast track targets unless the response is revamped.

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<sup>5</sup> This depends on the ability to attract and retain funding for ART and gradually target differentiated HTS towards priority populations. This outlook relates to the programmatic and financial gap analysis prevailing by February 2018.



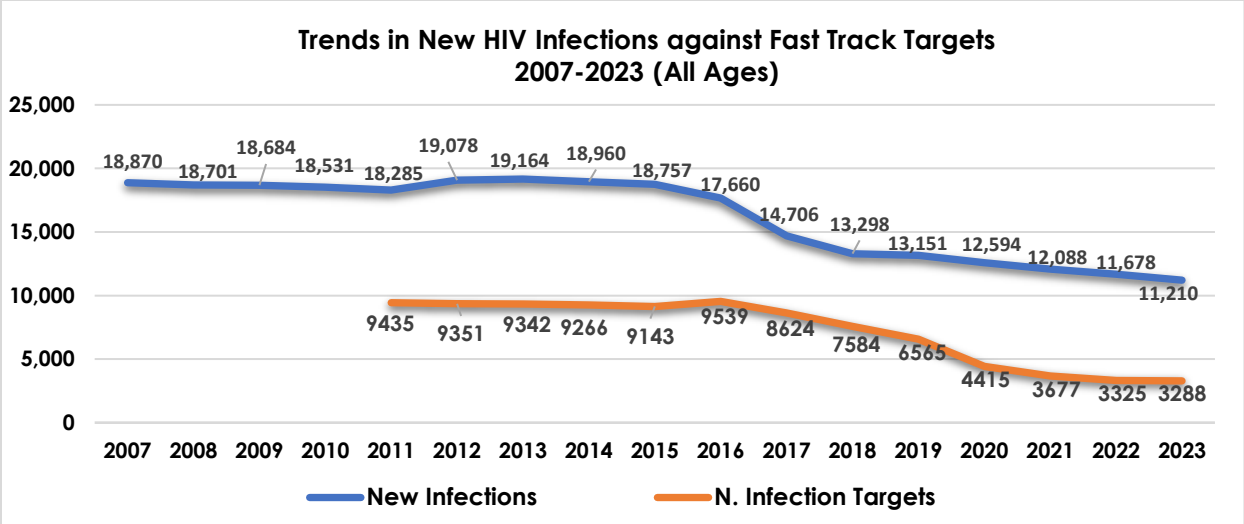
**Fig. Summary of results against 90-90-90 Targets**

If the Global Fast Track target for reduction of new infections by 75% against the 2016 baseline is adopted, Lesotho will need to reduce new infections to 3288 nationally by 2023; however, under the current scale and scope of the response, where roughly 70% of required funding is available (Financial Landscape Analysis, 2018) but not always efficiently allocated or absorbed; and priority populations are not yet efficiently targeted, the country will only reduce new infections to 11,210 missing the target by 70%, if the current programmatic scenarios are maintained.

While evidence points towards a slowly progressing response, recently Lesotho halved the number of TB related deaths and surpassed the annual AIDS deaths-to-treatment ratio. If the country also surpasses the new infections- to- net new enrolment tipping point, it will be a strong indicator that Lesotho is headed towards epidemic control and ending HIV eventually<sup>6</sup>. A summary of epidemiological (CHEAL, LePHIA, Spectrum HIV Estimates 2018; TB Epidemiological Review) and operational reviews (PMTCT/ SRMNCAH-N, Prevention Gap Analysis; PEPFAR COP Performance Reviews, Global Fund grant / district reviews and the Joint TB/HIV Program Review) found six cross-cutting issues in the response (Multistakeholder Review, November 2017).

The response did not always match evidence as required. For instance, HTS was not always targeted and differentiated to the optimal population groups or ages; SBCC messages did not efficiently address drivers and sources of the epidemic. Division of the country into priority and sustenance districts and subsequent allocation of 75% of available funds into five districts and about 25% into maintenance districts led to quality and coverage deficiencies across interventions including HTS; VMMC; SBCC, PrEP and numerous others. This weakened the prevention response in maintenance districts. An analysis of prevalence patterns over time (LDHS 2004-2014 and LePHIA 2017) show that there is no strong basis to divide the country into such geographical strata - rather, the response will make more headway if population based or client-centred.

<sup>6</sup> PEPFAR (2013) Illustrative Country Scenarios for Accelerated Progress Towards an AIDS Free Generation; Granich et al. (2015) Trends in AIDS Deaths, Incidence and ART Coverage in the Top 30 Countries with the Highest AIDS Mortality Burden;1990– 2013;



**Figure: Historical and current trends in HIV Incidence against Fast Track Targets for Lesotho based on HIV Estimates, Spectrum 2018.**

The scope of the response was inadequate to address diverse sources and drivers of the epidemic. For example, amongst AGYW, MSM, FSW, the mix of interventions targeted varied across geographies and implementers and was not always provided as a standardized or comprehensive combination prevention package that would address all major biological, behavioural and structural drivers of the epidemic. Significant portions of the population were left grappling with one or another driver. (Grant Performance Reports, Multi-Stakeholder Review; Prevention Assessment, 2017)

The scale of the response was not commensurate with the desired impact. Coverage of young men, Adolescent Girls and Young Women, FSW, MSM and interventions such as VMMC in some districts was not adequate to achieve impact (Joint HIV/TB Review; Global Fund, Grant Performance Reports 2017; Multi-stakeholder review, and Probabilistic Modelling.)

Overall coordination of the response was not optimal. NAC was recently re-established and is being revitalized to coordinate both the HIV and TB responses. Still, within MOH and among partners VMMC, condoms, HTS, TB collaboration with the laboratories; Health Management Information System are major areas that require strengthened coordination (Joint TB/HIV Review 2017; PEPFAR Performance Reviews 2017, 2018).

Lack of an operational plan not only affected coordination, but also shifted the timing and scheduling of the response. Some strategies and activities were implemented too late to achieve any impact. Enablers such as addressing sociocultural norms, legal literacy, and others were being implemented in communities at the tail end of the plan period even when efficiency gains would have been made through their earlier implementation.

Implementation, reporting and financial management capacity did not match the scale of response required. This was evident in the low funds burn rate of about 70% of available funds. Capacity building, especially of community-based implementers to take up adequate targets that efficiently complement government implementers stands to enhance the entire program. (Multi stakeholder Review, 2017). Lack of a common implementation framework led to delays and increased transactional costs as projects independently sought to define activities; which may have diluted the collective ability of interventions to impact the epidemic (Global Fund District Reviews, 2017; Multi-stakeholder Review, 2017). Section 3 of this strategy comprehensively informs on progress during implementation of the previous plan, challenges faced by each intervention and how they will be addressed during this plan period. It describes the goals, result areas, expected outcomes, strategies and interventions that will guide the country's HIV and AIDS response between 2018 and 2023.

## 3. STRATEGIC FRAMEWORK FOR NSP 2018-2023

### 3.1 Vision

Ending AIDS by 2030

### 3.2 Guiding Principles

- Human Rights Based Approach
- Global Vision to End AIDS and achieve Universal Health Care by 2030
- Results Based Planning and Management
- Value for Money (Efficiency, economy, effectiveness and equity)
- Gender Equality
- Multisectoral response that is inclusive, participatory and non-discriminatory
- While prioritising appropriately, ensuring that nobody is left behind.
- AID Effectiveness Principles:
  - National ownership
  - Harmonization
  - National alignment
  - Mutual accountability
  - Evidence-informed programming

### 3.3 Strategic Results (Goals)

Goals of the Lesotho National HIV/AIDS Strategic Plan 2018 to 2023 are:

1. Reduced new HIV infections from 13,300 in 2017, by at least 50% by 2023.
2. Reduced AIDS related deaths by 50% by 2023, from 4900 in 2017.
3. Mother to child transmission of HIV eliminated, from 11.3% to less than 5%, by 2023.

### 3.4 Program Results, Result Areas and Priority Interventions

The Lesotho National HIV/AIDS Strategic Plan 2018-2023 is accountability and results- based. The overarching goals will be achieved by stakeholders coordinating to deliver Program Results by performing interventions in several Result Areas. A description of current program implementation status precedes and informs each set of strategies and priority interventions. The response is organized in the following manner:

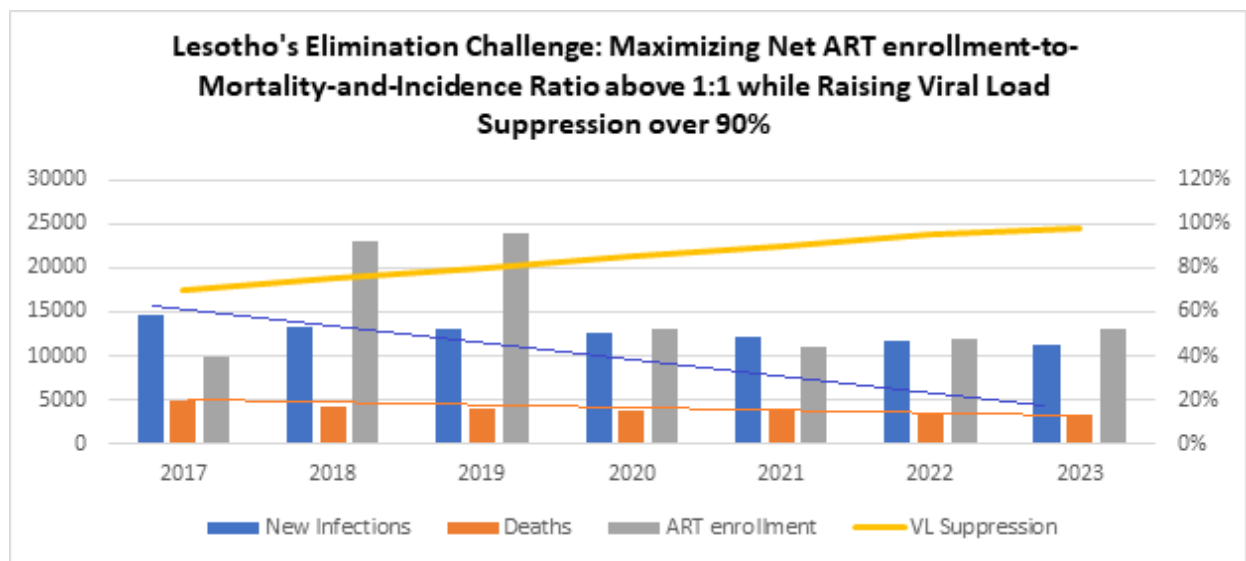
- Strategic Results (Goals)
- Program Result
- Result Area
- Expected Outcome
- Program Status (Progress and Challenges)
- Priority Strategies and Interventions

An orientation towards impact underpins this strategy, whose prioritization considers the following dimensions:

- Prioritization of populations based on evidence;

- Positioning of high impact interventions based on efficiency of approach, scope and scale in reducing mortality and new infections. This prioritization is further grounded on the known scientific efficacy of combination prevention interventions, by each source of new infection;
- Differentiation of approaches in diverse geographical locations based on impact and value for money considerations; balancing between biological and structural drivers of the epidemic;
- Sustainability and feasibility at different capacity/ financial allocation scenarios.

**Overview:** To illustrate, the objective of the 95–95–95 target adopted in this strategic plan (Program Result 1, of 8) is to achieve epidemic control by reducing the number of new infections in adults and children, and in key and vulnerable populations, and suppressing viral load sufficiently to gradually eliminate HIV. This means reducing the Incidence Mortality Ratio (IMR) by bringing the number of new infections below the number of AIDS-related deaths while maximizing treatment coverage. Lesotho will seek to diagnose 95% of all HIV-positive persons, provide antiretroviral therapy (ART) for 95% of those diagnosed, and achieve viral suppression for 95% of those treated, by 2023. Without epidemic control, not only do new infections continue to spiral, but also resource requirements continue to grow exponentially. Program Result 2 will seek to eliminate mother to child transmission and suppress viral loads, and expand coverage of ART among children.



**Treatment, safeguarding epidemic control** (as part of Program Result 2): To consolidate gains beyond epidemic control data show that net ART enrolment must stay above 13,000 annually during the plan period, hence efforts will be made to increase retention from the 70 percentiles in 12 months at present to as close to 95% as possible. Research in successful countries within East and Southern Africa shows that where the health worker to PLHIV ratio is low, retention and VL suppression are more easily achieved through a strong patient-centred community-based care and referral system that is quality assured by nearby health facilities, mentorship and supervision. **Program Results 4 to 8** of the plan address enablers without which neither the prevention nor treatment response can achieve desired results. These include removal of legal and gender related barriers; efficient provision of HIV-Sensitive Social Protection to prioritized populations; enhancing the community, civil society and population network response; strengthening critical areas of the health system; and ensuring adequate, sustainable financing and value for money. The figure below visually summarizes the strategic response into these eight carefully considered Program Results that will collectively contribute to the attainment of NSP goals. It shows the relationship between the operational plans and how each is related to a set of interventions, which when well implemented, will lead to the attainment of Result Areas. In turn, the attainment of Expected Outcomes under these Result Areas will contribute to the attainment of Program Results.

<b>Strategic Results (Goals)</b>	<p>Reduced new HIV infections from 13,300 in 2017, by at least 50% by 2023          Reduced AIDS related deaths by 50% by 2023, from 4900 in 2017          Mother to child transmission of HIV eliminated, from 11.3% to less than 5%, by 2023</p>								
<b>Program Results</b>	<b>Expanded Access to Treatment and Combination Prevention</b>			<b>Social and Structural Enablers</b>					
<b>Result Areas</b>	90% of people aged 15 and over have accessed combination prevention by 2023	Mother to Child Transmission Eliminated and 95% of children living with HIV on treatment by 2023	Test and Treat Cascade Fast Tracked to attain 95-95-95 targets by 2023	Gender and Human Rights Related Barriers removed by 2023	75% of PLHIV, at risk of and affected by HIV benefit from HIV-sensitive social protection by 2023	At least 40% of the HIV/TB response is community-led and sustainable by 2023	Health System is people-centred, and sustainably integrates HIV, TB, and other infections by 2023	Increased efficiencies and financial investments from less than 70% to 90% of the NSP budget by 2023	
	Combination Prevention: SBCC VMMC Condoms PrEP Focused interventions for key and vulnerable populations Focused interventions AGYW	Prong 1 Prong 2 Prong 3 Prong 4	Expanded and Differ. HTS ART Viral Load Suppress. TB and OIs	Removing Human Rights & Legal Barriers SGBV Gender Inequities Harmful Cultural Norms Laws	Social Protection for Orphans SP for AGYW in need SP for Herd Boys SP for Elderly Caregivers	Greater Involvement of People Living with HIV Resilient Community Systems Engaging CSOs Strengthening Key Population Networks	Integration into UHC package Service delivery: QA and Laboratory Procurement and Supply Chain Governance & Policy Human Resources Health Information Systems Coordination and Integration	Adequately Financed HIV Response Increased Sustainable financing Improved Efficiencies	
<b>Outcome Results</b>	Combination Prevention; Prevention pillars	EMTCT 95% Paediatric Treatment	95% HTS, 95% ART 95% VLS <5% LTFU	Gender Reduced SGBV Laws and Legal Literacy 7 HR Progs.	SP for PLHIV; Orphans and VC; AGYW; Elderly; Herd Boys	40% PLHIV Led Prevention and Adherence Programs CSS and 40% CSO Led Programs Strengthened Key Pop Networks	Demand Creation Strengthened and integrated Health System	90% NSP Financing HIV Fund Service delivery and operational efficiencies, including value for money metrics Tax efficiencies; Pvt. Sector; Sustainable Financing	
<b>Priority Strategies</b>									

National Operations Plan, M&E Plan (Separate, Annexed Documents) ; Procurement and Supply Management Plans and other documents describe activities related to implementation of prioritized strategies and interventions; service delivery models and sectors responsible for implementation, along with timelines, targets/ quantities, and flowcharts/ organigrammes.

## **Program Result 1: 90% of people aged 15 and over at risk for HIV have accessed combination HIV prevention by 2023**

Lesotho is part of the international HIV prevention coalition, having domesticated the global prevention roadmap (Lesotho HIV Prevention 2020 Roadmap to accelerate HIV prevention to reduce new infections by 75%). The nation has adopted all the international action plan areas. HIV prevention under the HIV and AIDS National Strategic Plan 2018-2023 will adopt a people-centred and value for money approach, providing tailored combination prevention packages to people based on their vulnerabilities and risk behaviours. A combination package of core interventions will be available to all populations, given that the great majority of new infections occur in the general population, while additional focused interventions will address specific populations at higher risk.

The prevention result areas reflect the cross-cutting need for targeted and differentiated social and behaviour change communication (SBCC) with advocacy and related approaches to transform harmful cultural and social norms; and the five pillars of HIV prevention in the Lesotho Roadmap on HIV Prevention to 2020. The Roadmap and the NSP domesticate the pillars of the 2016 UN Political Declaration on Ending AIDS and the SADC and African Union commitments. The pillars focus on the strategies of VMMC, condom programming and PrEP, and the populations of key and vulnerable people, and adolescent girls and young women and their male partners, people-centred throughout. Structural factors are considered further in Program Results 4 and 5 in relation to those that drive high risk sexual behaviour (such as gender inequality and sexual and gender-based violence, poverty and lack of social protection). The focus on gender and human rights is also integrated within the programming for HIV prevention and SRH.

### **Result Area 1.1: Social and behaviour Change Communication and Transforming Harmful Socio-cultural Norms, Values, Beliefs and Practices**

#### **Expected Outcomes:**

- At least 60% of males and 65% females 15 and over have comprehensive knowledge of HIV and AIDS by 2023 (increased from 31% for males and 39% for females)
- Contribute to reduced proportion of sexually active men and women aged 15 and over involved in concurrent sexual partnerships by 75% by 2023
- Contribute to reduced proportion of girls and women 15-29 and men over 24 involved in age-disparate sex by 75% by 2023

#### **Program (progress and challenges)**

##### **Progress**

Communication for social and behaviour change and demand creation, and transforming harmful socio-cultural norms, values, beliefs and practices will support the attainment of all program results. Behavioural, socio-cultural and structural factors are critical determinants of HIV risk in the different population groups and require responses tailored to diverse needs. This has not been sufficiently operationalised in the HIV response to date. Interventions with different population groups will address HIV risk perception, sexual behaviours, demand generation, gender norms, sexual and gender-based violence and power imbalances. All interventions need to take into account what is relevant to different age cohorts, and in different settings and populations.

Comprehensive knowledge about HIV and AIDS has increased nominally in the past five years. The proportion of the population who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission was 39% for women and 31% for men; against targets of 36% and 50% respectively. Many other aspects of knowledge and behavioural determinants are also important, such as where to



access services, risk perception including for reinfection, and agency. The percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 was 5.3% for boys and 23% for girls. About 67% of girls had their sexual debut before they attained the age of 18. Age-disparate sex (where the age gap between partners is 10 or more years) is common, while concurrent sexual partnerships with insufficient consistent correct condom use and voluntary medical male circumcision, contribute substantially to HIV transmission.

## Challenges

The key challenges include:

- Inadequate levels of knowledge and uptake of HIV prevention and other SRHR services in all age groups and for both sexes, including among key and vulnerable populations
- Persistent high-risk sexual behaviour including early sexual debut, concurrent sexual partnerships, age-disparate sex and sexual and gender-based violence
- Absence of a coherent SBCC and advocacy strategy differentiated to meet the needs of specific population groups
- Insufficient capacity at all levels to implement an effective SBCC and advocacy strategy.

## Strategies and interventions

**Strategy 1: Develop, fund and implement an SBCC and advocacy strategy and costed action plan linked to expected outcomes**

### Interventions

**Develop, fund and implement a differentiated and evidence-informed SBCC and advocacy strategy with a costed action plan linked to expected outcomes under each result area.** Mutually reinforcing multi-media channels will be used appropriately for different populations, including innovative use of social media, radio and television, community dialogue, interpersonal communication and other community approaches. The action plan will make logical links between expected outcomes and key messages, intended audience, channel of communication, tool and responsible actor, with a clearly defined monitoring and evaluation framework, costing and funding source. SBCC and advocacy should also be synchronised with community service delivery. In particular, the engagement of men is important to promote gender equitable attitudes and to enhance their health seeking behaviour.

**Audience segmentation** will be undertaken to ensure appropriately tailored messaging and approaches, addressing in particular: never married (younger) females and never married (younger) uncircumcised males in the general population; identified sero-discordant couples with an HIV positive male; key populations of sex workers and men who have sex with men; herd boys; prison populations; other vulnerable populations including pregnant and breastfeeding women and people with disabilities.

**Strategy 2: Build capacity of implementers at national, district and community level**

### Interventions

**Build capacity for well-informed SBCC** in stakeholder and implementers at national, district and community level in diverse sectors to achieve a multisectoral strategy. Include trained beneficiaries from all population groups in the design, implementation and monitoring and evaluation of SBCC strategies, advocacy and messaging relevant to them. Key populations (MSM, FSW, prisoners) and vulnerable groups, including AGYW, migrant workers, people with disabilities, mental disorders, and people living with HIV and other affected populations will be actively involved. Approaches are to be harmonised with differentiated service scale up and include comprehensive messaging for HIV

prevention linked with the full range of sexual and reproductive health and rights relevant to each population group. SBCC should include specific campaigns to address low demand and unmet need for health services particularly for hard to reach populations, including to increase male uptake of health services in general. The principle of leaving no-one behind will be adhered to with appropriate prioritising of populations in which and where most new infections are taking place. Public-private partnerships will be explored for both SBCC and advocacy and related service provision. Existing structures such as initiation schools will be utilised to implement SBCC rather than establishing new structures.

**Community-specific champions for HIV prevention** will be identified and supported to engage in communications for awareness and advocacy.

### **Strategy 3: Develop and implement a national campaign for male involvement**

#### **Interventions**

**Strengthen male involvement in all areas of HIV prevention and treatment access and wider health seeking behaviour.** Scale up local best practice behaviour change interventions and programs that have had successful outcomes, and develop a themed, continuous national mass media campaign designed to saturate knowledge, increase male involvement and uptake and promotion of HIV prevention, treatment, rights protection, SGBV reduction and mitigation products and services and to influence public perceptions.

### **Strategy 4: Transform harmful cultural norms and values and practices**

#### **Interventions**

**Establish tailored programs to transform harmful cultural norms, values, beliefs and practices** with strong community participation and mobilisation, well-defined curricula and gender transformative approaches that address norms, gender roles and power imbalances to prevent sexual and gender-based violence and reinforce HIV and SRHR knowledge and risk perception. Identify the most suitable delivery modalities depending on the population to be reached. In line with this:

- Inform, sensitise and negotiate with all communities on traditional and cultural practices and norms that increase vulnerability to HIV infection and other areas of SRHR, particularly for adolescent girls and young women
- Obtain directives to communities from state duty bearers, including law enforcement officials and health care providers, teachers and others, on non-tolerance of the norms and practices that infringe on the rights of women and girls, such as those that promote SGBV, child marriage, child sexual abuse and exploitation, early pregnancies or keep girls and boys out of school.
- Sensitised community leaders including traditional healers and multisectoral players, plus private sector health staff, should also assist AGYW to realise their rights and help transform harmful practices.

## **Result Area 1.2: Voluntary Medical Male Circumcision (VMMC)**

### **Expected Outcome**

80% of the male population aged 15-29 and 50% of the age range 15-49 have accessed quality VMMC by 2023.

Early infant male circumcision is scaled up to at least 80% by 2023.

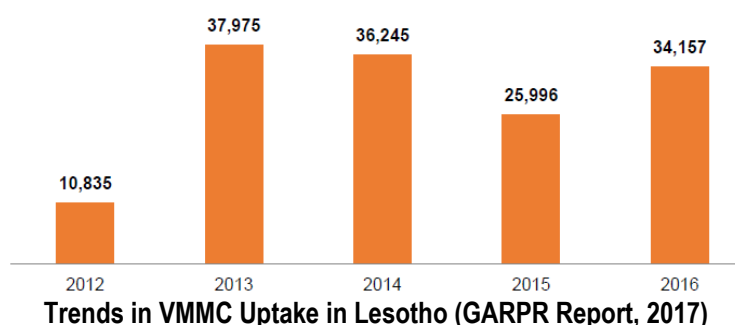
### **Program Status (progress and challenges)**

#### **Progress:**

Voluntary medical male circumcision has the potential to reduce the probability of HIV infection from HIV positive females to HIV negative males by over 60%. Consistent correct condom use, PrEP, regular HTC and safer sexual behaviour remain fully relevant and will be advocated at VMMC services. Lesotho has embarked on fast-track scale up of VMMC, having started with PEPFAR support for all 10 districts, then reduced to five districts where the majority of new infections are taking place. This PEPFAR-funded program for VMMC, implemented by civil society has achieved considerable success. In the five so-called maintenance districts that have been supported by the MoH with GF funding after PEPFAR withdrew, however, VMMC services have stagnated.

The Lesotho VMMC program aims to reach boys and men aged 10-49 years, prioritising younger males aged 10-29 before they become sexually active and/or before they attend initiation schools (usually in their 20s). The MoT Incidence Patterns Model (2018) estimates that numbers of new infections in never married medically uncircumcised males are second only to new infections in never married females. An important initiative is underway to link traditional male initiation schools and VMMC, so that VMMC is not seen as undermining but as additional to traditional practice. Nonetheless, resistance from traditional practitioners remains a serious challenge.

The proportion of males aged 15-49 who report having been medically circumcised is 23%, and 13.8% for the age group 50-59, against the NSP target of 64%. The AJR report (2016) found that only 28% of males 15-39 had undertaken VMMC. These figures fall far below the threshold to achieve significant population level impact. Numbers of males medically circumcised per annum are shown in the graph below.



### Challenges:

#### Various challenges to achieving VMMC targets include:

- The VMMC program is over-dependent on donor support, with inadequate MOH ownership
- Guidelines and the training manual were developed by international partners rather than MoH, further reducing national ownership
- VMMC service provision in the maintenance districts of Butha-Buthe, Mokhotlong, Qacha's Nek, Quthing and Thaba-Tseka has been largely neglected
- High turnover of trained personnel, partly because service provider incentive schemes are not standardized across partners
- VMMC is still centralized at hospital level, limiting service access at the periphery and for hard to reach populations
- General misunderstanding in the population of how and why traditional circumcision and VMMC differ in their effectiveness in reducing HIV transmission
- Weak referral linkages of HIV negative HTS clients to VMMC (as well as for other HIV prevention services)
- Insufficient health seeking behaviour among males in general
- Delayed and insufficient task shifting from doctors to nurses and hence insufficient qualified practitioners available (more male nurses needed in particular).

## Strategies and interventions

### Strategy 1: Redesign, fund and scale up a sustainable national VMMC program as part of overall SRHR for men, boys and male infants

#### Interventions

**MOH and partners will develop a sustainability plan for the VMMC program by 2019**, and mobilize additional financing from domestic sources to improve sustainability and political engagement on VMMC. NAC and MOH will review the VMMC coordination structure and include capacity building of health care workers so that VMMC can be rolled out in all health facilities (starting with those already providing VMMC). Differentiated service delivery models should be used, e.g. with targets for static clinics, dedicated circumcision camps and mobile clinics. Further task shifting is needed within the health system to increase the number of nurses qualified to undertake VMMC, and incentives will be explored for service providers. A handover plan will be developed for VMMC to be supported by MOH in all districts by establishing staffed VMMC posts in health facilities. MOH will improve VMMC coordination, integration and referrals to/at facilities including HTS, SBCC, condom and STI control and treatment, to make VMMC services routinely available within health facilities. VMMC will be included in the existing MOH reporting system for adverse events. MoH will also explore the piloting and roll out of non-surgical devices.

### Strategy 2: Accelerate integration and decentralization of VMMC services

#### Interventions

**Expand services** for VMMC throughout Lesotho, through PEPFAR-funded scale up in the five high HIV prevalence districts and with GF and GoL funding in the remaining five districts, and provision of medical equipment in all 10 districts. Accelerate integration and decentralization of VMMC services to health facilities, Khotla and other community service delivery points through outreach programs including mobile clinics in urban and rural areas. The minimum package requires SBCC, HTS, STI diagnosis and treatment, safer sex counselling and provision of condoms. It should also include provision or referral for PrEP for clients at higher risk, and ART for clients who are HIV positive.

Explore the ethics and sustainability of providing incentives for VMMC providers and for clinics offering VMMC.

Early infant male circumcision should be scaled up in health facilities, and particularly in MNCH care. Again, incentives for providing this service could be explored.

### Strategy 3: Innovate to address barriers and deterrents to VMMC and increase demand and uptake of services

#### Interventions

**Increase demand for VMMC** through innovative approaches tailored to specific audiences, incorporating VMMC in the SBCC strategy. Scale up SBCC, interpersonal communication and community dialogues at all levels with religious and traditional leaders, health care workers, paramount chiefs, “Blessers”, “Skokos” and others, teachers, journalists and media owners, district and community leaders and all HIV program implementers; Engage the Prime Minister and other ministers, cabinet and parliamentarians and male icons at national, district and local community levels. MoH will identify initiatives to encourage men to take up nursing as a profession given that some men prefer male health care providers. “Blessers”, currently involved in exploitative behaviour towards women and girls will receive SBCC interventions as part of their orientation towards HIV service uptake promotion.

VMMC will be included in comprehensive sexuality education to motivate young males. The program will prioritise the age group 10 to 29, particularly adolescents prior to sexual debut and/or participation in traditional initiation schools (for them to understand the difference between medical and traditional circumcision), and to ensure their active involvement in SBCC planning, design, messaging, and implementation. Particularly prioritise VMMC messaging for

men at higher risk for HIV, including men in discordant couples with the female as the HIV positive partner. As well as reaching the intended beneficiaries, address SBCC campaigns to mothers, wives and other sexual partners. Early infant male circumcision (EIMC) will be offered and provided in MNCH services, and SBCC will motivate uptake.

**Reduce cultural barriers to VMMC** by strengthening linkages between traditional initiation schools and VMMC. Engage traditional leaders actively in the HIV/TB program, with dialogue about general health, HIV, TB, STIs, and wider SRHR concerns, and explore with them how initiation schools and traditional leaders can become partners in the health system. Educate traditional leaders and the general population on the benefits of VMMC. Provide incentives for traditional practitioners to refer young men for VMMC when they attend initiation schools and provide additional support for the initiation schools. Counter anti-VMMC messaging with community gatekeepers and the media.

Pay male VMMC nurses to go to initiation schools so they may be accepted to conduct VMMC within initiation schools and close the gap between health workers and the schools.

Address male involvement in testing, condom use and uptake of VMMC, such as through male corners. Explore the ethics and sustainability of funding, such as providing travel money for VMMC recipients.

### **Result Area 1.3: Comprehensive Condom Programming and Lubricants**

#### **Expected Outcomes**

- At least 90% of males and females aged 15–49 who had sex with a non-regular sexual partner in the past 12 months report the use of a condom during their last intercourse
- At least 40 Million male condoms (60 for each male) and 1 Million female condoms and required number of water-based lubricants effectively distributed annually by 2023

#### **Program Status (progress and challenges)**

##### **Progress**

The percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who reported the use of a condom during their last intercourse was 54% for women and 65% for men of the targeted 60% and 75% (CHEAL, 2017). In the age group 15–24, reported condom use rates were higher at 60% for females and 72% for males. DHS data show improvements in knowledge and condom use over the past years in all categories of users, gains that need to be sustained through effectively addressing the remaining gaps and challenges with tailored interventions. Particular gaps remain in some key and poor and underserved populations. The 23 million annual target for male condom distribution was surpassed at 30 million in 2016, while the number of female condoms distributed annually, at 0.43 million, was far below the targeted 5.8 million. Uptake of female condoms was very low. Lesotho has established a multisectoral technical working group (TWG) on condoms, and is in process of developing a new condom strategy to improve supply chain management and demand and uptake of both male and female condoms and lubricant. This should reflect the condom cascade of generating knowledge and demand; ensuring availability and access to condoms, strengthening agency to negotiate condom use and skills for using condoms correctly, and access and use of condoms by different vulnerable populations at high risk, including assessments through market surveys and consultation with the target groups including AGYW, young boys, men, key populations and others.

##### **Challenges**

There are multiple challenges to achieving high levels of consistent correct condom use in all sexual encounters.

- The condom coordination structure within MOH (Supply Chain Management Directorate) needs strengthening through human resources and adequate budgets, among other interventions;

- Catholic-run hospitals and facilities within the Christian Health Association of Lesotho (CHAL) do not promote or provide condoms, making it especially important to provide condoms at multiple community sites within their catchment areas.
- Monitoring and management of the supply chain are inadequate at all levels, with challenges in forecasting, stockouts, stock piling, tracking, and insufficient in-country quality assurance.
- Insufficient access for youth and key and vulnerable populations in community outlets.
- Lubricants are not routinely available for FSW and MSM and others who need them
- Guidelines on how to use condoms are insufficient
- Distrust or dislike of female condoms and low uptake despite promotion efforts, due to culture, branding and other reasons; and insufficient demand for all condoms
- Condoms are not routinely provided after risk assessment, with inadequate counselling and provision of condoms in HTS sites
- UNFPA ensures quality assurance prior to the importation of condoms, but there is little quality assurance within the country (e.g. regarding storage and transportation)
- Public sector condoms and two brands of commercially sold condoms are available, but there is limited condom social marketing and market analysis.

## Strategies and interventions

### Strategy 1: Strengthen supply chain management at all levels

#### Interventions

**Finalise and fully implement the condom strategy** regarding supply chain management, including by strengthening the mapping, coordination, quality assurance, distribution and M&E frameworks by end of 2018. The Lesotho condom strategy should respond to the SADC guidance from October 2017 for fast-tracking people-centred condom provisions with mapping of condom needs and gaps in different population groups. Strong leadership commitment is essential.

As part of the condom strategy, perform comprehensive market surveys and analysis of the needs of different groups and types of condoms and packaging needed by each (level of attractiveness, non-homogeneity ; messaging; non heteronormativity, among other differentiations). In addition, condom distribution points must meet the preferences of specific groups.

Warehousing should be unified at central level and distribution be budgeted and coordinated through to facility/ health post level, and beyond to networks of key populations and others.

**MoH through the Supply Chain Unit will quantify needs for different condoms**, including branded condoms, using consumption data from dispensaries and population data on demand, and manage forecasting and reporting on use and uptake. Data should be disaggregated by user group. Level mapping studies are needed to define needs and strengthen forecasting, quantification and procurement. MoH should use the UNAIDS fast-track tool to improve male and female condom needs quantification for the general population and also for each population at higher risk, and adopt dynamic forecasting annually, with six monthly review.

In-country quality assurance needs to be in place through regular monitoring of storage and transport of condoms using LOTS quality assessment, and the present system of MoH procurement and import through UNFPA should be sustained.

Water-based lubricants will particularly be made available in the context of sex work, for MSM and for women experiencing vaginal dryness. Targets need to be set in the condom strategy for lubricant distribution.

Condom and lubricant distribution will be fully integrated with all other HIV prevention strategies.

## **Strategy 2: Strengthen demand creation for male and female condoms and lubricants**

### **Interventions**

**Finalise and fully implement the condom strategy regarding demand creation** and follow the SADC guidelines on identifying and prioritising populations at higher risk, setting ambitious targets for different populations, conducting male and female condom needs estimates, undertaking market research on preferences of different population groups and responding to the findings, and adopting client-centred approaches to generate demand. Female condoms require highly tailored programming with their niche role clarified for potential users. Condom use should be monitored every three to five years based on population surveys and IBBS. Beneficiaries, including young people, key and vulnerable populations and CSOs should be fully involved in planning, service delivery and monitoring. As well as generating demand, negotiation skills for condom use and for how to use condoms correctly are essential. Advocacy should be undertaken for condoms and lubricants to be available in secondary school through condom dispensers.

## **Strategy 3: Improve condom availability and access at facility and community levels**

### **Interventions**

**From facility level multiple channels** should be developed for condom distribution, including through community sites appropriate to the needs of diverse users (e.g. bars, hotels, restaurants, hairdressers/barbers, workplaces especially factories, youth centres and places where adolescents meet out of school, colleges, sports venues and all hotspots for sex work, and MSM meeting places).

**Different cadres should be involved** also in condom distribution (e.g. community workers, peers and others). All three modes of distribution should be utilised, that is free public provision, social marketing and commercially sold condoms.

## **Result Area 1.4: Pre-Exposure Prophylaxis**

### **Expected Outcomes**

- 50% of HIV negative FSW and 20% of HIV negative MSM receive PrEP
- 10% of AGYW 15-24 receive PrEP (those who are sexually active and at high risk)
- 80% of HIV-negative partners in sero-discordant couples receive PrEP

### **Program Status (progress and challenges)**

#### **Progress**

By the end 2017, there was no national implementation/operationalization plan for PrEP. Facilities were offering PrEP without client records and M&E tools, and awareness and uptake of PrEP were low. MOH and partners will accelerate the process of developing an implementation framework and SOPs and monitoring tools based on WHO guidance for PrEP. A national PrEP TWG has been set up to oversee the program and incorporate it into HIV prevention and treatment programming, with funding being sought. A PrEP advocacy and communication package will be developed as part of the NSP Action Plan/ Advocacy and Communication package for the uptake of the intervention within the broader HIV combination prevention package.

National ART guidelines recommend use of oral PrEP TDF/3TC or TDF/FTC for HIV negative individuals at significant risk (concurrent partners) for HIV infection, including sex workers, MSMs, sero-discordant couples, people with

concurrent sexual partnerships and prisoners. An estimated 15% of couples are discordant (LDHS, 2014). Pregnant and lactating women are also at increased risk. Target setting will need the identification of hotspots and behavioural surveys.

By March 2018, PrEP rollout was still in its initial stages in Lesotho, with most activities supported by PEPFAR implementers, focusing on AGYW, FSW, MSM, and sero-discordant couples in five districts. Support has entailed training of health workers, (including a training of trainers in all 10 districts), advocacy, demand creation, service delivery, cost- effectiveness modelling and developing an M&E framework. In 2017, about 1000 people had been initiated on PrEP.

## Challenges

- Awareness and uptake of PrEP services in the country are low
- There is no finalized national implementation plan or implementation guidelines on the roll out of PrEP in the country
- Facilities offering PrEP have not maintained client records and lack standard monitoring tools.

## Strategies and Interventions:

### Strategy 1: Provide PrEP services to people with substantial risk of HIV including FSW, AGYW, MSM, and sero-discordant couples

#### Intervention

**Create demand for PrEP services:** A PrEP advocacy and communication package will be developed to raise public awareness about PrEP and on where to access services, and to create positive perceptions and attitudes among potential PrEP users. The program will utilize mass, print and social media, community dialogues and other appropriate platforms for raising community awareness. PrEP messaging will also be channelled from peer-to-peer and especially among key populations and AGYW at higher risk. Grass roots advocacy will focus on community leaders, popular opinion leaders and other influential leaders to galvanize support and acceptance of PrEP at community level.

#### Intervention

**Establish PrEP monitoring and evaluation system:** The MOH with support from the PrEP TWG, will establish a PrEP M&E system that will be integrated within the National HIV M&E recording and reporting system. The current draft tools will be evaluated before national-wide roll out. A strong data usage system will be built at all levels and will be supported through quarterly national HIV support and supervisory visits and the mentorship program to ensure continuous quality improvement. The DHMTs will provide supervisory duties to health and community levels. Implementation science/ operations research will be embedded within the program to provide useful information to guide implementation.

#### Intervention

### Strengthen the roll out of PrEP services

PrEP services will be expanded to all the 10 districts in Lesotho and will be provided at both facility and community levels. Differentiated service delivery models will be designed to match the needs of specific sub-populations. Service delivery sites will include hospitals, health centres, health posts, and health facility outreach clinics in the community. They will also include youth resource centres, tertiary institutions and drop-in centres. PrEP services will be integrated within the broader HIV prevention programs. PrEP will be incorporated into programs targeting AGYW, MSM, FSW and prisoners (as part of a comprehensive health program), as well as in workplace health programs. Health workers



will be capacitated to provide and monitor PrEP for individuals at high risk and specially to provide on-going risk assessments for clients. Strong referral pathways will be built for PrEP to support effective linkage between the community and facility, and for ART care among clients who sero-convert. Effective systems for tracking clients who miss appointments will be put in place while building on existing tracking mechanisms. In collaboration with the Supply Chain Management Directorate, the program will facilitate continuous availability of PrEP commodities, including HIV RT kits, ARVs and monitoring laboratory diagnostics.

For all children below 18 years, a case by case investigation will be launched and where necessary, the child will be referred to appropriate child service authorities. Sexually exploited children will be prioritized for social protection services under Program Result 5 of this strategy and followed up through appropriate bi-directional referral services, since they may require protection. In addition, PrEP will be aligned to the age of consent for HIV testing and SHRH services. Global guidance, once developed, will be adapted for more appropriate service provision to adolescents.

## **Result Area 1.5: Combination Prevention Packages for Key and Vulnerable Populations**

### **Expected Outcomes**

- 95% of key and vulnerable populations (differentiated as key populations FSW, MSM including herd boys, prisoners, transgender persons; and as vulnerable populations, vulnerable unskilled workers and migrant/mobile populations, and TB key populations and patients) have accessed a comprehensive combination prevention package by 2023
- At least 90% of key populations (FSW, MSM, Prisoners and Migrant/ mobile populations) report the use of a condom with their most recent partner
- At least 50% of FSW, MSM, Prisoners and Migrant/ mobile populations both correctly identify ways of preventing sexual transmission of HIV and reject major misconceptions about HIV transmission by 2023
- Percentage of key populations who received an HIV test in the last 12 months and who know the results
- Comprehensive knowledge about HIV and AIDS increased by at least 50% by 2023 for young people and key populations adopt safer sexual behaviour

Key populations in Lesotho are predominantly female sex workers and their clients and men having sex with men, the latter including prisoners and herd boys (who are considered temporal MSM,<sup>7</sup> and have unique and specific needs). Other vulnerable populations for HIV include a range of low paid workers, migrants and others, AGYW, and people with disabilities and mental disorders, particularly disabled women who may suffer exploitation. They should be specifically addressed within the SBCC strategy for the general population and for AGYW and their male partners. The key population of people who inject drugs (PWID) is widely believed to be very small, although evidence is not available to confirm this. Likewise, there is almost no information on transgender people, and they are therefore subsumed within strategies addressing MSM and FSW.

### **Program (progress and challenges)**

#### **Progress:**

Relatively few new HIV infections (7%) are estimated to occur in key populations of FSW and MSM based on low size estimation (MoT Incidence Pattern Model, 2018). Nonetheless the high HIV prevalence in both populations indicates that far stronger HIV prevention is needed as well as scaled-up access to treatment, care and support, and an enabling legal and policy environment. An estimated half of FSW do not use condoms with concurrent, regular and non-paying partners, and 10% do not use condoms with clients. An estimated 10% of men are clients of sex workers (CHEAL, 2017) and the numbers who purchase sex have been growing. Most clients of sex workers are men in unskilled or low

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<sup>7</sup> I.e. only likely temporarily to engage in male to male anal sex in the absence of possible female partners

skilled employment around construction sites, mines, and other menial jobs. Many are mobile because of their work, including migrants, notably miners working in South Africa, and they have higher HIV prevalence as do their partners at home. Male prisoners are a particular population of MSM with their own specific needs. Female prisoners may also be at risk of sexual abuse and hence HIV infection.

PACT planned an integrated bio-behavioural survey (IBBS) of FSW and MSM in 2018 in four high-prevalence districts (Maseru, Leribe, Butha Buthe and Mafeteng) to update size estimates and analyse knowledge, behaviours and challenges, both legal and with regards stigma and discrimination. The GoL expressed commitment to promote an enabling social and legal environment for key populations, and an advocacy plan was underway for MSM. A national package of interventions for key populations was planned for 2019, and the Lesotho Key Population Strategy 2017-2022 was under endorsement. Sensitisation of health care providers to their health needs and rights has been undertaken and needs scaling up. Anecdotal evidence suggests that this is reducing stigma and discrimination in health facilities, although more and better coordinated efforts are needed. Harassment by police and other enforcement agents has been insufficiently addressed.

The military are an especially vulnerable population that is addressed by the Department of Defence with its own strategies for awareness generation and demand creation, and condom distribution and other HIV prevention and SRH strategies, including treatment. The DoD also plans to undertake 500 male circumcisions.

### **Challenges:**

Multiple challenges face FSW and MSM and transgender persons, including the following:

- They are hard to reach populations with information, SBCC and SRH services such as VMMC, condom programming, PrEP among other service provision, and support for FSW and MSM is poorly coordinated
- Unsafe sexual practices are widespread, with anal sex the riskiest for HIV transmission, and particularly high levels of concurrent sexual partnerships for FSW
- Stigma and discrimination from the general population, and duty bearers such as health care providers, police and others remain a widespread problem, and FSW in particular face the risk of violence
- There is a hostile legal environment wherein sex work and sodomy between males are penalised, and laws have yet to be changed (notably the Criminal Prosecution Act) to create an enabling policy and legal environment.

### **Priority Strategies and Interventions**

#### **Strategy 1: Comprehensive service provision for female sex workers, men having sex with men and transgender persons with a package of key interventions**

##### **Interventions**

- The HIV program will reach with combination prevention at least 6000 full-time and occasional female sex workers, their regular clients and stable sexual partners, and at least 14,000 men who have sex with men and transgender persons and their permanent sexual partners. The national combination prevention package for key populations will finalise the interventions.

**PrEP and adherence support** will be offered as part of combination HIV prevention to all FSW, and to all MSM and transgender persons and vulnerable populations testing HIV negative and found at interview to be at high risk. Anyone testing positive will be enrolled into ART as part of Program Result 2 (95-95-95 treatment cascade).

**Clients testing positive will be enrolled into ART** as part of Program Result 2 (95-95-95 treatment cascade). Referrals between networks and health facilities will be strengthened so that feedback is provided by facilities to networks.

**Night mobile clinics** will be increased in and around hotspots to provide moonlight services to FSW, their clients and MSM. Services will be delivered through peer outreach and dedicated clinics including private sector facilities.

**Health facility and community health workers will be trained** on human rights-based service provision to key and vulnerable populations, detecting and treating STIs among FSW and MSM including herd boys, and in general health service provision including for HIV. Refresher training will be provided for peer educators, whose effectiveness will be monitored. Adherence to prevention and treatment will be supported in the community through appropriate community systems strengthening.

## **Strategy 2: Community systems strengthening and capacity development of key populations**

### **Interventions**

- FSW and MSM/LGBTI networks will be strengthened, and their capacity developed to contribute actively to programming for HIV, TB and STI prevention and treatment access. They will be capacitated to address SGBV including violence by law enforcement agents. The DHIS 2 will be updated to contain modules from LOMSHA (Community Information System) and key populations. All initiatives to support key populations should include trained and supported key population beneficiaries in the design, implementation and monitoring and evaluation of programs that affect them.

## **Strategy 3: SBCC for key populations to increase knowledge, change high risk sexual behaviour, reduce SGBV, and increase demand for services**

### **Interventions**

**Appropriately focused, scaled up and coordinated SBCC will be strengthened** through participatory programming to address information gaps, improve risk perception and increase demand for services. SBCC for full- and part-time FSW, and their clients and other vulnerable populations, MSM and herd boys will include: condom negotiation skills, information on the correct and consistent use of condoms and water-based lubricants during sexual intercourse with all partners, reducing concurrent partnerships and the heightened risk in anal sex. Messaging will include the importance of regular HIV testing and linkage to care, PrEP, PEP and ART, and the benefits of VMMC for males who are not medically circumcised and also engage in heterosexual sex. As well as addressing behavioural and bio-medical strategies for HIV, STI and TB prevention and treatment, SBCC will address underlying factors including SGBV and harmful socio-cultural norms and practices, including elucidating the difference between traditional circumcision and VMMC.

**SMS and social media bulk messaging** will contribute to demand creation through innovative and mutually reinforcing channels, and beneficiaries will be actively involved in developing population appropriate messages and modes of communication. Key messages will be tailored to each key and vulnerable population on the full HIV prevention and treatment package and on co-infections and comorbidities.

**SBCC campaigns will be evaluated** regarding reach through innovative social media, linkages of FSW and MSM to the test-and-treat program and with regards results for non-stigmatising health services for FSW and their clients, and MSM. SBCC will also focus on reducing stigma and discrimination against FSW, MSM and transgender persons by the general population, community leaders, gatekeepers at all levels, policy makers and others.

## **Strategy 4: Combination HIV Prevention Package for Other Vulnerable Populations**

## Interventions

**Reaching vulnerable populations:** The HIV program will provide a combination prevention package to vulnerable populations at higher risk (including migrants and mobile populations and their stable partners, factory, construction, mine, artisanal and transport workers, vehicle mechanics, domestic workers/gardeners, border officers, unskilled workers, and TB key populations) with combination prevention and treatment services tailored to the specific needs of each population. These vulnerable populations form the majority of clients of FSW. There is considerable overlap between the package for key and for vulnerable populations.

**PrEP and adherence support** will be offered to HIV negative clients of sex workers insofar as they can be reached, and to HIV negative partners (see provision for key populations above).

**Program Result 2 interventions** will be extended to factories, mines and other workplaces, with establishment of public-private partnerships. Referrals between the workplaces and nearby or home health facilities (those in the areas from which migrant workers originate) will be strengthened so that feedback is available from facilities to networks.

**Labour sending communities** also need to be addressed as the female partners of migrants and their male partners are at increased risk (IBBS on labour sending communities, 2018).

**For cross-border migrants** it will be important that Lesotho and South Africa coordinate interventions and ensure effective tracking. The DHIS 2 will be updated to contain modules from LOMSHA (Community Information System) and workplaces.

**Health facility and community health workers will be trained** (see provision for key populations above).

**A strong SBCC component will be developed** (see provisions under key populations above).

## Strategy 5: Protection against human rights abuse and violence

### Interventions

**Strengthen protection through the package of services and capacity development among key and vulnerable populations.** The National Action Plan on HIV and Law, April 2018, should be fully implemented. This has four goals:

- To strengthen the anti-discrimination and human rights protection in law and policy
- To eradicate gender inequality, harmful gender norms and gender-based violence
- To increase awareness of rights, decreasing stigma and discrimination
- To strengthen access to justice and law enforcement.

These goals particularly apply to key populations regarding HIV prevention, treatment and care, and also to other vulnerable populations including AGYW, people living with HIV, migrants, people with disabilities, those with mental health disorders and others.

HIV prevention in key populations requires building awareness of human and legal rights, particularly regarding the Sexual Offences Act to strengthen its implementation. Skills also need to be built to prevent violence and to seek redress. Initiatives should include weekly monitoring and reporting of violations against FSW and MSM at community level through phone and face to face feedback meetings between the FSW and MSM/LGBTI networks and the Lesotho Mounted Police Service, and anti-discrimination support with LMPS.

**Coordinators and implementers under Program Result 4 will aim to create an enabling environment** in terms of laws, regulations, policies, and protection through social contracting with the government for pro bono legal services

to address discrimination, violence, and barriers to services for key and vulnerable populations (government to provide funding and NGOs and CSOs to provide services).

- **The Herd Boys Strategic Plan will be updated and operationalized.** It will include interventions to address their structural socialization, capacity building and empowerment programs to enhance herd boys' literacy regarding human rights, laws, gender-based violence, and income generating activities among others. Strategies to address SRHR, including HIV prevention and treatment for herd boys within programming for MSM should specifically address their situation, and involve trained herd boys in their design, implementation and monitoring and evaluation.

## **Strategy 6: Reaching prison populations with adoption of International UN guidelines on HIV prevention and treatment for prisoners while incarcerated and on release into the community**

### **Interventions**

**SBCC for prisoners** will include, in addition to SBCC for other key and vulnerable populations as above, review, translation, simplification and production and dissemination of human rights and gender SBCC materials responsive to stigma and violence against prisoners, and harm reduction interventions. Key messages will include human rights and gender mainstreaming training for community volunteers reaching prisoners. Prison health workers will be trained on human rights and gender mainstreaming issues related to prisoners (including informed consent, confidentiality, stigma and discrimination).

**Survivors of sexual violence in prison** will have access to HIV related legal aid services, with correctional service officers trained on human and legal rights in relation to prisoners and on monitoring and evaluation of human rights and gender mainstreaming. They will also be offered post-exposure prophylaxis.

**Male and female prisoners will receive HIV combination prevention services** including condoms and water-based lubricants. They will be offered HTS and those testing negative will be offered PrEP and adherence support as needed while HIV positive prisoners will be linked to the ART program provided in prisons and then linked with health facilities in their communities and followed up upon release. Prisoners will also benefit from TB screening, diagnosis and treatment of sexually transmitted infections and other co-infections and comorbidities; wider sexual and reproductive health services; and immunization against hepatitis. They will be linked with TB/HIV services under Program Result 3 on treatment.

### **Result Area 1.6: Prevention for Adolescent Girls and Young Women and their Male Partners**

#### **Expected Outcomes:**

- 60% of adolescent girls and boys have comprehensive knowledge of HIV and AIDS and reject major misconceptions, by 2023
- 90% of adolescent girls and boys and young male and female adults (15-24) have accessed a comprehensive combination prevention package by 2023
- Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 reduced to 1% by 2023
- 65% of young people aged 15 – 24 reached with HIV prevention programmes during the last 12 months (for example CSE, DREAMS)
- 90% of adolescent girls and boys and young male and female adults (15-24) years received an HIV test in the last 12 months and who know their results by 2023
- 100% of young women and men at higher risk aged 15-24 use PrEP by 2023 90% of young people aged 15-24 living with HIV infection receiving antiretroviral therapy by the end of 2015

- 80% of males aged 15-29 medically circumcised according to national standards.

## **Program Status (progress and challenges)**

### **Progress:**

Adolescent girls and young women have been recognised globally and in Lesotho as a priority vulnerable population to reach, given high incidence rates in the 15-29 age group. In Lesotho, roughly equal numbers of females and males have HIV in the age group 10-14, but by age 20-24, HIV prevalence in females (16.7%) is over four times that in males (4.0%) (LePHIA, 2017). In the age range 15-24, HIV prevalence in females is about 13% compared with 6% of males. Lesotho has a young population structure, so numbers of AGYW and male cohorts are substantial. In Lesotho, young unmarried women have the highest numbers of new infections of all the populations included (MoT Incidence Patterns Model, 2018). This is partly due to concurrency and age-disparate sex with older men whose HIV prevalence is higher. Also, younger adolescent girls are more susceptible to HIV infection because their reproductive system is not fully mature. Less than 70% of adolescents who know their status are on treatment, compared to about 90% of people aged 50 and above living with HIV. Overall, the HIV response in Lesotho for AGYW has been especially inadequate.

Nonetheless, there are clear signs of progress, and a national package of interventions for AGYW will be revised by mid-2019. In late 2017 comprehensive sexuality education (CSE) was adopted as a strategy in schools, reaching boys as well as girls, training of health care providers has been undertaken regarding the provision of youth friendly health services, and wider options for health care access for AGYW and males are being developed. Sexual and gender-based violence, known to be linked with higher rates of HIV (LePHIA, 2017) (see Program Result 4), and socio-economic and socio-cultural factors that increase the vulnerability of AGYW are beginning to be addressed. A situation analysis of adolescent girls was undertaken (Bophela Ba Rona, 2013) and this, plus more recent analyses that include AGYW, provide considerable strategic information to guide programming for them and their male partners. The DREAMS package of support is being rolled out in two districts with PEPFAR funding, and a DREAMS-light package will be supported by the Global Fund and GoL in the remaining eight districts to reach in school AGYW 10-13 and 14-19, out of school AGYW 14-24, tertiary students 20-24, and male partners of all ages. In these eight districts comprehensive knowledge has been found to be low, HIV prevalence (15-24) is high, and there is a lack of other interventions addressing HIV and TB needs in this age cohort. Programs will reach schools, community venues, youth clubs and other safe spaces, tertiary institutions, health services and adolescent-friendly corners and workplaces. While the most pressing need is to reduce HIV incidence in AGYW, the needs of boys and young men for HIV prevention and increased care and treatment uptake remain important for their own sake as well as to reduce HIV risk in AGYW.

The Sexual, Reproductive Maternal, Neonatal, Child and Adolescent Health and Nutrition (SRMNCAH-N) plan also provides clear guidelines to reduce maternal and neonatal mortality and for SRH for children and adolescents. The Ministry of Education is rolling out a child friendly schools framework, one pillar of which addresses HIV prevention and AIDS care and support, with another pillar addressing broader safety and protection, psychosocial care and support. Younger children should be well considered in this framework, particularly as they gradually become sexually active or may face abuse.

Of particular importance, evidence shows that keeping girls in school, year on year, significantly reduces their risk for HIV acquisition. This should thus be supported by various means of social protection and social asset building (see result area). Also, poorer girls often miss days at school because of their menstrual periods and provision of sanitary wear makes a significant difference.

### **Challenges**

The many challenges facing adolescent girls and young women include:

- Insufficient knowledge and low risk perception, with taboos against discussing sexuality
- Early sexual debut
- Age-disparate sex leading to higher risk for exposure to HIV
- Insufficient youth and gender sensitive health facilities and youth corners, impeding sexual and reproductive health seeking behaviour including condom uptake and other SRH services
- Gender inequity and inequality in power relations with men
- School drop out after primary school and insufficient retention rates in secondary school, e.g. because of pregnancy
- Poverty and pressure to engage in transactional sex and/or sex work, particularly among orphaned and vulnerable children
- Sexual exploitation of children under 18
- Traditional practices such as early marriage and early pregnancy
- Insufficient active engagement of AGYW and male partners in design of interventions to support them.

Challenges in addressing these barriers include the weak health system, insufficient financial backing and government ownership, poor coordination of services and limited linkage with demand creation efforts and SBCC in the community. An integrated, comprehensive multisectoral response to the needs of AGYW is required.

### **Priority strategies and interventions**

**Strategy 1: Finalise, roll out, monitor and evaluate a comprehensive HIV, TB, SRHR and SGBV package for adolescent girls and young women and male partners**

### **Interventions**

**The overall package of interventions for AGYW and male peers, to be finalised in the upcoming strategy, will include:**

#### **Prevention**

- Tailored social behaviour change communication and advocacy, ensuring that children of different ages and young adults are appropriately reached with knowledge and skills for safer sex (including risk perception, protective sexual behaviours and integrated service uptake), with AGYW and male counterparts actively involved in SBCC design, implementation, monitoring and evaluation
- Messaging should include specific SRHR information, including on options and services available
- Comprehensive sexuality education in and out of school
- Tailored support at tertiary level developed with active student involvement
- Scale up of best practice young woman project / campaign (parallel to a “stylish man” project / campaign), to strengthen AGYW agency as an independent, responsible, confident woman who can assure her sexual and reproductive health and rights
- Access to client-centred, adolescent and gender friendly health services and multiple community outlets for integrated SRHR/HIV/TB/SGBV services, including for psycho-social support as needed
- Pre-exposure prophylaxis for 50% at higher risk, with appropriate case review regarding SGBV, child protection issues and referral as indicated and adoption of upcoming global guidelines
- Male and female condom provision (and lubricant as needed)
- AGYW network empowerment at community level

- Strengthened integration of SRH and HIV services including link with SRMNCAH-N for AGYW
- Empowering AGYW with agency to realise their SRH rights including against SGBV
- Addressing stigma and discrimination against sexually active AGYW
- Addressing SGBV and wider gender related inequalities in the community and among duty bearers
- Protection from sexual exploitation of children
- Social asset building and comprehensive livelihood strategy to reduce vulnerability of AGYW
- Cash transfers and other social protection to keep AGYW in school, development of a re-entry policy for pregnant adolescents, and advocacy for free secondary education
- Changing harmful cultures and norms and practices including legal review and strategizing to reduce child marriage
- Parental engagement and community mobilisation
- Support for teenage mothers
- Robust monitoring and evaluation of the overall strategy for AGYW and male involvement, with active involvement of AGYW and male counterparts.

#### **Treatment**

- Tailored HTC including self-testing (linked to prevention and treatment)
- STI diagnosis and treatment
- Supported transition from paediatric to adult care for HIV positive adolescents
- Management of co-infections and comorbidities
- Linkages to ART; SRHR/SGBV; eMTCT and social protection
- Ensuring child friendly school environment for learners with HIV and on treatment, including upholding of privacy and confidentiality

These are elaborated below in relation to results for HIV prevention, treatment, gender and human rights, and/or social protection. Programming should actively involve both females and males, and should be tailored to the needs of different age cohorts and specific situations and population groups.

## **Strategy 2: Comprehensive sexuality education and social and behaviour change communication**

### **Interventions**

**Strengthen teaching capacity** of teachers and other educators including trained peers to teach the full curriculum of Comprehensive Sexuality Education (CSE), including the sensitive issues relating to gender, sexuality, HIV and wider sexual and reproductive health and rights, and gender-based violence. Mentorship programs in schools to reinforce preliminary training, and sufficient quality assurance must be ensured. Use of tools such as Auntie Stella (Zimbabwe) and others will be explored to improve teaching skill development and effectiveness. South-to-south learning from good educational practices on CSE will be supported.

**Roll out CSE curriculum nationally** in all secondary and primary schools, and also as needed in tertiary institutions. Condom distribution in tertiary institutions is essential and advocacy for condom and lubricant dispensers secondary school settings should be developed, with the minimum requirement of informing students where to access condoms. Parents and community leaders need to be sensitised regarding the value of CSE to reduce opposition to sexuality education. Out of school youth also need to be reached with CSE, and community opportunities to reach them need to be explored and strengthened. These will include interventions in workplaces through the private and public sectors and multiple community venues with trained cadres to reach them. Trained peers will be actively engaged in efforts to reach out of school youth. In-school CSE will link with the child friendly schools' framework of the Ministry of Education



to optimise the potential to make schools a safe and constructive venue for learning and supportive of HIV prevention, care and treatment.

**Comprehensive and consistent SBCC** is needed, tailored to the specific needs of different populations of young people, particularly those who are most vulnerable. See also section 1.1 on SBCC. SBCC messaging for HIV, STI and pregnancy prevention will emphasize delayed sexual activity, consistent correct condom use for dual protection, and other contraceptive methods, VMMC, avoiding age-disparate and concurrent sexual partnerships, reduction of SGBV, gender equality, and negotiation skills for condom use and other safer sexual practices. It will also include information on use of hygienically proven new razors during cultural shavings, scarification and cuttings, and not sharing cutting instruments. Utilize Mahokela, chiefs' meetings and sessions on CSE and similar localized channels for negotiations with communities as a complementary avenue. Sensitise and train chiefs and engage their leadership to address CSE, harmful norms and violence in their community settings.

### **Strategy 3: Adolescent and gender friendly health services**

#### **Interventions**

**Ensure health providers and health facilities are adolescent and gender friendly.** The sensitization and training of health providers in all facilities to be adolescent and gender friendly, and to avoid stigmatising or judgemental attitudes, will be scaled up nationwide. Confidentiality needs to be assured, and sufficient access to male and female condoms and wider sexual and reproductive health services in an integrated, comprehensive service package. Services will include: offer and provision of HTC and self-testing when appropriate; VMMC; PrEP for individuals at higher risk (e.g. those involved in concurrent sexual partnerships or transactional sex, or who have recently had an STI diagnosis or TB); integrated disease screening including STI diagnosis and treatment; contraceptive choice including condoms, emergency contraception and other options; hepatitis vaccination, and HPV vaccination for girls; and direct support and/or referral for both HIV positive and negative clients. These are elaborated under Program Result 3 on treatment. Health facilities will adopt the WHO international guidelines on criteria for adolescent/youth and gender friendly services. Integrated disease screening, and referral will integrate contact TB screening, contact tracing and provision of isoniazid (or other) preventive therapy in youth friendly corners, in health facilities and during community outreach for HTS for adolescents and young people.

To increase uptake and adherence to ART, the HIV/TB program will support formation of peer-support groups, community action groups and/or similar facility or community structures for HIV adolescents and young people living with HIV. Active involvement of adolescent females and males and young people is a prerequisite for programs to assist them, particularly in the design and implementation, monitoring and evaluation of SBCC and all SRH service provision. This will include training adolescents and young people living with HIV as effective advocates, community supporters, and counsellors within families and communities, linking children, adolescents and young people with health facilities, and promoting treatment adherence. Lesotho will learn from successes elsewhere, notably WHO and international partner strategies for scale up of quality adolescent sexual and reproductive health. Other south-to-south learning opportunities and good practices will be adopted.<sup>8</sup>

**Expand adolescent and youth SRH services beyond general health facilities** Access to adolescent and youth health care services will be widened through youth corners, mobile clinics and health posts specialising in support to AGYW, key populations, and males, among other initiatives. Workplace based SRH services will particularly support

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<sup>8</sup> An example to consider is the Zvandiri program for HIV positive children, adolescents and young people in Zimbabwe, among others.

young women in the workplace. They will not only prioritize young women in sectors such as garment factories, but also strengthen male involvement and uptake of SRH services including for HIV prevention, treatment and care.

**In school SBCC and SRH services will be initiated and/or effective linkages put in place** for adolescents to access SRH services including contraceptives, in particular male and female condoms and water-based lubricant if needed, HTC, HPV and hepatitis vaccine, and counselling and referral for VMMC. SRH services should be available during or after school hours, with full confidentiality assured, in line also with legal age limit of 12 years regarding parental consent for specific interventions.

#### **Strategy 4: Empowering AGYW**

##### **Interventions:**

**Socio-economic interventions to reduce the vulnerabilities of AGYW** will be broadened and scaled up to reduce reliance on sex work, transactional and/or age-disparate sex, and to keep adolescent girls in school. Activities will include social asset building groups, financial literacy training, savings, management, starting businesses and supporting the enrolment of young people in internship programs, among others. Social protection will be provided to a limited number of extremely vulnerable AGYW through nutritional support for the families of HIV positive AGYW with children, or those at risk of selling sex to support their families. Social protection will also include preferential/ affirmative enrolment into public and private sector and community projects and direct grants/cash transfer to keep girls in school. These are addressed further under the social protection result.

**Reducing sexual and gender-based violence** requires multi-sectoral SGBV/SHRH services that promote and implement laws and policies to reduce violence against women, gender inequality and HIV transmission against adolescent and young women and men. This will be addressed by having an AGYP representative in every community linked to LMPS to report on a weekly basis on violations against AYP through phone and face to face feedback meetings. Coordination is needed by the Gender and Child Services Unit. Survivors of SGBV will be provided post-exposure prophylaxis (PEP) and post-rape care by trained, sensitised health care providers. They will link with trained and sensitised police and other law enforcement agents to act against the perpetrator. Legal literacy and pro bono legal services will be availed to those whose rights have been violated.

AGYW need knowledge and capacity development to safeguard their sexual and reproductive health and rights, including strategies to prevent SGBV and how to access full medical and legal support after rape or other sexual or physical violation.

Negotiations with communities on traditional and cultural practices, interpretations and norms that increase vulnerability to HIV infection will be complemented by directives from duty bearers, including law enforcement officials on non-tolerance of the norms and practices that infringe on the rights of women and girls, such as those that promote SGBV, child sexual exploitation, early pregnancies or keep girls and boys out of school.

Mahokela, chiefs' meetings and community dialogues on the importance of comprehensive sexuality education for children and adolescents will be developed, and may be used as a complementary avenue for prosecution (e.g. through the Sexual Offences Act). Extensive community outreach will focus on reducing SGBV, child sexual exploitation, teen pregnancies and illegal abortions, as well as promoting HIV prevention and treatment access and SRH rights for adolescents and young people.

## **Program Result 2: Mother to Child Transmission Eliminated and 95% of children living with HIV on treatment by 2023**

### **Results Area 2.1: Mother to Child Transmission of HIV Eliminated**

### **Result Area 2.2: 95% of children living with HIV on treatment by 2023**

#### **Expected Outcomes**

- % of estimated HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission increased from 66% in 2017 to 95% by 2023
- % of infants born to HIV positive women receiving a virological test for HIV within 2 months of birth increased to 98% by 2021 and maintained to 2023.
- Contribute to reduction of pregnancy in girls including orphans before age 18 by 75% by 2023

#### **Program Status**

##### **Progress:**

International data from the Conference on Retroviruses and Opportunistic Infections (CROI, 2018) reiterated that pregnant women are at increased risk of HIV infection. The Lesotho Strategic Plan for eMTCT of HIV and syphilis 2018 to 2022 will guide elimination of MTCT. The plan considers it essential to reach pregnant women/ expectant mothers effectively. HIV testing is offered to all pregnant women attending ANC with high coverage, of over 95% of pregnant women knowing their HIV status during the first ANC visit. Following the launch of Option B+ policy, women living with HIV are initiated on ART on the same day of diagnosis. The eMTCT programme is well integrated and delivered in the MCH platform facilitating good service integration between eMTCT and SRH. However, considering that figures vary, one estimate is that only 66% of the total number of HIV positive pregnant women received antiretroviral therapy to reduce the risk of mother to child transmission in 2017/18 out of a target of 75% (Nu=8166/12335). eMTCT ARV coverage has remained low. This may be partly related to lower than expected numbers of women attending ANC facilities.

By 2016, over 50% of pregnant women had begun ART prior to the current pregnancy. This correlates well to ART coverage within the general population. Ninety-three percent of infants born to HIV positive women were thought to receive a virological test for HIV within two months of birth by 2017/18 on one estimate, but these data are not considered reliable. Qualitative HIV diagnosis for infants is centralized and conducted at the NRL. The final MTCT rate has dropped from close to 30% in 2004 to 12.4% in 2016. However, the programme needs to close the gaps to reach the target of the eMTCT plan of less than 5% MTCT by 2022.

A program of early infant male circumcision (with a few days of birth) is being rolled out in two districts which, depending on results, will be expanded to cover the whole country. Targets need to be set for 2023.

##### **Challenges:**

Challenges arise within all four prongs of the elimination of mother to child HIV transmission cascade (preventing HIV in women of reproductive age and their partners, preventing unintended pregnancy in HIV positive women, preventing MTCT, and promoting long-term ART adherence in HIV positive women, children and other family members.

- Full eMTCT coverage remains low, against a backdrop of high HIV incidence in the general population and among ANC women. New infections in the mother can occur at any point of pregnancy and breastfeeding,

and attention to helping women remain HIV negative, and quickly identifying any new infection through retesting, is promoted in WHO guidelines

- Conflicting data capture is of serious concern and data require urgent validation for effective program monitoring
- AGYW are at risk because of insufficient youth and gender friendly health services and of family planning, and adolescent pregnancies are increasing. Early marriage is another factor. Some facilities do not provide quality eMTCT services, and Catholic faith-based facilities do not provide family planning
- The low eMTCT ARV coverage may partly be explained by findings from the last LDHS (2014) where four in 10 women (42%) reported at least one problem (getting permission to go to the doctor, getting money for advice or treatment, distance to a health facility, and/or not wanting to go alone). The most commonly reported problems were sourcing money to pay for treatment (27%) and distance to the health facility (26%). Many deliveries (23%) occurred in the home.
- Loss to follow-up of HIV exposed children after birth and breastfeeding can be associated with the mother's choice of relocation following delivery. Most women prefer to give birth at the health facilities closest to their rural homes and return to their matrimonial homes a few weeks following delivery
- Male partner involvement remains low at 8% in 2016 despite the initiatives such as index-case testing (albeit not yet scaled up nationally) that have had little success. Male partners seem reluctant to come to health facilities to test or may be highly mobile.

## **Strategies and Interventions:**

### **Strategy 1 (Prong 1): HIV prevention in the reproductive age population**

#### **Interventions**

HIV prevention in the reproductive age population falls within the strategies of combination HIV prevention for the general population, for adolescent girls and young women in particular, and for other vulnerable and key populations. These include female sex workers, factory workers, female migrants, prisoners, orphans and other vulnerable children, women with disabilities or mental disorders, survivors of sexual violence and some transgender women. Also essential is the increasing inclusion of strategies to address men and boys. Strengthened efforts are needed to engage men further in HIV prevention and to strengthen their health seeking behaviour through tailored SBCC in diverse community settings and in the workplace. Couple HIV testing, and counselling should be strongly promoted, and partners empowered to disclose their status whether tested together or not. eMTCT information and/or services should be integrated with all other HIV prevention and SRH strategies, and in MNCH, ART and TB services.

Of special importance is the high incidence of new HIV infections in AGYW and in unmarried young women, and inadequate adolescent and youth friendly health services. Strategies and interventions are elaborated in the prevention program results areas.

### **Strategy 2 (Prong 2): Prevent unintended pregnancy in HIV positive women**

#### **Interventions**

Reducing unintended pregnancy should aim to address the Lesotho Family Planning 2020 guidance and commitments including to ensure that ANC services are adolescent responsive and friendly and cater to the needs of young mothers. Interventions to prevent unintended pregnancy in HIV positive women should link fully with initiatives to prevent unintended pregnancy in all girls and women through multiple approaches: SBCC appropriate to diverse populations of women of reproductive age and to men and boys to generate knowledge and demand for modern contraception, with skills building to use condoms correctly whenever procreation is not intended; and effective supply management of contraceptives including male and female condoms. Women need information and access to other contraceptive

methods to optimise dual protection against infection and unintended pregnancy, and men and boys should be sensitised to support this.

Information, counselling and provision of contraception should be standardised at HTS, during ANC visits and post-partum, being an important part of the full sexual and reproductive health, maternal, neonatal, child and adolescent health (SRMNCAH-N) package. Access to emergency contraception should be widely available, and CSE and SBCC strategies need to include information on this. Legal access to medical abortion in Lesotho would also reduce unintended births and greatly reduce the likelihood of women seeking unsafe abortion. Some women and girls who can afford this currently seek legal abortion in South Africa. Those seeking unsafe abortion in Lesotho are putting their lives at considerable risk, contributing to total maternal mortality, and need non-judgemental access to quality post-abortion care.

Particular issues to address are the high rate of teenage pregnancy, with adolescent mothers forming about half of all ANC attendees, including younger adolescents. Effective strategies should be analysed through south-south learning and adopted. Low uptake of family planning methods by adolescents, sub-optimal care in eMTCT services in general and with regards adolescent friendly health service provision also need to be addressed. In catchment areas of Catholic-run facilities under the Christian Health Association of Lesotho community access to condoms needs particularly to be strengthened. Interventions to prevent unintended pregnancy are included within the SBCC strategy, condom programming and in the prevention result area on adolescent girls and young women.

### **Strategy 3 (Prong 3 & 4): Promote early HIV and syphilis testing, treatment, care and support for pregnant and breastfeeding women, their partners and children**

This strategy will cover Prongs 3 and 4 of a comprehensive eMTCT approach. Interventions described in this section are aimed at supporting a rapid expansion of the eMTCT program, that promote early HIV and syphilis diagnosis and prompt treatment among those who test positive including mothers and their partners, infants, children and adolescents. Timely access to ANC services will remain a critical pathway to facilitate access to eMTCT services within the SRMNCAH-N platform.

#### **Interventions**

**Strengthen eMTCT program coordination, management and strategic information:** The MOH eMTCT program in collaboration with key partners including UNICEF, WHO, UNFPA, UNAIDS and BOS will undertake an exercise to validate all critical eMTCT data elements such as estimation of numbers of pregnant women in Lesotho, in order to support tracking of program performance against the NSP targets. The MOH will integrate eMTCT program data into the EMR to aid the longitudinal tracking of pregnant women and their infants. The program will improve its communication and coordination arrangements with sub-national level and with the private sector for meaningful engagement and effectiveness towards reaching intended goals. MOH capacity needs to be built to develop and implement policies and programmes across the board, with prioritization of those most in need. Overall monitoring of access to and enjoyment of sexual and reproductive health rights and services will be explored as a strategy to generate strategic information for measuring progress and gaps.

**Increase HIV and syphilis testing for pregnant and breast-feeding women and their partners:** HIV and syphilis testing services will be expanded within the SRMNCAH-N platform. Special focus will be given to supporting re-testing of pregnant women at 36 weeks and during post-natal and breast-feeding periods for early detection of sero-conversions. The eMTCT program will expand couple counseling and testing services. Innovative approaches involving existing community structures will be employed to attract men to HIV services including provision of HIV self-test kits. PrEP will be offered to negative sexual partners in sero-discordant couples. The eMTCT program will pilot the duo HIV/syphilis test kits that are currently in the market in collaboration with the HTS TWG to explore their cost effectiveness and the feasibility of implementation.

**Provision of timely and uninterrupted quality treatment, care and support for HIV positive pregnant and breastfeeding women and their partners:** The eMTCT program will enhance its implementation of the ‘test and treat’ strategy for women during pregnancy, delivery and breast-feeding period with a special focus given to AGYW considering their heightened vulnerabilities and HIV risk. The eMTCT TWG will provide guidance to the program on effective strategies for the identification and management of high-risk infants including guideline revision and capacitation of health workers particularly those working in the SRMNCAH-N settings. The program with support from laboratory services will expand viral load access and provide 6-monthly VL monitoring for all HIV positive pregnant and lactating mothers receiving ART. Health workers will be capacitated to effectively manage patients with high viral load with support from the facility-level ART advisory committees. Nutrition interventions will be scaled up with nutrition assessments, counselling and support services implemented at all facilities including the provision of therapeutic food for malnourished mothers and infants. Retention in care will be prioritized by putting in place measures to track mothers and babies through facility- and community-level interventions. Referral systems will be strengthened within and across facilities. The program will avail and support consistent use of appropriate referral tools including mHealth technology to confirm referrals across facilities. Community health workers will be capacitated to monitor and address treatment adherence issues by mothers in the community. The program will support development and implementation of a differentiated package of interventions for HIV positive pregnant and lactating adolescents. It will require strengthened linkages with all areas of SRHR and MNCH provisions to achieve integrated quality services, including for TB, STIs, hepatitis vaccination for young people and HPV vaccination for girls 9-15 years as part of cervical cancer primary prevention program, and prevention and support regarding SGBV. All sexually active HIV-infected women and sexually active adolescent girls will be screened for cervical cancer upon HIV diagnosis and annually thereafter (visual inspection with acetic acid [VIA] will be performed for pre-menopausal females and Pap smears for post-menopausal women).

**Improved timely diagnosis, treatment, care and follow up of HIV exposed infants and children living with HIV:** The eMTCT program will document lessons learnt from pilot studies on POC EID to inform further rollout. The eMTCT TWG will provide guidance to the national program on considerations for introducing birth testing. In consultation with laboratory services, the program will develop strategies to reduce the TAT for EID including use of mHealth to facilitate rapid return of results to facility and clients (refer to lab section). With respect to high mobility of mothers in Lesotho, consideration will be made for referral and tracking of individual HIV-exposed infants rather than mother-baby pair. HIV positive infants will be rapidly linked to and initiated on ART to avert early mortality. Mothers and caregivers will receive counseling on infant and young child feeding.

**Increased demand for timely uptake of eMTCT and SRMNCAH-N services.** This will require promotion of uptake of all elements of integrated eMTCT and SRMNCAH-N services, including increasing uptake of ANC 1 and ANC 4 and early medical male circumcision, plus intensifying community engagement and ensuring a strong emphasis on male involvement. The program will build the capacity of VHWs to create demand for timely uptake of SRMNCAH-N and eMTCT services. The ‘male-friendly’ service package will be re-defined and provided to men. An advocacy and communication package will be designed to promote early and regular ANC and PNC care with tailor-made messaging for AGYW and to increase community engagement and male involvement, as part of the overall SBCC strategy. Traditional leaders and religious leaders will be specifically targeted to help address some cultural and religious barriers to timely uptake of services. Health posts that have been established will be supported to provide eMTCT and SRMNCAH-N services.

The program will monitor access and utilization of SRMNCAH-N to progressively improve quality, coverage and effectiveness of interventions.

## Program Result 3: Test and Treat Cascade Fast Tracked to attain 95-95-95 targets by 2023

### Result Area 3.1: Differentiated and Enhanced HIV Testing Services

#### Expected Outcome

By 2023, the program will have increased the proportion of people living with HIV who know their HIV status to 95%, for all ages.

#### Program Status

##### Progress:

The Lesotho HIV Testing program seeks to identify PLHIV in a timely manner through the provision of quality testing services for all including adults, children, couples and families and effectively link them to appropriate prevention, care and treatment and support services. The country has embraced the '5 Cs principle' for effective HTS including Consent, Confidentiality, Counselling, Correct test results and Connection. HIV Testing Services have been rolled out to all public health facilities with over 80% of people tested within health facilities and the remainder at community level. There has been more than a three-fold increase in the number of people tested (including adults, adolescents, and children) per annum from 274,240 in 2011 to 916,649 in 2016. According to LePHIA (2017); 77.2 % of people aged between 15-59 years living with HIV know their status. These include 81.5% of females and 71% of males. This progress has been due to effective targeting and differentiated testing approaches. Within the general population, the proportion of people who know their HIV status stands at 58% for women aged 15-24; 62% for women aged 15-49 and 50% for men aged 15-49 years. HTS services are well integrated in hospitals across the various entry points including out-patient departments, in-patient departments, TB, ANC and men's clinics. The Lesotho HTS Guidelines have provision to consent for an HIV test for any person aged 12 years and above with sufficient maturity to understand the benefits, risks and implications of testing. This policy facilitates access to HTS services by younger adolescents. PEPFAR implementers are supporting targeted HIV testing in selected populations and index partner testing as innovative approaches to testing aimed at improving testing yield. Of note is that over 80% of HIV testing facilities participate in quality improvement activities with more than 90% of them recording improvement in overall performance.

##### Challenges:

- Low uptake of HTS (including index testing) among adolescents, key populations, and men.
- Testing points and general facilities supported by PEPFAR are better resourced than their Global Fund financed counterparts (more nurses, counsellors and data clerks, commodities, mix of available services), and are more prone to utilizing data and conducting implementation science to inform ongoing decision-making.
- Health workers are unable to identify clients who drop out of care and present at other facilities as new clients (re-entry); while data gaps exist in reporting tools for linking of clients to post-test services.
- Quality assurance challenges exist including unclear internal quality assurance processes among some service providers.
- Lack of professional counsellors in government hospitals and health centres compromise the quality of counselling services.
- Index partner testing is not provided in five districts, and this undermines programme reach and yield.

**Strategy 1: Strengthen management and coordination of the HTS programme to improve its effectiveness and efficiency**

Management and coordination strategies will focus on enabling the implementation of HTS policies and guidelines at all levels of the national healthcare structure in Lesotho.. It is critical for the management and coordination of the HTS programme to remain dynamic and responsive to emerging implementation issues across all partners and sectors, in order to ensure that an enabling environment for HTS implementation remains. In 2018 the programme will accelerate its efforts to strengthen HTS linkage to SBCC, and patient tracking modules in HMIS, establishing additional testing corners, standardizing referrals and expanding outreach for groups showing low HTS uptake (men and adolescents.)

#### **Interventions:**

##### **Strengthen national and district HTS coordination structures**

On a quarterly basis the HTS TWG will be convened as a technical and oversight committee for the programme to provide strategic direction and monitor programme performance according to national policies and guidelines. The HTS Policy will be reviewed in 2020 to accommodate emerging HTS-related issues. Biannual program review meetings will be convened with stakeholders to assess programme performance and provide course correction in a timely manner. Districts will be capacitated to conduct supervisory visits to health facilities through procurement and deployment of one vehicle per district. The central level will conduct quarterly supportive supervision to the DHMTs at sub-national level while the DHMTs in turn will conduct monthly supervisory visits to health facilities.

##### **Recruit, deploy and institutionalize key human resources for the HTS programme**

The HTS Programme will fill in all key positions to ensure 100% staffing complement to enable the programme to be effective. The following positions will be prioritized: HIV/AIDS counseling expert, HIV/AIDS counseling officers (at facility and community level) and Assistant HIV/AIDS counseling officers. Furthermore, the programme will lobby for the establishment of additional positions critical to the success and sustainability of the programme. A position paper will be drawn and presented to key ministries, including Ministry of Public Service and Ministry of Finance to justify the positions of senior, professional and lay counselors in the MOH establishment list. HTS services will be provided by trained and certified health-care providers, community health workers or counsellors working under the supervision of a suitably trained professional health worker. Counsellors will receive HTS training with special training on psychosocial support and counselling for children for those attending to children. Annual refresher training sessions will be organized for all health workers involved in the HTS program.

##### **Strengthen and increase the capacity for quality assurance program**

MOH and partners will support all health facilities to implement continuous quality improvement activities to optimize the quality of HTS. The HTS TWG will expand its mandate to include quality improvement and quality assurance monitoring activities. The QA and QI strategy and SOPs will be updated annually. All sites providing HTS services will be enrolled to participate in the External Quality Control (EQA) exercise, with the central laboratory quality assurance unit. External quality controls will be tested in accordance with national standards regularly by all testers with summary reports submitted to the central laboratory. Special support for QA will target districts where HTS quality has been sub-optimal including Botha Bothe, Mophale's Hoek, Mokhotlong, Quthing, and Thaba Tseka. In order to assure access to safe and appropriate diagnostics; the HTS program will procure WHO-prequalified HIV Rapid test kits.

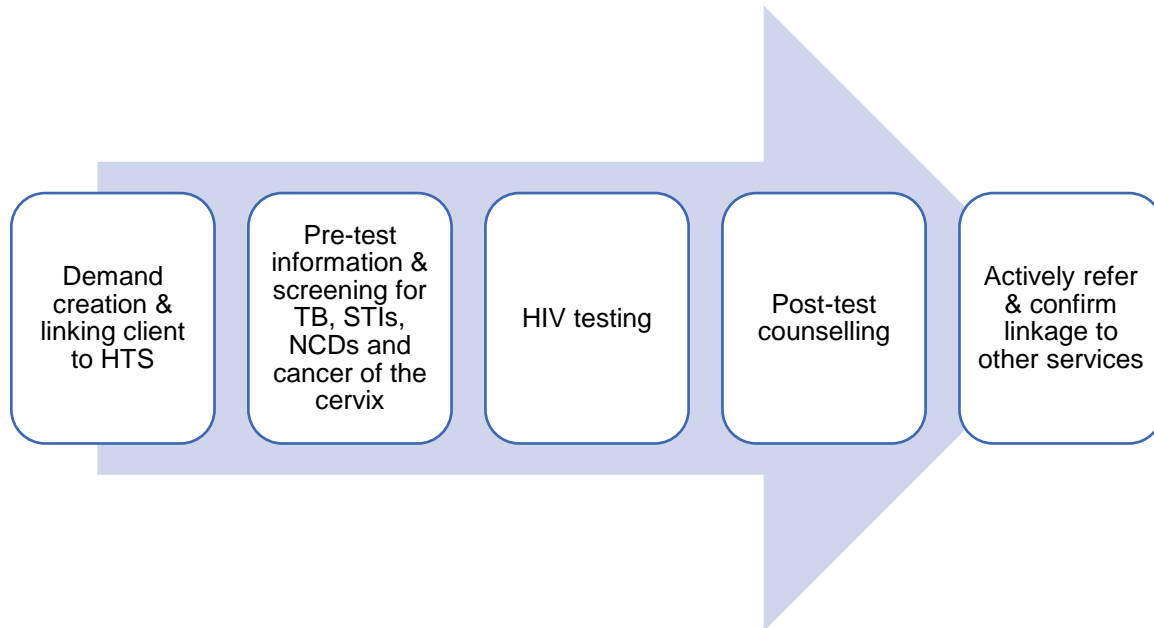
##### **Strategy 2: Strengthen service delivery capacity for high quality and targeted HTS**

The program will continue to identify people and begin treatment early on in their infection, so they become virally suppressed leading to reduction of mortality and HIV transmission rates. It will tailor messages to keep those who test negative from getting infected, and work with people who test positive to become champions at voluntary disclosure, passing key SBCC messages and preventing new infections and reinfections. Differentiated and targeted HIV testing services will be strengthened to identify more new clients particularly among the asymptomatic ones who are not



seeking care. HIV services will be expanded out of facilities into communities in all districts, with innovative ways to avail and promote testing in hard-to-reach communities and individual groups.

HTS will be delivered using a continuum of services which includes demand creation and linking clients to HTS, pre-test information including screening for tuberculosis (TB), STIs and cervical cancer, viral hepatitis, HIV testing post-test counselling, active referral and linkage to other services.



#### Interventions:

**Optimize facility-based testing including Provider-Initiated Testing and Counseling (PITC) and Voluntary Counseling and Testing (VCT):** These will focus on infants, children, men and adolescents and young women, among specific populations and geographic areas at service delivery points and facilities. Due to the high mortality rate among the untreated HIV infected infants; HIV testing among infants and children will be integrated within child health programs. All HIV exposed infants will have a DNA PCR test done at 6 weeks of life with prompt treatment initiation for those with a positive test. Testing of children will target those with clinical indications such as failure to thrive, skin rashes, oral candidiasis and chronic cough. HTS will be offered to all children admitted to medical wards; receiving treatment for TB or malnutrition; children whose parents or siblings are living with HIV; orphans and vulnerable children. Certain groups of adolescents will also be prioritized for HTS due to their heightened vulnerabilities to HIV infection and difficulties in accessing services. These will include the undiagnosed vertically-infected adolescents; those who acquired HIV horizontally; adolescent KPs, orphans and the socio-economic vulnerable adolescents.

Facility based HTS yield is estimated to be nearing saturation, and patients at low risk of HIV continue to be tested. Identification of high risk patients who are likely to test HIV-positive will be optimized and testing will prioritize people identified as likely sources of new infections, for example uncircumcised men, discordant couples, key populations and others. VCT, the traditional approach of offering HTS services, will be provided to those clients who walk to testing centres wishing to receive an HIV test. However, in Lesotho HTS is more effective when integrated with other medical services and offered to clients as PITC through the “Opt-Out” strategy. PITC will be offered in all clinical settings but prioritized in ANC and TB settings, STI clinics, VMMC, malnutrition clinics and among KPs clinics.

A key intervention within the strategy is regarding re-testing clients to verify HIV status aimed at reducing misclassification of HIV test results. Retesting will be carried out periodically to individuals with ongoing risk of

contracting HIV (including KPs, individuals with known HIV positive partner, pregnant and breast-feeding women, STI patients, individuals on PrEP). All people newly or previously diagnosed with HIV will be retested (ideally by a different service provider and with a different specimen) prior to ART initiation. All pregnant women who test HIV negative in the first trimester, will be retested during 3rd trimester, during labour or shortly after delivery. HIV testing will be carried out every 3 months throughout the breastfeeding period.

**Conduct community-based testing including Outreach HTS, home based and targeted campaigns:** These approaches will help increase early diagnosis, reaching out to first-time testers and people who shun health facilities. Interventions will focus on clients with poor access to other testing services including groups of men 15-24 years, people around mining, construction sites, their family members, bed-ridden individuals, the disabled, the under 5 years old children, adolescents, and people LTFU for HIV related opportunistic Infections. The program will put special emphasis on linking clients tested in the community with post-test follow up services. HTS services will be provided within the context of multi-disease campaigns such as screening for STIs and cardiovascular risk factors (diabetes and hypertension) targeting men, adolescents, MSMs, FSWs and factory workers. In order to increase reach for youth and men; the programme will conduct targeted testing campaigns at tertiary institutions and work places.

**Scale up Index testing and Partner Notification:** Index testing will be expanded from five to all ten districts, focusing on sexual partners, especially of those newly testing positive; sexual partners of key populations and adolescents; and children of positive patients. The aim will be to increase coverage for index case testing from the current 30% (PEPFAR supported sites) to reach 90% among the eligible clients. This will lead to high yield among sexual partners of diagnosed patients. Index testing will be performed at service delivery points at facilities, communities and workplaces. Existing community structures (VHW, Peer to Peer) will conduct index testing, and partner notification. HIV Recency Testing to track hot-spots for new HIV infections will be carried out to generate strategic information and inform prioritization of HTS. Transport services will be boosted by procuring and deploying appropriate modes of transportation including motor bikes and vehicles. Horse hire will be secured in areas with difficult terrain.

**Strengthen HIV self-testing:** MOH will systematically roll out the HIV self-testing approach for persons 12 years and above to increase testing coverage. HIV self-testing will target those populations with poor access to HTS or considered to have high HIV risk including men, adolescents; migrant populations; key populations; tertiary students; pregnant women in the community; mobile populations, and young women. Use of HIV ST approach will be expanded to workplaces such as at construction sites and factories.

MOH will forecast, quantify and procure HIV self-testing kits and distribute them at public health institutions and private settings including private clinics and pharmacies. An advocacy and communication package for HST will be developed in 2018 to mobilize and sensitize communities to help create demand for HTS services. Health workers will be trained on the new HIV self-testing approach.

**Strengthen linkages of clients to HIV treatment, care and prevention services.** Linkage is the process that supports people testing for HIV and people diagnosed with HIV to engage with prevention, treatment and care services as appropriate for their HIV status. Clients tested at the different entry points will have appropriate referrals to HIV treatment and care services; STI infection prevention; diagnosis and treatment; screening for cancers; family planning; and to interventions including screening for tuberculosis, hypertension and diabetes mellitus; the adolescent package; SBCC; condoms and VMMC. The MOH will promote use of referral tools to support linkage from testing to treatment services and support routine tracking and documentation of linkages to treatment. The establishment of the unique identifier will facilitate longitudinal tracking from the point of diagnosis along the care cascade.

## Result Area 3.2: Treatment, Care and Support

### Expected Outcomes:

At least 95% of eligible adults and children living with HIV who know their status reached with lifesaving antiretroviral treatment by 2023.

At least 95% of adults and children living with HIV who know their status enrolled onto treatment by 2023

### Program Status (Progress and Challenges)

#### Progress:

The Government of Lesotho initiated the Antiretroviral Therapy (ART) Programme in the public health sector in 2004 using a nurse-driven model. Since then, the country adopted a public-health approach to care to widen service access through decentralization of ART services to lower levels. The country launched the 'Test and Treat' Policy in June 2016, which occasioned a rise in ART coverage for adults and children from 42% in 2015 to 57% in 2016. A year later in 2017/18, further scale up was noted with ART coverage for adults and children reaching 62%, out of a target of 65% for 2018. In comparison to LePHIA data of 2017; 90.2% of PLHIV in the age group 15-59 years were on ART which translates to nearly 70% (90.2% of 77.2%) of PLHIV who know their HIV status) to be on ART. The paediatric treatment coverage was reported to be 70% (LePHIA, 2017) which is much lower than that reported for adults (90.2%). The disparities between survey data (70%) and program data (62%) could be attributable to differences in the methods used to collect the data. LePHIA survey reported data for the 15-59-year age group while program data covered all age groups including children, adolescents and adults. Data quality issues from the ART program M and E system may also potentially result in under-reporting of the number of patients receiving ART.

The reported high unmet need for treatment at 50% for adolescent boys, 43% for adolescent girls, and 24% for children aged 0-14 years (COP 18) calls for urgent attention in order to reduce AIDS-related morbidity, mortality and improve the quality of life among the underserved groups. Despite low treatment coverage for children below 15 years of age; encouraging rates of HTS to treatment linkages of 89% were reported (LePHIA, 2017). The country has clear guidelines on HIV management for paediatric and adolescent cases. These are part of the National ARV consolidated guidelines. Family-centred approaches are being practiced at some clinics managed by civil society in Maseru, which began as paediatric clinics but evolved over time to include adolescents and adults' services in pursuit of a 'family centred approach' to care.

The Lesotho treatment program initiates ART to everyone living with HIV regardless of their CD4 or clinical stage (Treat All) and has made some adaptations to the ART service delivery models in line with the approach of 'differentiated service delivery' (DSD)/ Differentiated care. Differentiated care is client-centred and adapts across the cascade to the needs of groups of people living with HIV, while alleviating some burdens on the health system. Examples of adapted models for PLHIV in Lesotho include- less frequent clinic visits, multi-month prescriptions (3-6 months) and community delivery of ARVs. The first line ART for adults and adolescents is a combination of Tenofovir, Lamivudine and Efavirenz. The country is preparing to transition towards Dolutegravir-based first line regimen in the near future, however, emerging safety concerns of DTG use released through a statement issued by WHO<sup>9</sup> (18<sup>th</sup> May 2018) may require adjusting the DTG transition plan. Preliminary findings of the NIH-funded study carried out in Botswana found four cases of neural tube defects out of 426 women who became pregnant while taking DTG. The country will carry out

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<sup>9</sup> WHO. Statement on DTG- Geneva 18 May 2018  
[http://www.who.int/medicines/publications/drugalerts/Statement\\_on\\_DTG\\_18May\\_2018final.pdf?ua=1](http://www.who.int/medicines/publications/drugalerts/Statement_on_DTG_18May_2018final.pdf?ua=1)

consultations with stakeholders to determine the most appropriate course of action in light of these and other emerging scientific findings.

Routine viral load monitoring has been adopted as the preferred approach to monitor treatment response for PLHIV on ART with increasing laboratory capacity to conduct viral load testing, albeit some constraints. Guidance has been provided on the evaluation of treatment failure and conducting enhanced adherence counselling sessions; with patients being switched to 2<sup>nd</sup> and 3<sup>rd</sup> line ART according to national guidelines. Health facilities use appointment and tracking systems to trace and retrieve treatment defaulters. There has been no reported stock outs of ARV medicines in the past 2-3 years at public health institutions and ARVs are offered free of charge to patients as per government policy.

### Challenges:

- No national HIV Program manager to coordinate the ART programme; The HIV Focal Coordinators at DHMT level lack the clinical background and skills required to support HIV care providers at hospital and facility levels.
- Adolescents living with HIV in Lesotho have high mortality rates while men have lower enrolment and retention rates with higher mortality rates compared to their female counterparts.
- There is limited capacity to manage HIV patient information; hence data discrepancies are observed when reported from different sources. Health facilities experience difficulties tracking treatment defaulters, especially migrants to South Africa.
- Lack of a national HIV Drug Resistance (HIVDR) strategy; currently support for HIV DR testing services is limited to a few implementing partners.
- The long turnaround time for viral load tests (1 to 3 months) undermines their intended purpose. Few baseline CD4 tests are conducted due to frequent breaking down of machines; lack of adequate reagents and limited health worker knowledge on the role of a baseline CD4 tests.
- Frequent staff rotations, shortages, and lack of senior ART clinicians compromise program quality. Health workers lack confidence and competence in providing paediatric HIV management.

### Priority Strategies and Interventions

Key interventions will include HIV care (previously pre-ART); Antiretroviral therapy; treatment monitoring (Viral Load) and drug surveillance; adherence support and patient-centred tracking; differentiated service delivery models; prevention, diagnosis and treatment of opportunistic infections; psychosocial support; TB/HIV care and treatment; with most community level activities gradually led by People living with HIV.

**Table: Comprehensive package for HIV care and treatment services**

Clinical evaluation	<ul style="list-style-type: none"> <li>• WHO clinical staging</li> <li>• Diagnosis and management of opportunistic infections and co-morbidities</li> <li>• Screening and treatment for TB, STIs, pregnancy, and cervical cancer</li> </ul>
Co-trimoxazole and INH prophylaxis	
Laboratory investigations	
Primary and Supportive Care	<ul style="list-style-type: none"> <li>• Immunizations</li> <li>• Monitoring of growth and development</li> <li>• Nutrition assessment, counselling and support</li> </ul>
Education and Counseling	<ul style="list-style-type: none"> <li>• ART/Adherence readiness assessment</li> <li>• Disclosure support</li> <li>• Prevention counselling (PHDP package)</li> <li>• Community support and linkages</li> <li>• Screening for substance abuse and mental health</li> </ul>

Clinical management of patients presenting with Advanced HIV	
ART initiation	
ART Monitoring	<ul style="list-style-type: none"> <li>• Clinical assessment</li> <li>• Laboratory testing</li> <li>• Continuous adherence monitoring and support</li> </ul>

**Strategy 1: 95% of people testing positive for HIV enrolled in the ART program**

**Management, Coordination and Capacity Building for ART delivery:** As a matter of urgency, MOH will lobby for resources and recruit for the position of the HIV Programme Manager to coordinate the health sector AIDS responses. Additionally, MOH will advocate for the realignment of the job description for the District AIDS officers’ position, to suit the job requirements. The HIV Treatment TWG will meet quarterly for programme oversight and monitoring of performance as per guidelines. ART service providers will be capacitated through training sessions on comprehensive HIV management and through the follow-on mentorship programme to build individual skills and competencies to deliver quality program. An online distant learning package will be developed to manage patients with advanced HIV disease to improve their knowledge on patient care. Coupled with this training, a data management and utilization course will be developed and run among health workers at facility and community levels to increase their HIV data management skills and utilization for decision-making and programming.

**Treatment Optimization:** The MOH will support all health facilities to implement the “Treat All” approach where patients testing HIV-positive, at facility and community level receive counseling services and when ready receive same day ART initiation to optimize treatment outcomes. Community ART initiation will be further scaled up while paying special attention to effective linkage to facility care in order to improve ART services to communities with poor access to health facilities. A Transition Plan to support the phasing in of Dolutegravir-based ARV regimens was planned for 2018. The Treatment TWG will make evidence- informed decisions considering emerging DTG safety concerns issues. Additional ARV regimens will be systematically introduced into the health system whenever newer effective medicines become available and recommended by WHO.

**Strengthen Clinical Management of HIV infected children, adolescents and adults**

The laboratory department of the MOH will provide baseline diagnostic tests as per national ARV guidelines including a CD4 test, renal function test, hepatitis screening, Cryptococcal antigen test for adolescents and adults with CD4 count <100 cells/mm<sup>3</sup>, liver function test, VDRL, full blood count (FBC), blood glucose and a pregnancy test. Providers will be trained and mentored to manage patients with Advanced HIV disease according to the National ARV Guidelines. Patients presenting with advanced HIV disease also known as ‘late presenters’ are defined as patients with CD4 count <200 cell/mm<sup>3</sup> or WHO stage 3 or 4. Late presenters require more intensive care and support in order to reduce the high rates of HIV morbidity and mortality seen in this group. The District Advisory clinical committees will be set up at all districts to support a decentralized management system for patients with Advanced HIV disease.

**Scale up of Male targeted services:** Gender sensitive health providers (male service providers reaching men in the general population, service providers who went to traditional initiation schools for initiation, faith leaders, networks of people living with disease, among others) will scale up targeted services to boys and men at male corners within health facilities providing HTS, STI screening and treatment and ART. Mobile clinics will provide comprehensive services (Including HIV self-testing) in places where men frequently gather, including traditional initiation schools; men groups in churches; work with faith leaders through community-based models e.g. Channels of Hope Model; soccer tournaments and in institutions, using musicians (celebrities). Networks of people living with HIV will be strengthened to attract more men.

**Strategy 2: Increase Retention in care at 12 months to 95% by 2023**

**Treatment adherence support and patient-centred tracking at facility and community levels:** Community systems will be strengthened, and each patient assigned to a preferred family member or community level “Buddy” or person accompanying them for treatment. This will be an extension worker, village health worker or person who has been consistently enrolled in the ART program for several years - quality assured by a nurse or extension workers from a nearby facility. Village level workers will follow up on clients, promote adherence and retention in the ART program. The MOH and partners will develop an individualized patient tracking system, building upon community patient tracking tools such as COMCARE. Community Structural Systems will be strengthened to coordinate patient tracking and adherence support. Transport, psychosocial support and other social protection will be provided to the neediest patients enrolled in ART currently facing these significant barriers to access.

**Expansion of differentiated models of care (MMD, CAGs, integrated outreach, extended hours of service, pharmacy fast-track refills):** The MOH and partners will develop an Operational manual and a Job Aid in 2018 to guide the implementation of Differentiated Service Delivery (DSDs) models. Appropriate DSDs models including MMD, CAGs, extended hours of service, community ART delivery, mobile clinics will be scaled up nationally with the choice of DSD informed by the local context and population needs. The supply chain management system for ARVs and medicines for OIs will be revamped to allow longer multi-months dispensing of medicines of 3-6 months.

**Expand treatment and adherence support interventions for children and adolescents living with HIV:** This plan will prioritize infants and children as this vulnerable population has an exceptionally high risk of poor outcomes from HIV infection with up to half of children dying before the age of two years in the absence of any intervention. Children will be initiated treatment on the same day of diagnosis with adequate counselling given to caregivers of younger children and to adolescents in preparation for life-long therapy. **The service package for children** will also include TB screening, prevention, and treatment; cotrimoxazole prophylaxis; nevirapine prophylaxis for exposed infants; growth monitoring; infant and young child feeding counseling; nutrition assessment, counseling, and support (NACS); linkage to immunization services; treatment of opportunistic infections; linkage to OVC services; and micronutrient supplementation. In addition to adherence counseling; support for disclosure is critical as evidence suggests that older children who do not understand their HIV status have worse adherence and retention. Peer support and counseling at facility and community level will be promoted. The national HIV treatment program in collaboration with the Family Health department will adapt the WHO Tools for the Assessment of adolescent friendly- health services and carry out health facility assessments and capacity building to expand the provision of adolescent-friendly health services. For school age children; appointments will be scheduled outside school hours and some during school holidays. The treatment program will explore use of innovative approaches e.g. social media to create demand for services among adolescents.

**Strengthen the capacity of community systems to provide nutrition services for people living with HIV:** The link between HIV and nutrition is often described as a vicious cycle: both malnutrition and HIV weaken the immune system. HIV infection increases nutrient requirements and at the same time impairs nutrient intake and absorption. On the other hand, poor nutrition increases the risk of opportunistic infections and accelerates the progression of HIV and AIDS. Nutritional interventions are therefore a critical part of the HIV care package. Food insecurity has been noted to be an important factor that drives the Lesotho HIV epidemic. High rates of stunting were observed from the LDHS (2014) where 33% of Basotho children were stunted, while 11% were severely stunted. The Lesotho MOH with support from its partners will review and update the nutrition and HIV training package and Guidelines for Nutrition among PLHIV and orient, train and mentor health and community service providers on nutrition assessment and counseling tools and job aides. MOH will procure anthropometric equipment for nutrition assessments and provide routine nutrition assessment, counseling and support with appropriate referral at facility and community level. Specialized nutritious foods and micronutrient supplementation will be provided to treat acute malnutrition and micronutrient deficiencies among PLHIV. Due to food insecurity concerns in Lesotho; routine screening for food security will be provided by

trained care providers with appropriate referrals. To inform programming; MOH and partners will carry out a study to assess the prevalence of malnutrition among PLHIV.

**Prevention, Diagnosis and Treatment of Opportunistic Infections and other HIV-associated illnesses:** This will entail prevention, diagnosis and treatment of opportunistic infections; including setting up systems for diagnosis and treatment of close to 80% of **Viral Hepatitis** cases; and other OIs. The HIV Treatment program and the Laboratory Services department will mobilize resources to support the procurement of reagents for baseline screening for Hepatitis B surface antigen (HBsAg) for all diagnosed HIV infected people. MOH in consultation with partners and stakeholders will update national policies to guide vaccine administration among HCWs and other high-risk groups Hepatitis B vaccination program will be introduced and scaled up. The MOH will facilitate the procurement of ARVs (Tenofovir/Lamivudine) and scale up the management of HIV/Hepatitis B co-infected patients in all the districts.

Human Papilloma Virus (HPV) has been linked to cervical cancer; a major cause of morbidity and mortality among women LHIV. For this reason, MOH with support from its partners will prioritize all sexually active HIV-infected women and sexually active adolescent girls to be screened for cervical cancer upon HIV diagnosis and annually thereafter (visual inspection with acetic acid [VIA] will be performed for premenopausal females and Pap smears for postmenopausal women). In addition, the HPV vaccine which is given to all girls from 9-15 years as part of its cervical cancer primary prevention program will be expanded more widely to effect public health impact.

Given that patients with HIV are at an increased risk of contracting other sexually transmitted infections (STIs); MOH will capacitate health workers on early detection and management of STIs according to the National Guidelines for Syndromic Management of STIs. MOH will expand the syndromic management of sexually transmitted infections; train personnel on screening for STIs among key and vulnerable populations; integrate STI screening with HIV, TB screening and eMTCT/ SHRH. The HIV treatment program will facilitate effective linkages among HIV infected clients to condom programmes to prevent pregnancies and/or STIs.

**Development of an Electronic Patient-Level System for longitudinal Tracking of Patients:** The EMR will be updated with a unique identifier. MOH will advocate for the improvement of the ID registration process with Parliamentarians. The electronic database will be decentralized and at a later stage block-chain technology with a patient tracking use case will be adopted to ensure credibility and non-duplication of cases. Patient data from outreaches and health facilities including the maternity wards (SHRH/ SGBV/ SRMNCAH-N); ART, HTS, VMMC and other departments will be integrated into the EMR with provision for use of the system by private care providers. The EMR will have its own module integrated onto DHIS2.

### **Strategy 3: Viral Load Suppression rates increased to 95%**

**Treatment Monitoring (Viral Load Testing):** The laboratory system will be strengthened to scale up viral load monitoring from 45% to 95% of all individuals on ART. This will entail expanding diagnostic services, using innovative methods and equipment and strengthening the specimen referral system to reduce Turnaround Times and inaccuracies. Routine Viral Load Testing will be conducted at 6 and 12 months after ART initiation and every 12 months thereafter as per guidelines. VL testing will be decentralized with refurbishment of two laboratories to expand their testing capacity. MOH will lobby for the deployment, training and retention of additional laboratory scientists to man the two laboratories. Sample transportation system, tracking and e-reporting will be scaled up to reduce the TAT by at least 50%. Botha Bothe and Mafeteng viral load platforms will be upgraded to high capacity platforms, similar to the Leribe and the National Reference Laboratories. MOH will assess and upgrade laboratory capacities in view of the increased workload. Practical short and long-term recommendations to strengthen the laboratory system in readiness

for VL Scale up, will be implemented.<sup>10</sup> The VL Strategic Plan will be revised in 2019 to support expanded coverage of testing to 95% by 2023.

**Drug Resistance Surveillance:** HIV drug resistance testing is being offered to a few patients at a high cost by CSOs in selected facilities, and in South Africa for patients failing any PI based regimens. MOH with support from WHO and partners will develop an HIV Drug Resistance (HIVDR) strategy to prevent, monitor and respond to HIV DR and coordinate DR surveys. The plan will domesticate the five strategic objectives of strengthening HIV DR prevention and response; monitoring and surveillance; research and innovation; laboratory capacity; governance and enabling mechanisms in the Global Action Plan on HIV DR.<sup>11</sup> The HIV Drug Resistance Survey will determine: 1) prevalence of HIV drug resistance (HIVDR) among treatment-naïve and –experienced adults and children; 2) prevalence and pattern of acquired drug resistance mutations in those with virological failure, defined as VL  $\geq$ 1000 copies/ml; and 3) prevalence of VL suppression among adults and children receiving ART. Over the next 3 years the National Reference Laboratory will establish genotyping capacity and perform HIV resistance testing for eligible patients according to the ART Guidelines.

### Result Area 3.3: TB HIV Collaboration

Lesotho is among the top 20 countries with the highest TB and TB/HIV incidence rates globally. Some progress has been noted in reducing the TB incidence and mortality in the past 15 years. The estimated TB incidence was 724 per 100,000 population in 2017 (Global TB Report, 2017) compared to TB notification rate of 342/100,000. The treatment coverage was only 46% in 2016 and the huge gap between the case notification rate (CNR) and the estimated incidence means many TB cases go undiagnosed and untreated. TB mortality in the country remains unacceptably high. Whereas mortality among TB/HIV co-infected patients is falling; mortality among HIV negative TB cases has stagnated since 2005. The reduction in mortality among the co-infected cases may be attributable to the effectiveness of ART (Joint TB/HIV Review Report, 2017).

A National Tuberculosis Strategy 2018-2023 has been developed to guide Drug Susceptible TB Prevention and Care, MDR-TB treatment and HIV/TB Collaborative activities. TB is the leading cause of morbidity and mortality among HIV-infected patients. HIV is the single most important factor fuelling the TB epidemic in settings with a high prevalence of HIV infection as Lesotho. Patients infected with HIV have a 10% annual risk of developing active TB disease compared to the 10% lifetime risk of HIV-negative persons. Thus, early diagnosis of TB among PLHIV is important for many reasons- firstly it facilitates prompt treatment and cure for TB; secondly, it minimizes the negative effects of TB on HIV progression; and thirdly it impedes transmission of TB in the community. Similarly, early diagnosis of HIV among TB patients will enable early HIV treatment initiation and reduction in morbidity and mortality associated with TB/HIV coinfections. NAC in collaboration with MOH will be responsible for coordinating this strategy. However, strategies highlighted here relate to TB/HIV collaborative activities implemented by the HIV Program.

### Expected Outcome

TB deaths in people living with HIV reduced by 75% by 2023.

### TB Program Status

TB notification rates have decreased since 2009 (TB Epidemiological Analysis 2016). This is possibly due to increased ART coverage in the general population; earlier initiation of treatment following the introduction of after scaling up of the Gene Xpert technology, and improved sample transportation system; effects of improved socio-economic variables such as individual incomes / GDP per capita, life expectancy and decreasing Under-5 mortality. Notwithstanding the above; still people living with HIV, children, healthcare workers, including laboratory staff; prisoners, smokers, miners,

<sup>10</sup> Final Report for a Joint Review of HIV/Tuberculosis and Hepatitis Programmes, pages 91-100

<sup>11</sup> WHO (2017) Global Action Plan on HIV Drug Resistance 2017-2021



prisoners and diabetic patients remain key TB populations. Notifications among children have been under-reported, while since 2015, the number of Drug-resistant TB cases has risen dramatically. Lesotho has a high burden of TB/HIV co-infection rate at 72%. It is estimated that there were 12,000 incident TB cases among PLHIV in 2015. Given the high co-infection rates; the National TB Guidelines (2016) recommend that TB and HIV programmes should implement collaborative activities along the following areas: *establishing the mechanism for collaboration between HIV and TB services; reducing the burden of TB among PLHIV; and reducing the burden of HIV among TB patients.*

**Table: TB Indicators in Lesotho, 2016 (Source: TB Epidemiological Analysis, 2016)**

Indicator	Result
TB Notification total - all forms (no. of TB cases)	7,246
TB Notification rate per 100,000 population	362
Proportion of TB patients with known HIV status	94.20%
Proportion bacteriologically confirmed TB cases	50.60%
Proportion of HIV positive among TB patients with known status	72.50%
Proportion of HIV positive TB patients on ART	85.70%
Proportion of HIV positive TB patients on CPT	98.30%
Proportion of children under 15 with TB of all cases	3.30%
Proportion of children under 5 with TB of all cases	1.40%

#### Progress:

The proportion of estimated HIV-positive incident TB cases that received treatment for both TB and HIV by 2017/18 was 75% of the 80% planned. The TB and HIV programmes established a collaborating mechanism according to the National TB Guidelines (2016), aimed at reducing the burden of tuberculosis among people living with HIV and vice-versa. Integration of HIV and TB services at hospitals and health facilities is sufficient; while some facilities provide services using the 'One-stop shop' model. The Joint TB/HIV Review (2017) found evidence of ART initiations within some TB clinics. People living with HIV are screened for TB using the TB symptom checklist at every HIV entry point. Integration of HIV testing in all TB tools and availing of TB/HIV IEC materials in facilities has resulted in high levels of HIV testing among TB patients. The country adopted Isoniazid Preventive Therapy (IPT) an anti-TB medicine given to eligible HIV-infected patients after ruling out TB disease. The MOH has adopted use of highly sensitive molecular GeneXpert technology as the first TB diagnostic tool for all presumptive TB cases. An increase in the proportion of bacteriologically confirmed TB cases was observed along with the introduction and rollout of GeneXpert testing since 2013. This has improved the turnaround times for TB diagnostics, especially where on-site services are available.

#### Challenges:

- The TB program manager was hitherto not formally established within MOH HR structures, hence suffered from inadequate skilled personnel, ineffective coordination between the TB program and National Reference Laboratory, and a myriad of other challenges including:
- Treatment success for new and relapse TB patients has been below 80% since 2008 and fallen far below the national target of 85% according to the NSP.
- High death rates of 14% in 2015 and high proportion of not-evaluated treatment outcomes (9.7%) in 2015. The challenges experienced in TB case management and the ascertainment of treatment outcomes partly emanate from frequent movement of miners to and from South Africa and across districts.
- A low childhood TB case detection rate of 3.3% of all notified cases of TB in the country in 2016 (227 out of 6,937 cases whose age was reported). This is lower than what should be expected (5-15%) in high TB burden countries. Many health care workers have limited capacity and confidence to diagnose and manage childhood TB; this is more evident in health centres contributing to the low childhood TB detection rate
- Inadequate prevention among Health Care Workers and other risk groups;

- Weaknesses in laboratory PSM and linkage of data with clinical services;
- Low IPT uptake compounded by stock outs of Isoniazid and vitamin B6 medicines; and limited IPT data. Some patients were reluctant to take Isoniazid prophylaxis.
- Low quality of screening among PLHIV; example no questions were elicited for TB symptoms coupled with inadequate documentation of TB screening among PLHIV.
- Inadequate ART coverage among confected patients.

## Priority Strategies and Interventions

### Strategy 1: Strengthen coordinating mechanisms between TB and HIV programmes

In addition to the HIV programme; the coordination of the TB program has been shifted to NAC beginning this planning period. The National AIDS Commission will therefore become the National HIV and TB Commission with clear terms of reference to execute its mandate. Measures to strengthen NAC are outlined in this strategic plan. NAC and MOH will integrate and quality assure multi-sectoral TB/HIV service provision delivered by health workers, traditional healers, village health workers, sputum collectors, lay counselors, peer educators and the private sector.

**Expand HIV/TB coordination structures:** At national level a Joint Technical Working Group will be set up for HIV and TB to provide technical oversight for the two programs. The TWG will meet on quarterly basis to review progress on implementation and help address policy and programmatic bottlenecks that impede progress. Similar structures will be set up at district level to play a similar role. The MOHCC will update the TB/HIV collaborative guidelines in line with new normative global guidance. The HIV program will primarily focus its efforts in addressing the 3 'I's, *namely intensified TB case finding among PLHIV; treatment of latent TB infection using Isoniazid (with a shift towards shorter TB treatment regimens); and establishing effective airborne infection control measures in all HIV services.*

**Joint Planning and Review Mechanisms:** The HIV and TB programs will convene annual planning and review meetings together with district representatives and their key stakeholders. The purpose of the meetings will be to review programme successes, challenges and to make recommendations for innovative and effective interventions for the following year, guided by the NSP. In order to maximize on efficiencies and forge programme and service integration; the two programmes will conduct joint support and supervisory visits to sub-national levels including conducting integrated training and mentorship activities for TB/HIV care providers.

**Strengthening M and E for TB/HIV Collaborative activities:** The TB/HIV TWG will oversee the surveillance of TB and HIV programs among TB and HIV patients including the harmonization of programme indicators.

### Strategy 2: Intensified TB Screening among PLHIV

#### Screen TB among PLHIV at community and facility levels

Integration of TB services in the HIV care and treatment settings is key for delivering these services. The HIV programme will accelerate its efforts to institutionalize intensified TB screening among PLHIV at facility and community levels and promptly provide TB treatment for the identified TB cases. Where service integration is not feasible; effective referral mechanisms will be established and maintained between the HIV and TB services so that patients are able to access both HIV and TB services. In the communities; VHWs will be capacitated through training, to screen PLHIV for TB including those that are taking preventative TB treatment and especially in between clinic visits. VHWs and other recognized/certified community cadres will assist in the collection of high quality sputum specimens. At the health facility level; lay counselors, cough monitors, nurses and other personnel will be responsible for screening PLHIV for TB using the TB-symptom check-list and initiate the TB diagnostic cascade. NTP and HIV Programs will integrate monitoring of service provider compliance to guidelines on TB screening in HIV clinics in MOH routine data quality assessments and supervision visits. The TB and HIV Programs will jointly conduct outreach activities targeting priority populations for TB screening and HIV counselling and testing services, leveraging on the three X-ray mobile units purchased for the national TB prevalence survey.

**Improve cascade of diagnosis for TB:** The HIV and TB Programmes will accelerate use of GeneXpert MTB/RIF assay as the first TB diagnostic tool for presumptive TB cases. The programs will jointly mobilize resources to procure, install and optimize use of 13 GeneXpert MTB/RIF assay machines to expand TB diagnostic capacity and linkage of laboratory data with TB registers. The additional support will cover 13 health centres located in hard-to-reach mountainous areas. Laboratories in each of the 13 health centres will be renovated and capacitated with qualified and trained laboratory scientist to effectively run the required tests. The HIV/TB TWG will consider the feasibility of introducing TB-LAM for TB diagnosis among the severely immune-compromised PLHIV considering the costs, cost-effectiveness, the burden of PLHIV who are severely immune-compromised among other contextual issues.

### **Strategy 3: Establish effective airborne infection control measures in all HIV services**

#### **Establish infection control measures at facility level**

Nosocomial transmission of *M. Tuberculosis* has been linked to close contact with persons with TB disease during aerosol-generating or aerosol-producing procedures among other exposures. The MOHCC will re-establish infection control committees at facility level with clear terms of reference to facilitate prompt detection, airborne precautions, and treatment of persons with TB disease. The TB Coordinators will be capacitated to supervise and mentor infection control committees and support compliance with stipulated standards to minimize risk of nosocomial TB infections among inpatients according to the Infection Control Guidelines. Health facilities will develop and orient all staff on infection control plans including use of personal protective equipment (N95 respirator masks) when working in close proximity to TB patients. Measures will be put in place to facilitate annual screening of health workers for TB. In addition, NAC and MOH will institute infection control measures in prison settings.

### **Strategy 4: Provide treatment of LTBI to eligible People living with HIV**

#### **Provide Isoniazid Preventive Therapy to eligible PLHIV**

The MOH will reinvigorate the IPT programme through several deliberate interventions. Isoniazid preventive therapy has been shown to reduce the risk of active TB disease in persons infected with HIV. It is used to treat latent TB infection and reduce the risk of progression to active TB disease. IPT programming will be part of the HIV program's mandate. Health workers and particularly HIV care providers will be retrained on IPT provision including the importance of excluding TB disease prior to the commencement of IPT. A strong advocacy, social mobilization and communication package will be developed and implemented to generate sufficient demand for the program as currently many negative perceived myths and misconception have slowed the program's uptake, apart from the erratic supply of medicines. The HIV and TB programs will collaborate closely and support NDSO in resource mobilization, forecasting and quantification for medicines for the treatment of LTBI and Vitamin B6 to ensure an uninterrupted supply of medicines. The HIV/TB TWG in liaison with the TB Advisory Group will identify from the current evidence the most appropriate options for the treatment of latent TB infection and oversee their introduction and use in Lesotho. As a priority, an effective M and E system will be developed in 2018 to accurately track progress on program implementation.

## **Program Result 4: Gender and Human Rights related barriers to service delivery, accessibility and utilization removed by 2023**

### **Result Area 4.1: Removed legal, policy, religious and cultural barriers to HIV services**

### **Result Area 4.2: Sexual and gender-based violence eradicated**

#### **Expected Outcomes:**

- Contribution towards 50% reduction in proportion of women and men who experienced physical or sexual violence from an intimate partner in the past 12 months, from current baselined of 62% female and 37% males.
- Contribute towards improved gender equality index (value), from 0.962 to (0.999) by 2023
- 75% of people living with, at risk of and affected by HIV know their rights and are able to access legal services and challenge violations of human rights
- 95% of sexual and gender-based violence cases prosecuted successfully
- 50% reduction in the number of women and men 15–49 years old who are reported as having discriminatory attitudes towards people living with HIV by 2023
- 90% women and men 15-49 years with accepting attitudes towards PLHIV
- At least four of the five planned laws and policies updated by 2023: The Sexual Offences Act (2003); Legal Capacity of Married Persons Act (2006); Gender and Development Policy; National HIV and AIDS Policy (2006) and National HIV and AIDS Bill.

#### **Program Status**

##### **Progress:**

In the Sustainability Index (2017) Lesotho scored 4.73 out of 7 on the existence of an enabling policy and legal framework that promotes and protects human rights. The response has taken gender into account, albeit mainly at the policy level through policies to empower women and to enable men, women, boys and girls access to health and HIV services without discrimination - based on sex, HIV status or any other grounds. The National Action Plan on HIV and Law was developed in April 2018 with four goals: To strengthen the anti-discrimination and human rights protection in law and policy; To eradicate gender inequality, harmful gender norms and gender-based violence; To increase awareness of rights, decreasing stigma and discrimination; and to strengthen access to justice and law enforcement.

United Nations agencies, Civil Society and the Gender and Child Protection Unit of the Lesotho Mounted Police Service have built the capacity of duty bearers on human rights principles, including free and informed consent; privacy and confidentiality, legal rights education, fair enforcement of existing laws and Sexual and Reproductive Health Rights including referrals to PEP and PRC. Community leaders, children and youth are continuously trained on GBSV prevention and recognition; child protection; prevention of trafficking in persons and other areas, at national, district and community levels. Civil society collaborates with government agencies, development partners, LMPS and other stakeholders to provide ongoing training and retraining at all levels. A standardized system for monitoring rights violations among children, adolescents and young people and train chiefs (Mahokela- community policing system) has been developed and is currently being deployed, partnering the police, community leaders and adolescents. Civil society have also been trained and are being facilitated to provide HIV related legal aid services to gender-based violence MSM, FSW and other survivors.

Government has developed guidelines for the management of survivors of sexual abuse whose uptake is difficult to monitor due to lack of performance data. There are no mechanisms to effectively track progress on the impact of the

work of the ministry of gender in addressing gender equality and GBV. UNFPA and a wide variety of partners support such activities, but with limited budgets.

### **Challenges:**

**Persisting high levels of sexual and gender-based violence:** 62% of women and 37% of men across the general population still report having been survivors of violence. About 10% of women and girls have been forced to have sex; and HIV prevalence is 58% higher among women and girls 15-24 who have been raped; and 26% higher in the general female population. There is a persistent culture of gender based, including intimate partner violence in society; with few successfully prosecuted cases of sexual violence and many cases unreported. A multi-country GBV assessment reported that Lesotho had the highest sexual harassment prevalence rate at workplaces and in schools. Men and boys including herds boys are left behind in many interventions to prevent SGBV and require customized interventions to reach them.

**Gender inequality :** Lesotho ranks low in the Gender Inequality Index (UNDP 2015) due to economic inequity and disparities, harmful gender and cultural norms and inadequate access to reproductive health services persist, with negative effects on HIV prevention and treatment. 80% of children who have recently become orphaned are paternal orphans.

**Inadequacies in laws, regulations and policies relating to HIV:** The Legal Environment Assessment (2016) reports that the HIV response has not achieved the desired and necessary changes in the policy, legal and regulatory aspects, governing HIV-related issues in the country, thereby impacting negatively on the lives of all affected populations. The Sexual Offences Act (2003) and Legal Capacity of Married Persons Act (2006), Gender and Development Policy; National HIV and AIDS Policy (2006) ; The National HIV and AIDS Bill; are not yet been updated. In addition, MOSD is working towards getting the Disability Equity Bill enacted; as well as updating the Elderly Act; and Labour law to protect people living with disability and mental disorders; workers especially in urban areas; the elderly, among others, and assure them of social protection.. Other policies that would be critical in reducing incidence have not been revised. It is difficult to enforce some laws since the penal code does not include sentences / punitive measures for some human rights violations. Legislation is not yet harmonized; and some bills have been pending for a long time. Amending, enacting or formulating these laws and policies would better protect PLHIV against discrimination; introduce penal sections for punishment of SGBV, sexual exploitation and child marriage cases; assist in channelling additional HIV funds from domestic sources; among other uses

**Inadequate knowledge and M&E on gender based and rights violations:** Data on the violation of the rights of people living with HIV and Key Populations / SGBV is scarce, while there is no mechanism to report and redress discrimination. There are no functional mechanisms for monitoring SGBV; and there is no implementation framework / costed workplan, financial resources, accountability and low knowledge. LOMSHA is not yet fully operational and Human Rights and Gender Equality indicators are yet to be incorporated.

**There is no mechanism to report and redress discrimination.** The Lesotho Stigma index reported stigma and discriminatory practices in social service facilities. End users are unable to navigate the health and justice systems; and there is persistent stigma and discrimination against some key populations by duty bearers within and outside the healthcare setting.

**Highly centralized and weakened human rights response:** Human Rights stakeholder collaboration is weak and cross-communication does not happen; the pool of qualified Human Rights practitioners is not yet adequate. There is a need to revise the plan on how to strengthen Human Rights coordination especially at district and community levels

### **Result Area 4.1: Removed legal, policy and cultural barriers to HIV services**

**Strategy: Strengthen anti-discrimination and human rights protection in law and policy**

### **Interventions:**

- Revise the National HIV and AIDS Policy into one comprehensive policy by 2019, through a task team established by NAC and MOH;
- Review and update health guidelines, programs, the M&E system and train human resources to include the right to health of key populations through a broad range of stakeholders;
- Enforce laws and policies protecting rights of clients to privacy and confidentiality and prosecution of offenders;
- Review and amend laws criminalizing HIV non-disclosure and key populations with the engagement of the Law Reform Commission, NAC, MOJ, LMPS, CSOs, development partners, media, MOH and other stakeholders;
- Support More and schools to ensure institutional policies against sexual harassment, SGBV, stigma and discrimination
- Enhance meaningful participation and coordination for stronger inclusion of people living with HIV, young people, women and girls, people living with disabilities, indigenous populations and key populations in HIV programmes design, implementation and evaluation;
- Review and harmonize definitions of sex and gender to engage diversity of gender and sex;
- Address new trends of migration beyond South Africa - Ensure bilateral agreements with other countries attracting miners from Lesotho, based on the SADC framework on migration of peoples.
- Harmonize the Criminal Procedures Act with the Sexual Offences Act - decriminalizing sex between two consenting adult men; and providing clarity on sex between two consenting adult women, intersex, and other gender non-conforming people so as not to criminalize;
- Strengthen workplace policies and programs to mainstream HIV workplace policies in public sector; reengage private sector and prioritize HIV programs for migrant workers.

### **Strategy: Increase awareness of rights, and decrease stigma and discrimination**

#### **Interventions:**

- Adapt materials and methods to specific sub population needs, and increase knowledge around legal aspects of HIV, human rights, gender equality among vulnerable populations including young people, and key populations, in order to reduce stigma & discrimination
- Conduct training and sensitization for communities, vulnerable and key populations, political, religious and community leaders, health care providers, law enforcement officials
- Establish mechanism to report and redress discrimination in public and private sectors
- Develop and implement media campaigns
- Measure stigma and discrimination through Stigma Index study
- Advocacy against discrimination based on sexual orientation and gender identities
- Enhance meaningful participation and coordination for stronger inclusion of people living with HIV, young people, women and girls, people living with disabilities, indigenous populations and key populations in HIV programmes design, implementation and evaluation.
- Build the capacities of healthcare workers to provide services in a non-stigmatising and non-discriminatory manner.

### **Strategy: Strengthen access to justice and law enforcement**

#### **Interventions:**

Support strategic & progressive litigation on HIV-related cases by:

- Developing prosecutorial and judicial guidelines on responding to criminalization of HIV transmission and workplace HIV-related issues
- Sensitizing and engaging lawyers, the judiciary, LMPS, community chiefs and others on HIV-related law and human rights issues
- Promoting pro bono legal support services for HIV-related litigation through support to public and non-state actors.
- Providing pro bono legal services to survivors of SGBV or other forms of violence, divorced, separated and widowed survivors of misapplication of customary law, key populations and others.
- Engaging with and strengthening the capacity of CSOs to identify and refer cases
- Lobbying development partners, other donors and government to fund strategic litigation cases

## **Result Area 4.2: Sexual and gender-based violence eradicated**

### **Strategy: Eradicate gender inequality, harmful gender norms and gender-based violence**

Stakeholders will strengthen policy, legal and accountability frameworks to advance gender equality and empower women and young people especially girls to exercise their reproductive rights and to be protected from violence and harmful practices. Stakeholders will strengthen multi-sectoral capacity to prevent and address gender-based violence and harmful practices at national and district levels and ensure linkages between SGBV/ SHRH and HIV are clear – based on SOPs for Prevention and Response to SGBV in Lesotho (2017). Civil society and the LMPS have begun a program to connect communities to police in order to prevent and monitor cases of GBV and other rights violations in the community, and feed into LOMSHA, which will eventually link to DHIS.

#### **Interventions:**

- Enact the Domestic Violence Bill
- Ensure the Child protection and Welfare Act 2011 and Legal Capacity of Married Persons Act 2006 considers marriage before 18 years an offense. Enforce through capacities of law enforcers, access to justice, know your rights, and monitoring
- Develop costed strategy and implementation plan to end child marriage
- Amend inheritance laws to promote gender equality in inheritance
- Improve gender equality, reduce harmful gender norms and GBV at community level
- Strengthen the comprehensive response to GBV
- Prosecute infringements through the Sexual Offences Act 2003 to deter lawbreakers and drastically reduce instances of SGBV.
- While it is stated that sex work is not an offense; prostitution and running a brothel is illegal under the law. Therefore, provisions in the law should be revised and amended.
- Communicate success stories in SGBV reduction and prevention; and successfully prosecuted cases and positive judgements through mass media to deter potential instances of SGBV
- Expand male involvement in strategies and activities to eradicate gender-based violence

**Strategy: Roll out prevention and response to SGBV through implementation of Standard Operating Procedures for Prevention and Response to Gender Based Violence (2017) in communities and among service providers.**

- Priority interventions to prevent and address SGBV including intimate partner violence;
- PEP and other post violence care; crisis response services;

- Medical-legal linkages including training and linking nurses, physicians, laboratory technologists, police, prosecutors and judicial officers; pro bono legal services for prosecution of SGBV perpetrators;
- Ensure nationwide training of health workers, police, social services/social workers, CSOs and other service providers on SOPs for Prevention and Response to SGBV (2017);
- Ensure availability and accessibility of friendly HIV prevention /testing /treatment services and accountability for quality services tailored to the needs of population groups, including women and girls, adolescents and young people, people with disabilities, sex workers, men who have sex with men, transgender people, prisoners and aging people living with HIV;
- Publication of successfully prosecuted cases and punitive sentences and damages in mass media as a social deterrent.

**Strategy: Strengthen referrals and linkages to Differentiated HIV Testing, SHRH/ SGBV (RMNACH), ART, and TB**

- Update referral and integration strategies for HIV Testing, SHRH/ SGBV (RMNACH), ART, and TB
- Accompany some referral cases to facilities
- Review mechanism for referral and feedback between facilities and communities
- Harmonize community and facility patient tracking tools;
- Expand use of unique client identifier system to efficiently link clients/ survivors across a variety of required interventions

**Strategy: Enhance formulation and implementation of gender empowerment policies**

- Strengthen policy, legal and accountability frameworks to advance gender equality and empower women and young people especially girls to exercise their reproductive rights and to be protected from violence and harmful practices.
- Build capacity of civil society and state sectors including Education, Agriculture, Mining, Labour, Law and Justice, Social Development, among others to recognize and eradicate gender-based violence and other harmful practices at all levels- based on SOPs for Prevention and Response to SGBV in Lesotho (2017).



## **Program Result 5: Strengthened national social and child protection systems to ensure 75% of PLHIV, and those at risk of and affected by HIV benefit from HIV-sensitive social protection by 2023**

By 2014, the Kingdom of Lesotho was spending at least 9% of her Gross Domestic Product or 197 Million US Dollars annually on social protection, relatively one of the highest such expenditures among developing economies. Commitment to social protection is anchored on Section 26 (2) of the constitution, which seeks to entrench the promotion of equality of opportunity for disadvantaged groups to enable them to participate fully in public life. The National Social Protection Policy 2014/2015 -2024/2025 and Strategic Plan 2014/2015 – 2018/2019 address risks and challenges across the life-course of individuals. The social protection strategy is structured around four key life-course stages (pregnancy and early childhood; school age and youth; working age; and old age) plus the two dimensions of shocks and of disability/chronic illness that may impact at any stage of the life-course, including HIV and AIDS.

By 2013 no less than 10 Programs were transferring money or in-kind assistance to individual households in Lesotho, with at least five designed as safety nets to reduce extreme poverty directly in the homes and pockets of individuals. A value for money analysis by the World Bank<sup>12</sup> and some technical assistance by UNICEF and other partners have partly informed current improvements in social development strategies. At least five existing safety net programs could benefit the most vulnerable to HIV. These include:

- The Child Grants Program (Administered by Ministry of Social Development- It covers poor households including some of the OVCs and ultra-poor children)
- Old Age Pension (Ministry of Finance)
- School Feeding Program (WFP, GOL and other partners)
- Bursary Scheme (Ministry of Education)
- Nutrition Support Program (By FAO, WFP, Ministry of Agriculture and Food Security)

Social care is also provided by groups owned by churches, NGOs and individuals. The government monitors registered entities for standards compliance. In addition, the government is improving legislation to provide an enabling legal framework and raise quality standards through updates to the Children's Welfare Act; Disability Equity Bill; the Elderly Act; and Labour law. Following a World Bank review of the Social Safety Nets Program, the government adopted several policy recommendations and is implementing a reform and rationalization program expected to progress through 2019/2020.

### **Result Area 5: HIV-Sensitive Social Protection availed to the most at risk and vulnerable populations to decrease vulnerability**

Ultra-poor and poor PLHIV and their families, OVCs and elderly caregivers, Adolescents and Young People at risk of HIV infection and Herd Boys prioritized in this Social Protection Program roughly number less than 200,000 individuals, less than the total number of people and households already receiving Social Assistance. Indeed, while a HIV-sensitive study / mapping has not been conducted, a significant number of the populations covered by this Program Result may already be beneficiaries of the national social assistance program and have been captured in the National Information System for Social Assistance (NISSA). Cognizant of this, Result Area 5 will be informed by several practical steps for Fast-Tracking HIV- sensitive social protection, namely:

- o Triangulating information systems using both the NISSA, LOMSHA and other community information systems to better identify and map the individuals most in need of social assistance, including the nexus between

<sup>12</sup> World Bank (2013) Lesotho A Safety Net to End Extreme Poverty

poverty, orphan hood, life stages and HIV/ AIDS prevention, treatment adherence and mitigation – link them to sources of support and monitor them continuously.

- Enhancing livelihoods of people living with, at risk of or affected by HIV, including ultra-poor and vulnerable AGYW and other populations;
- Increasing enrolment and retention in school, particularly secondary school for adolescent girls and young women;
- Increasing access to social protection and socio-economic services for key populations; and
- Strengthening the engagement of civil society in social protection;
- Revitalizing multisectoral collaboration in provision of HIV sensitive social protection;
- Jointly advocating with the OPM through NAC, and line ministries for improved laws, provide a more enabling legal framework and improved standards through updates to the Children’s Welfare Act; Disability Equity Bill; the Elderly Act; and Labour law to protect people in urban areas, including migrant workers.
- Promoting good nutrition among people living with HIV and the affected.
- Gradually transitioning from social protection to social development.

### Expected Outcomes

- 75% of people living with, at risk of and affected by HIV, in most need, benefit from HIV-sensitive social protection by 2023
- Current school attendance among orphans and non-orphans aged 10–14 increased from 82% to 95% by 2023
- At least 90% of vulnerable children and orphans 0-17 years received basic external support
- At least 90% of stunted, severely or moderately acute malnourished people on ART and 80% of TB patients, MDR TB patients in need and their families receive nutritional support
- At least 75% of adolescent girls and young women, with dependents, involved in regular sex work receive some form of care, nutrition and economic support by 2023
- At least 80% of the most vulnerable households (child headed/ extremely poor) receive external economic support

### Program Status (Progress and Challenges)

#### Progress

- The National Policy on Social Development and National Social Protection Strategy 2014/2015 – 2018/2019 have been in place to guide protection of vulnerable groups.
- Some pragmatic policies include support for communities through cash assistance to families, disabled persons and chronic illnesses, public assistance grants, food parcels and psychosocial support through multi-disciplinary teams.
- The National Social Protection Strategy is structured around four key life-course stages (pregnancy and early childhood; school age and youth; working age; and old age) and two dimensions of shocks and of disability or chronic illness that may impact at any stage of the life-course.
- The government is also improving legislation to provide an enabling legal framework and standards through the Children’s Welfare Act; Disability Equity Bill; the Elderly Act; and Labour law to protect people in urban areas.

#### Challenges:

- Social protection has faced some planning and design shortfalls. Only MDR-TB patients and the few TB clients with moderate malnutrition of BMI of 18.5 and below are benefiting from the social grant under the disability and chronic illness category.
- Set as far back as 2010 and never reviewed, some social transfer amounts remained low through 2018. For instance, the child grants program provides 360 Maluti (about \$30) for a family with one child, the price equivalent of a 12.5 kg bag of maize meal; and about double the amount for a family of five or more. Public Assistance ranges between \$20 and \$70 a month.
- Updating the socioeconomic status of beneficiaries has been a challenge since budgetary needs constrain expansion of NISSA to cover 100% of the population, while the capacity of MOSD to coordinate implementation of social assistance across sectors is limited.
- The various stakeholders were previously unable to integrate programs (MOSD, MLGC, MOA, MOE, WFP, UNICEF, and others) and are implementing in silos; hence remain program rather than people-centered.
- Many patients do not complete their full course of treatment due to extreme poverty despite free treatment. Some migrate to South African mines for better job opportunities and return in a worse state.
- High poverty and unemployment rates, food insecurity and HIV/AIDS impact on household economic status, especially children and older people infected and affected by HIV/AIDS.
- Treatment interruptions among some patients due to lack of food has prompted some village health workers and other partners to provide stop-gap assistance.
- Eligibility for supplementary nutrition targets MDR patients and those with a BMI of 18.5 and below; which cuts out a number of otherwise eligible clients and may come too late into disease progression;
- Most health care providers are unaware of social protection policies and how to link HIV patients and the vulnerable;
- Processes for accessing social support for clients are long and bureaucratic;
- Lack of standardized government funded disease based social protection package;
- No data on economic impact of TB /HIV on communities and families
- Lack of baseline HIV sensitive data and a level of mismatch between people receiving social care and the vulnerable or ultra-poor that are most in need due to lack of information and inadequate consideration of HIV in packages;
- Some ultra-poor and poor PLHIV, Key populations and other vulnerable populations, including some AGYW, orphans and other vulnerable children, the elderly, sex workers and TB patients; some unemployed and migrants are likely to be excluded and may be missing assistance.<sup>13</sup>
- Fatigue by social workers, with some providers not meeting quality standards,
- Impediments within the legal framework, especially in the Children's Welfare Act; Disability Equity Bill; the Elderly Act; and Labour law.

## **Priority Strategies and Interventions**

### **Strategy: Integrate and strengthen the HIV and Social Assistance Information Systems**

- Support expansion and personification of NISSA (a database of individuals, including their socio-economic status) from 75% of rural areas to 100% of the country, and integrate information on the ultra-poor and the poor from NISSA, with data from the HIV program on PLHIV and most vulnerable populations - to better target social protection - including information on orphan headed households, other LOMSHA information, the planned patient tracking information system to cover TB/HIV in the Social Protection program.
- Link NISSA to the national identification system to enable tracking of recipients and avoid duplication.

### **Strategy: Remove barriers and expand coverage of HIV-sensitive social protection**

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<sup>13</sup> The National Policy on Social Development (2014/2015 – 2024/2025)

- Enforce the existing requirement on allocation of at least 2% of budget by each ministry towards HIV and channel some of the funds to HIV sensitive social protection through NAC.
- Conduct a service availability mapping and rapid assessment on barriers that people living with, at risk and affected by HIV face in accessing social protection programmes; what can be done to remove the barriers; and develop a HIV sensitive social protection framework.
- Orient health care workers on social protection and develop streamlined Standard Operating Procedures to connect individuals and families in need of social protection services to MOSD, MOA, MOE, MOF, other line ministries, PEPFAR and Global Fund implementers and other stakeholders providing social assistance;
- Strengthen HIV and HIV sensitive child protection capacities of social workers through the MOSD
- Strengthen the HIV and Social Protection literacy of civil society organizations to broker, advocate and demand HIV sensitive social protection.
- Ministry of Social Development / social protection department to disseminate Social Protection policies to all stakeholders across sectors and coordinate sectors better under Office of the Prime Minister (through NAC)
- In the long term, conduct a study on socio-economic impact of TB and HIV on families and communities to obtain baseline information and inform prioritization and funding allocation within social assistance programs

**Strategy: Analyze and prioritize filling current gaps in HIV-sensitive social protection**

- Review eligibility guidelines for social protection to prioritize HIV and AIDS
- Case finding, and bi-directional referral system should be developed and implemented in order to identify and link vulnerable groups to social protection services
- Provide nutrition for severely or moderately acute malnourished PLHIV on treatment and their families
- Provide social protection including cash transfers and incentives targeting adolescent girls and young women to enrol and keep them in school, and ensure provision of sanitary wear so that poorer menstruating girls do not miss days of school each month.
- Connect non-covered OVCs in HIV database to the orphan bursary programs
- Continue social protection for MDR-TB patients on treatment
- Expand social Protection, care and support for Orphans and Vulnerable Children
- Scale up HIV sensitive social protection for People Living with HIV including people with Disabilities
- Rapidly link children and infants through the PMTCT and other programs to treatment, care and adherence support, through the health facility-community continuum
- Under the SADC strategy, follow up with South African authorities to ensure continued social protection and treatment for emigrating PLHIV, TB patients and key populations.

**Strategy: Expand and differentiate HIV- sensitive social protection for People Living with HIV AIDS and their families**

- Integrate HIV-specific data on PLHIV into NISSA
- Prioritize and link PLHIV to the relevant Social Protection, Treatment, Care, & Support programs
- Ensure PLHIV can afford access to basic medical, health and social service (through fee waivers, transport vouchers, stipends/ grants, social insurance, increased information on existing services, simplified processes to access benefits; providing identity cards to people and families who need them in order to access the services; and other methods. Grants will prioritize PLHIV not capable of producing to support themselves.
- Break down social, policy and legal barriers that hinder provision of social protection services for extremely poor key populations with HIV who are eligible to benefit from existing social protection services
- Strengthen integrated HIV and social protection case finding to ensure that people vulnerable to HIV including adolescent girls out of school or at the verge of falling out of school are included in SP programmes.

- Support caregivers, MMGs and CAGs to provide ongoing social assistance and adherence support at community level
- Ministry of Agriculture will provide education, nutritional counseling and seed provision to promote homestead gardens in collaboration with partners such as FAO;
- Rural finance programs will be encouraged to scale up successful income generating economic activities for PLHIV such as vegetable production, and market support provided;
- Conduct positive deviance studies on the status of rural agricultural activities and scale up best practices across communities (CAGs).

**Strategy: Expand and differentiate HIV- sensitive social protection for orphans and other vulnerable children and their elderly caregivers**

Orphans comprise more than 10% of the country's population. There is no significant difference in the proportional distribution of orphans across districts. The following interventions have been prioritized for OVCs:

- Integrate HIV-specific data on OVCs and their elderly caregivers into NISSA
- Measurement and improvement of nutritional status: Support for Moderate Acute Malnourished (MAM) for under 5 children and orphans; and referral of Severe Acute Malnourished (SAM) children to health centres through Community Health Workers in collaboration with partners;
- Improved collaboration between MOA and MOH in terms of information sharing on food and nutritional status and implementation support at community level;
- Enhance school feeding programs with the support of MOA and partners such as WFP and providing refresher training to caregivers and CAGS on nutrition
- Provide hygiene support and psychosocial support to all orphan and child headed households (12% of households with orphans)
- Through MOSD and MOE, provide identify and prioritize OVCs for provision of education support to keep OVCs in school
- Provide nutrition, hygiene support and psychosocial support to adolescents, elderly caregivers in orphan and child headed households
- Accelerate programs to strengthen caregivers and orphans through psychosocial support; economic support; structural protection from SGBV; income generation; schooling; community-based support; and access to other essential services
- Synchronize with other line ministries and partners to ensure provision of shelter, security, education, sanitation and other services as stipulated in the orphan strategy
- Link the PMTCT program including children/ infants to the national social protection program;

**Strategy: Expand and differentiate HIV- sensitive social protection for Adolescents and Young People at risk**

- Integrate HIV-specific data adolescent girls and young people at risk, including Female Sex Workers, into NISSA
- Enhance linkages with the education sector to support child friendly policies, keep girls in school (community, teacher, caregiver training; parenting programs; educational supplies; school or other special fee waivers; supplies, including sanitary pads for menstrual hygiene management; sets); direct conditional payments;
- Provide nutrition, hygiene support and psychosocial support to AGYW with children, involved in occasional or regular sex
- Socioeconomic support (income generation; WORTH model; social grants; parenting and caregiver programs)
- Structural support and household level monitoring to prevent SGBV, pregnancies and sexual exploitation
- Reintegration, including that of adolescent mothers, into the formal education system; supporting access to non-formal/vocational education and distance learning opportunities
- Ensuring supportive learning environments (protection; knowledge, attitude and skills; care and support)

**Strategy: Expand and differentiate HIV- sensitive social protection for Herd Boys**

- Integrate HIV-specific data on herd boys into NISSA
- Targeted social mentoring and other interventions for Herd boys to address structural socialization
- Reform structural barriers to enhance the ability of herd boys to enter into formal schooling
- Capacity building and empowerment of Herd Boys on i.e. Human Rights, Gender Based Violence Education, Income Generating Activities etc.
- Support for non-formal education programs and integrating HIV prevention and treatment; including Comprehensive Sexuality Education
- Review and operationalize Herd Boys Strategic Plan, prioritizing aspects that better identify and link Herd Boys most in-need, to Social Protection.

## **Program Result 6: At least 40% of the HIV/TB response is community-led and sustainable by 2023**

Lesotho is considered a global leader in revitalizing Primary Health Care, rooted in full community and partner engagement and participation. However, the demand for care services at health facilities has outstripped the capacity of existing health systems. Lesotho's community system has traditionally provided a strong complement to the health / hospital system. At least 38% of hospitals and health centers are owned by Civil Society. Studies show that 90% of UHC services are provided at primary health care level, which relies on the community for complementary, referral and feedback services. TB and HIV remain the top two causes of morbidity and mortality and continue to require joint partnership of communities. In Lesotho, majority of patients with communicable and non-communicable diseases including TB, HIV and AIDS are currently cared for by community based care and support structures. Over 30% of the budget is implemented through the community system. The attainment of 95-95-95 targets proposed in this plan will depend on demand creation at community level for the uptake of HTS, treatment, care and support as well as prevention of HIV, TB and SBGV, Opportunistic Infections, referrals to health centers and hospitals, patient tracking and other aspects. For these reasons, engagement and strengthening of CSOs and communities is critical to the attainment of this NSP's targets and will constitute a key Program Result, especially as the country moves towards attaining Universal Health Coverage (UHC) by 2030.

### **Result Area 6.1: Strengthened and Resilient Community Systems**

### **Result Area 6.2: Accountable, increasingly engaged and capacitated Civil Society Organizations**

### **Result Area 6.3: Strengthened networks of people living with disease, key populations, adolescents and young women to plan, deliver, monitor and sustain interventions**

#### **Expected Outcomes:**

Community Systems Strengthened to achieve a score of 8 on Responsiveness (2016 Sustainability Index and Dashboard Summary for Lesotho)

% of service deliveries that are driven by the Community increased from less than 30% currently to over 40% by 2023 (Using budgets as a proxy)

#### **Program Status**

Sparse health system resources translate to one nurse serving as many as 300 people living with HIV and TB, which would make patient tracking at health facility level a daunting task. High Loss to Follow Up (LTFU) rates complicate the country's quest for 95-95-95 targets, especially viral load suppression, unless some tasks are systematically shifted to the community.

#### **Progress:**

Several normative documents have been developed, including the Decentralization Policy 2014, Primary Health Care Revitalization Action Plan (2011-2017) and National Health Sector Strategic Plan 2013-2017, which aim to guide decentralization of services at the community level. An Integrated Community HIV and TB Services strategic plan was developed to strengthen the national response to HIV and TB at community level. In 2013, the government adopted a strategy to enhance government/NGO collaboration, which guides health care facilities in approving, coordinating, monitoring and evaluating service provision and funding allocation.

In addition, a strategy has been developed to work with CAGs for treatment support in communities. Village Health Workers are formally recognized and are receiving stipends in some districts, with plans to scale up to all 10 districts.

Home Based Care kits are in place along with a formal referral system with VHWs, but the functionality and monitoring of referrals and feedback remains weak; there are no national indicators on community linkages.

District coordination mechanism consist of the DHMT, an institutional framework with distinct composition, roles and responsibilities to address technical, managerial, and M&E issues.

In addition, partners have implemented strong support for CSO engagement at design, planning, intervention and organizational levels. Significant portions of the PEPFAR, Global Fund and other partner programs are implemented by Civil Society. For example, in 2017 the US Government undertook a HIV policy scan which defined policy and legal opportunities for HIV Testing Services and Civil Society engagement.

Going forward, there will be continued CSO and Community System Strengthening with enhanced accountability measures; integration of LOMSHA into DHIS 2; and strengthened community level demand creation which engages communities further to lead the response. Lesotho's community systems currently score 3.2 on 'Responsiveness' out of a target of 8 (2016 Sustainability Index and Dashboard Summary).

## **Challenges**

### **Community System and CSO Challenges:**

There has hitherto been neither a strategic plan nor policy guidelines that provide a framework or describe the process, coordination, oversight and content of monitoring, evaluation and review of civil society activities. These are now included in Section 4 of this plan, the Result Framework and in the M&E Plan that accompanies it. The Ministry of Health is yet to be optimally decentralized to coordinate seamlessly with the community, at household level. Other challenges include:

- TB and HIV remain the top two causes of morbidity and mortality and continue to require joint partnership of communities.
- Persistent Stigma of HIV and TB in health facilities
- Poor tracking system for patients
- Quarterly meetings between the AIDS Partner's Forum and Development Partners for Health are held regularly but attendance by government is not always guaranteed;
- Health partnership forum which is co-chaired by WHO is not functional mainly due to frequent changes of government officials
- Health Sector Strategic Plan was finalized after the HIV NSP; and this may emerge with some dissonance;
- Coverage of private health care providers in TB care and prevention remains low within the districts
- DHMTs have no transportation and rely on CSOs to provide support, compromising CSO's work
- No supervision of CSO work by DHMTS - targets not agreed or monitored.
- CSOs provide reports to DHMT but feedback is often not provided
- Inadequate compliance in reporting (accuracy, timeliness and consistency)
- Data for M&E and improvement of service delivery is limited due to reliance on a paper-based system in Lesotho.

### **Other Civil Society Organization challenges**

- CSOs face difficulty in accessing funds to implement HIV activities, with most of the finances originating from development partners through international NGOs
- There are no formal processes for CSO tendering and contracting by government;
- There is an unenforced restriction on CSOs deemed to be against "public morality"
- Inadequate involvement of civil society and private sectors in data collection, validation, and utilization.



### **Community Level Health worker challenges:**

- Weak coordination of the programme and between partners working with VHW, leading to sub-optimal support for VHW, fragmented programmes, activities, support and incentives;
- VHW work under unfavourable conditions, such as accompanying patients to and from health facilities at night on foot, while some patients stay far from health facilities;
- Minimal capacity building initiatives for VHWs to carry out their tasks – for example, some VHW are asked to administer injections;
- No provision of protective materials such as aprons, gloves, masks (kits) as well as incentives (boots, sunhats, and freezer-jackets for some VHW);
- There is no harmonization of payment of incentives between government and partners; Most are owed more than 12 months or more of their allowances;
- Lack of policy guidelines in districts or standardized reporting tools for community-based TB, HIV/AIDS care;
- Sparse population density and difficult terrain creates access challenges in highland districts.

### **Result Area 6.1: Accountable, increasingly engaged and capacitated Civil Society Organizations**

#### **Interventions:**

- Develop a Community Health Strategy consolidating interventions from the Decentralization Policy 2014, Primary Health Care Revitalization Action Plan (2011-2017) and National Health Sector Strategic Plan 2013-2017,
- Expand roles of Community Structural Systems in NSP implementation
- Strengthen civil society (NGO, CBOs, FBOs and private sector) organizational capacities in program management; financial management systems; value for money evaluation; M&E and Research; ensuring equity and efficient delivery; and fund them to lead prevention and social protection programs at community level;
- Engage civil society in National Strategic and Operational Planning and Budgeting including at design, implementation and monitoring phases;
- Develop a framework for FBOs and religious leaders, and statement of commitment to reinvigorate the sector's role in the strategic HIV response
- The role of Civil society (NGO, CBOs, FBOs and private sector) in optimizing demand for and supporting delivery of Program Results 1 to 8 HIV Testing Services (Treatment, Care and Support, Community aspects of EMTCT delivery; HIV Prevention; human rights and gender programs; social protection; collaboration with the health system; and resource mobilization and efficiency audits) under this NSP will be enhanced and supported financially. This will include but not be limited to demand creation and implementation in the following areas:
  - Delivery of the 95-95-95 cascade, combination prevention and EMTCT
  - Development and Implementation of the NSP Communication Plan for Behavior Change; Service Uptake and Effective Coordination
  - Conducting Periodic HIV and TB Stigma index in the health facility
  - Conduct monthly PMTCT cascade analysis at the health facility level
  - Support quarterly district M&E review meetings—inviting community stakeholders
  - Orphan and Adolescent Girl protection through the Mahokela; direct mobile phone links and meetings for information sharing on SGBV and other rights violations with the Lesotho Mounted Police Service
  - Monitored participation in health facility meetings
  - Training on current and new health sector guidelines for all civil society service providers
  - Civil society to participate in the periodic health facility meetings

- Civil society working at the community to hold periodic meetings with VHW for coordination and collaborative response
- Quality assurance for CAGS; MMG and other community adherence support groups, service providers
- Inclusion in joint meetings with Village Health Workers and health facility staff;
- Implement social accountability programs for improved health service quality monitoring

### **Result Area 6.2: Strengthened networks of people living with disease, key populations, adolescents and young women to plan, deliver, monitor and sustain interventions**

Greater engagement of PLHIV, Key Populations and AGYW networks is a key missing link in demand creation for uptake of prevention and treatment aspect, Prevention with Positives- itself a critical aspect in incidence reduction- and in enhancing social protection, among other benefits. Interventions will include:

- o Financing and training of networks of people living with HIV
- o Training of up to 30,000 peers in HIV prevention, prevention with PLHIV, voluntary disclosure, stigma reduction and advocacy
- o Strengthening networks of organizations advocating for rights of and delivering services to key populations and vulnerable populations on SBCC; prevention; voluntary disclosure; referral; commodity monitoring service delivery and demand creation
- o Support development and sustainability of the national Key Population Technical Working Group
- o Enhanced engagement of people under TB treatment in service delivery e.g. prevention
- o Enhanced engagement in implementation of the NSP Communication Plan/ SBCC Strategy
- o Linkage of networks of people living with disease to LOMSHA and DHIS2 for easy follow up of access and patient tracking; provision of data for implementation science/ operations research
- o Greater involvement of adolescents living with HIV to train other adolescents on sexuality education and HIV prevention
- o Greater participation of People Living with Disease, Key Populations, Women and Adolescent Networks in community meetings; participatory assessments; program and survey designs
- o Joint monitoring coordination through regular feedback and information exchange meetings with Gender and Child Protection Unit of the Lesotho Mounted Police Service (LMPS) at community, including Mahokela, district and national levels

### **Result Area 6.3 : Strengthened and Resilient Community Systems**

#### **Strategies and Interventions:**

#### **Strategy: Integrate and strengthen community health information systems:**

#### **Interventions:**

- o Enhance integrated reporting between community and government structures. CSOs at community level will report through LOMSHA, which will in turn channel information to the DHIS 2.
- o Update DHIS 2 to include community and key population modules or indicators, which will be verified monthly, with all the health sector indicators.
- o Compliance in form of accuracy, consistency and timeliness will be monitored and weak organizations supported through joint M&E strengthening activities. Quarterly reports will be availed and published in a portal within 30 days of reporting.
- o Patient tracking tools at the community level, such as COMCARE, will be availed to CSO implementers across all districts.

- Standardize and digitize (computerize) the LOMSHA and HMIS systems and integrate into from community to tertiary hospital level.
- Build capacity of community health system (CSOs, FBOs, CBOs, CHW, PLHIV networks, KP networks etc.) in data collection

**Strategy: Strengthen Civil Society and Government Coordination in Policymaking, Program Coordination, Research, and Referral/ Feedback mechanisms:**

- Strengthen coordination between Government, Civil Society and Community Structures at national, district and community levels;
- Support for coordination meetings between government, civil society
- Support for inter CSO coordination (civil society constituency meetings and activities)
- Develop policies on coordination between government and civil society at local levels.
- Develop roles, responsibilities, outcomes, and monitoring systems to ensure civil society engagement in decision making and program monitoring.
- Engage CSOs in advocacy for improving the policy, legal and governance environments especially under Program Results 1 to 4.
- Develop contracting policies between government and CSOs including monitoring and accountability mechanisms;
- Update procurement policies to allow for civil society involvement in tender design and monitoring

**Strategy: Institute Strategic Human Resource Management at Community level**

- Engaging CSOs and community roles in identification, recruitment, training, quality assurance and management of community level health workers, especially in areas and interventions where government capacity is limited;
- Align coordination and capacity building of VHW and other cadres at community level
- Ensure adequate remuneration of CHW and work towards harmonization of salaries and incentives for health workers especially at primary level, in working towards value for money in HIV service provision and Universal Health Coverage
- Develop differentiated task shifting and task sharing models at district and intervention level

**Strategy: Support infrastructure, other resources and capacity building for communities to support service delivery**

- Providing infrastructure support to communities including health posts for AGYW; Khotla (male clinics); mobile clinics for outreach; computers, mobile phones and tablets for data capture, analysis and sharing; and similar;
- Provision of standardized information collection and sharing tools: registers, data entry sheets and software;
- Integration into DHIS2 and patient tracking modules
- Availing health products and commodities including condoms and lubricants, some medicines and others, including through quantification, distribution and storage support.
- Developing community capacity to research HIV program needs and design
- Developing and continuously monitoring CBO capacities in financial management, M&E and program implementation, referral, reporting and feedback with DHMTs

## **Program Result 7: Health System is people-centred, and sustainably integrates HIV, TB, Hepatitis and other infections by 2023**

Premised on the health sector strategy, this program result will focus on strengthening aspects of the health system that are most critical to delivery of the HIV, TB and other related disease programs in this strategic plan. It will lay the foundation for integration of HIV into the country's Universal Health Coverage strategy. Priority areas for attainment of Program Results will include strengthening Strategic Human Resources for Health; Procurement and Supply Chain Management; laboratory systems for effective service delivery; Health Management Information System, Sustainable Financing and Governance. Priority policy and governance strengthening strategies are described in the next section, while financial system strengthening is covered under Program Result 8.

### **Result Area 7.1: Human Resources for Health**

#### **Program Status:**

#### **Progress:**

While acute staff shortages still exist, the overall vacancy rate reduced from 43% during the previous year to 22% by 2015/2016. According to the Annual Joint Review report of FY 2015/16, about 50% percent of the health centers (GOL, CHAL, Red Cross run facilities) were staffed according to the minimum staffing requirements. Government continues to support health sector staffing despite a period of significant austerity while development partners and civil society play pivotal roles in financing additional staff. A transition plan is being developed to promote domestic sustainability of Human Resources.

#### **Challenges:**

- Acute staffing shortages persist. Up to 1000 people living with HIV are served by one doctor and three nurses
- Inadequate numbers and mix of human resources for health and difficulties in filling vacant established positions within the MOH structure;
- Attracting and retaining HRH by GOL is challenging;
- Over dependency on partner-seconded staff- PEPFAR, Global Fund and CSOs have hired more than 2000 staff, many of them in critical areas;
- Sustainability of MOH maintaining the services after partner support has ended;
- Staff salaries for similar positions vary depending on the funder;
- Allegiance of seconded staff is to their employers and not to MOH supervisors;
- Planning for transitioning seconded staff to the government payroll fails when the Ministry of Public Service is not consulted before signing agreements with donors to support staff;

#### **Strategies**

**Strategy: Review staffing gaps and expand staff capacities to support 95-95-95 targets and ensure accessibility:**

- Prioritize recruitment of lay counsellors; Health Assistants, Microscopists; Pharmacists, Pharmacy technicians, Viral Load Technologists; Nurses; CSO implementers; and data clerks;
- Expand service availability through task shifting; PPP and CSO partnerships

**Strategy: Strengthen quality assurance in all districts**

- Increase and monitor MOH QA and supervisory visits through DHIS2
- Engage civil society, academia and private sector in mentoring and QA;

**Strategy: Strengthen government ownership and integration of HRH**

- Engage MOPS and MOF in donor HRH negotiations and grant signing
- Review donor / financing agreements to include clauses for transitioning seconded staff to government pay roll and MOH inclusion in selection of staff
- Rationalize staffing through harmonization of salaries across MOH, donors; strengthening policies on seconding staff to work within MOH structure; and MOH engagement in planning
- Integrate and transition HIV into the national Universal Health Coverage financing strategy, through a rights-based approach, to ensure staff under HIV and TB program continue to be expanded as part of the overall national HRH approach.

**Result Area 7.2: Pharmaceutical Services**

Consistent with the National Medicines Policy, the MOH Pharmaceutical Department aims to ensure availability and accessibility of good quality medicines at an affordable cost. The National Health Policy 2011, Medicines Policy 2005 and National Health Strategic Plan 2011-2016 stipulate that MOH and partners will ensure availability of adequate quantities of safe and affordable medicines that are used rationally in the health sector, in accordance with Standard Treatment Guidelines, and are contained in the essential medicines list (EML). Roles of the Pharmaceutical Department therefore include policy formulation, product selection and rational use, drug regulation and quality assurance, storage of medicines in facilities, and dispensing among others.

**Program Status****Progress**

**Pharmacovigilance:** There is a functional National Pharmacovigilance Committee with finalized terms of reference.

**Human Resource:** Pharmacists and pharmacy technicians have been recruited and deployed to public health centers and hospitals in five districts (Maseru, Leribe, Berea, Mafeteng and Mohale's Hoek) through US Government support.

**Product Selection:** Product selection has improved significantly since 2011, with disease programmes seamlessly introducing new products and formulations to ensure appropriate regimens are used in the country. The pharmaceutical department adopted comparative registration and prequalification protocols to facilitate importation of products. The use of child-friendly formulations has significantly improved; The country currently uses appearance on products lists under the WHO prequalification scheme and United States Foods and Drugs Administration (FDA) as basis for selection and procurement.

**Rational Use of Medicines:**

- The Lesotho Essential Medicines List and Standard Treatment Guidelines (2017) were developed and disseminated to the health facilities with the support of World Bank and US Government.
- A National Antimicrobial Resistance Committee has been established, and its terms of reference endorsed by the Minister of Health. Committee members include Ministry of Health officers; Ministry of Agriculture and Food Security, Ministry of Tourism, Environment and Culture; Ministry of Water, academia, private sector, media, councils for health professionals, veterinarians and farmers, WHO and FAO, among others.
- Five technical working groups have been formed and oriented on combating antimicrobial resistance in line with the five strategic objectives of the Global Action Plan (GAP).
- **Drug regulation:** The Pharmaceutical Department controls the export and import of medicines through consignment import and export clearance permit issuance processes, and by requesting related documents in

compliance with World Trade Organization treaty obligations as well as Southern African Development Community protocols on health.

- Quality assurance: Health facilities have Standard Operating Procedures for pharmacy, which guide selection, and use of pharmaceuticals within health facilities.

### **Challenges**

- Shortage of human resource negatively impacts on rational use of medicines as pharmacists tend to focus uniquely on availing and dispensing medicines;
- Lack of a fully functional national drug regulatory agency has led to gaps in registration and product quality monitoring within the country.
- The pharmaceuticals department is implementing the outdated Orders of 1970 (Public Health Order and Medical, Dental and Pharmacy Order) which do not delegate it the necessary power for enforcement in regulating the conduct of the profession, or licensing of pharmacies and medicines use within the country, particularly medicines circulating within the private market.
- There are no reports from health facilities regarding pharmacovigilance issues such as products with quality problems and adverse drug reactions. Such data is very useful in drug selection processes at the central level.
- There is no funding to support capacity building on antimicrobial resistance or to establish stewardship programmes in health facilities.

### **Strategy: Strengthen pharmacovigilance system:**

- Establish pharmacovigilance and medicine information center
- Develop pharmacovigilance guidelines
- Monitor Adverse Drug reactions and compile periodic safety update reports through linking pharmacovigilance data with the DHIS2.

### **Strategy: Entrench regulation and quality assurance:**

- Enactment of the Medicines and Medical Device control Bill
- Establishment of the National Medicines Regulatory Authority.
- Establishment of a Pharmaceutical Laboratory
- Development of medicines testing guidelines and SOPs

### **Strategy: Support and quality assure product selection:**

- Establish a National Pharmaco-Therapeutics Committee to address specification, development and adaptation of the global and regional essential medicines lists for Lesotho; rationale use; among other roles;
- Review, updating, harmonization and optimization of the Lesotho Essential Medicines list and Standard Treatment Guidelines from which HIV/AIDs, STIs and TB, and others emanate, and optimise for fixed dose and newer formulations;
- Develop transition plans for the introduction, changes and phaseout of products.

### **Strategy: Ensure rational use of medicines to reduce development of drug resistance**

- Revive the district & hospital Pharmaco-therapeutic Committees
- Establish Antimicrobial Resistance Stewardship programme in health facilities.

### **Strategy: Expand human resources (Pharmacy):**

Government posts at all levels should be Created and placed equitably to address the lack of pharmaceutical structure with chain of command addressing decentralized pharmaceutical services and other challenges, as well as the structure of the Ministry of health for continuity, sustainability and retention of partner supported staff at the end of the contract period.

## Result Area 7.3: Laboratory Systems

### Program Status

#### Progress:

As part of improving and increasing access to HIV/TB diagnosis and treatment monitoring services; the capacity of laboratories has been strengthened at national and district levels. The national laboratory and strategic plans are in place. Viral load, EID and GeneXpert services are being decentralized and scaled up. Viral load testing coverage has increased to over 45% while POC EID rollout covers nearly 50% of facilities where EID services are being offered. EID is centralized at the NRL Molecular laboratory. DBS samples for EID testing are received daily. Although, priority is given to paediatric samples for qualitative PCR testing.

The national quality assurance programme is being implemented. Over 80% of HIV testing facilities participate in quality improvement activities with more than 90% of them recording improvement in the overall performance. Following best practice, the lab informs all clients of testing interruptions via a memo.

#### Challenges:

According to the Human resource plan for 2017, 60% of laboratory positions are vacant resulting in high workload and being a risk to treatment monitoring and VL;

- Key staff not trained on functionality of the remote management dash board to monitor testing quality for viral load and EID testing in all laboratories with LIS.
- Reagent stock outs were reported for viral load and EID testing in June 2016
- the TAT for EID is 7 days however due to the viral load backlog, EID TAT is 3 months.
- Weak procurement and supply chain management that led to frequent stock-outs of laboratory reagents.
- Long TAT for viral load test results and reporting.
- Performance verification of the new COBAS x4800 was limited to method comparison (accuracy) since lab did not have access to verification panels to verify the analytical measurement range (AMR) and linearity.
- Biosafety cabinet was overdue for service maintenance and pipettes not routinely calibrated. The latter was due to lack of weights and scales, and lack of SOPs to perform pipette calibration or funds to outsource pipette calibration.
- Centrifuges for plasma separation at the NRL and in district labs are not calibrated; general support for maintenance of equipment is required;
- Standard lab request form (LRF) exists for HIV viral load testing however the LRFs are incompletely filled by the requesting clinics. Specifically, the date and time samples are collected and separated were mostly missing from the LRFs reviewed. However, the lab indicates date and time of sample receipts in the lab information system (LIS) as well as on the LRFs. date-mark machines to record date and time on LRFs have been out of use since 2014.
- Equipment maintenance and servicing has not been consistent.

### Strategies and Interventions

#### Strategy: Assess and strengthen lab system capacity nationwide to meet scale up needs

- Adoption of strategic human resource management techniques to fill lab vacancies: contracting; hiring; training; outsourcing lab technologists and , clerks. ...
- Reduced TAT through decentralization and increasing access to Viral load, EID and TB of EID testing to district regional hospital labs and health centres including CAP/ CTM 96 platforms.
- Capacity building for clinicians and other HCW on the viral load testing algorithm to limit the number of VL test requests from patients not eligible for VL testing; Reinforce compliance to laboratory SOPs
- Revised sample transportation system to ensure only transport triple packaged specimens packed separately from the LRFs (ii) Retraining on safe handling of biological samples using WHO guidelines (iii) Procurement and use of adequate ice packs to transport frozen plasma samples;
- Updated viral load scale up plan according to the WHO (Treat all) guidelines

- Implement laboratory quality improvement. This will entail improved lab practices by developing guidelines, updating manuals and standard operating procedures; upgrading equipment; establishing sample storage and inventory system with an alert mechanism and electronic database to ensure adequate storage, tracking and /or retrieval of cryopreserved samples; Storage of plasma samples in frost free -20 °C and -80° C freezers;
- Ensured, continuous service provision by bundling all viral load platforms with comprehensive service contracts so that supplier of equipment or reagents is obligated to maintain equipment;
- Collaborate with Pharmaceutical Directorate to conduct surveys for pre-treatment drug resistance (PDR) and acquired drug resistance (ADR) based on the WHO global guidelines for HIVDR.

#### Result Area 7.4: Supply Chain Management

The Supply Chain Management Directorate supports forecasting/quantification, procurement of health commodities, and the logistics management system, among other roles.

##### Progress:

The Procurement and Supply Chain for Lesotho has steadily improved since conception in 2015, with virtually no stockouts reported for ARVs or second line TB medicines. The GHSC health facility monitoring report for one quarter in 2017 in five districts found 90%, 84% and 78% of health facilities in priority districts reporting no stock out of condoms, test kits and reagents respectively.

**Financing of medicines, medical devices and medical technologies:** The Government of Lesotho progressively moved to finance 100% of all first line TB medicines and at least 70% of all required ARV medicines based on the 2017/2018 budget; while partner commitments for laboratory diagnosis has steadily increased since 2011.

**Forecasting and quantification:** The Supply Chain Management Directorate (SCMD) and support from development partners (USAID) has improved standardization and reliability of national quantifications. The MOH quantification sub group conducts and reviews quantifications quarterly to inform government processes and procurement. MOH has successfully adopted the use standard tools for quantification of HIV and TB medicines namely Quantimed™ and QuanTB™ respectively and Pipeline Software for supply planning.

**Procurement of health commodities:** Lesotho has continued to use national systems to procure ARVs, TB medicines and laboratory commodities/equipment financed by government and PEPFAR hence building local capacity for laboratory procurement, the mechanism still requires a waiver from the Ministry of Finance since the reagents used are either machine-specific or rely on a sole supplier.

**Warehousing and last mile distribution:** NDSO distributes to the last mile (to all health facilities); with TAT of seven days or less, from receipt of regular orders and two working days for emergency orders. NDSO handling charges for products have been standardized. SCMD has adopted a hybrid system called “Informed push” for distribution of Category A products which include ARVs, Lab Products and others , to address the high workload and lack of skill in calculating the inventory parameters at health facility level.

**LMIS, Systems Quality Assurance & Coordination:** An integrated eLMIS has been rolled out for all products to be reported within one platform. The SCMD has been created to coordinate the overall national commodity supply management particularly quantification, procurement planning, LMIS and reporting, supply chain diagnostics, and supervision. The supply chain management TWG is inclusive of partners, programmes and key players at national level. All medicines can be sampled from health facilities for quality testing in an ISO-certified drug quality control laboratory. District logistics officers have been deployed to support supply management. A system has been developed to streamline distribution through either DHMTs or Health Facilities depending on implementer mandates and catchment areas.



## **Challenges:**

- Significant inadequacies in the quality of the data used to inform national quantifications, particularly VMMC, selected second line TB medicines.
- Despite standardization of the quantification tools, there has been inadequate training and orientation of national staff at SCMD and the District Logistics Officers in use of both Quantimed™ and QuanTB™ relevant for quantification and EWS.
- Unclear condoms and VMMC commodities planning system leading to stock piles due to parallel and uncoordinated procurement, distribution and financial systems.
- Significant delay in release of funds for procurement of medicines and health supplies and low amounts due to quarterly release warrants from MOF
- Current regulations do not allow for pre-financing/prepayment for orders as required by suppliers particularly GDF leading to long lead time.
- Procurement unit faces significant challenges in program giving appropriate specifications for requests and non-willingness to accept open bidding for some bids (laboratory);
- Delayed gazetting of the SCMD within the MoH structure may drastically affect delivery of global fast track results (95-95-95) as envisioned in this strategy;
- Prolonged procurement process for category B products (commercial products)
- Poor partners coordination by MOH at executive level, leading to inappropriate introduction of new initiatives and products;
- Difficulties in acquiring waivers from Ministry of Finance due to poor adherence to procurement regulations.

## **Strategies and Interventions**

### **Strategy: Improve MOH Supply Chain Management capacity:**

- Gazette SCMD and harmonize TOR with other units of MoH for effective functioning and supervision of national supply chains
- Develop Supply Chain Manual; SOPs and SCM M&E framework; forecasting and quantification methods; SCM indicators.
- Train relevant personnel on use of Quan TB, Quantimed™ tools and other quantification tools
- Advocate with MOF and other financiers such as GDF for review of financing agreements and timelines for procurement; and to allow for pre-financing/prepayment for orders as required by suppliers (Providing NDSO with funding while SCMD conducts audits and reconciliation)

### **Strategy: Strengthen the SCM Information System**

- Introduce informed push system for all programmes' products including Category B health commodities
- Improve Supply Chain partners coordination under the office of PS health and planning department
- The integrated LMIS system will be expanded for all programmes products to enable stock status data for improved M&E and decision making;
- Integration of newly developed Supply Chain M&E Framework indicators into LMIS and DHIS 2 and overall national M&E framework for health sector
- Improved inventory management of health commodities by introducing the electronic inventory management tool/ system.
- Support and build capacity of district TWG to validate supply chain data and build capacity at health facility level
- Continuously train district and facility staff on data analysis; visualization, and data use

### **Strategy: Enhance quality assurance, compliance and coordination of SCM**

- Fund supportive supervision and mentorship using the competence based approach (where an action plan is developed after assessment, supervision and action plan for areas of improvement contextualized to the recipient of support)
- Develop procurement plans and procure based on monthly supply plan results, especially for condoms and VMMC commodities
- Support partners coordination subgroup meetings and provide continuous updates to executive level
- Orient national and district teams (both state and non-state) periodically on compliance with procurement regulations

## **Result Area 7.5: Health Management Information Systems**

### **Challenges:**

- Non-integration of community, vulnerable group and key populations data into DHIS2
- Individual patient tracking currently not possible at a national scale
- Insufficient information sharing between the MOH and the partners
- HMIS is largely paper based for the rest of data
- Parallel health information systems leading to inefficiencies in resource utilization
- There is no overall DHIS2 roll out and sustainability plan
- No transitional plan for MOH from DHIS2, i.e. no research institution for long-term sustainability
- Limited data use at both central, district and facility level for effective programming
- Inadequate supervision and mentoring by central to districts and districts to facilities undermines data quality

### **Strategies and Interventions**

#### **Strategy: Integrate LOMSHA, NISSA, key populations and EMR and others into DHIS2**

- Expand parameters / indicators for collection and integrate community level information system (LOMSHA) including key population data into DHIS
- Introduce patient tracking through Unique Identifier and later apply blockchain technology to increase accuracy

#### **Strategy: Digitize and promote data analysis and use for policy formulation**

- Support periodic forums and channels for information sharing between program result areas, technical working groups and sectors
- Computerize and make mobile, HMIS and strengthen linkage from facility to national level

#### **Strategy: Enhance coordination towards a single sustained information system**

- Develop M&E Plan and enforce coordination by government; develop single tool and activity repository;
- Strengthen national capacity to manage the HMIS including tools such as DHIS; and strengthen research and dissemination capacities, including linkages with academia for sustainability;
- Develop capacities to collate, analyse and use data for policymaking and implementation science

#### **Strategy: strengthen data quality**

- Re-institute joint DQAs and supervision visits through this plan's multisectoral coordination framework (Described in Section 6); and
- Monitor the continuous conduct of joint supervision, including through consolidation of NAC, MOH, CSO, other sectors and development partner workplans supervision, mentoring and DQA/ verification budgets.

## Program Result 8: Increased efficiencies and financial investments in HIV and TB programs to 90% of the NSP budget by 2023

Result Area 8.1: Expanded financing for HIV Response

Result Area 8.2: Sustainability of the response with increased domestic financing

Result Area 8.3: Increased Value for Money (Efficiency, Economy, Equity and Effectiveness)

### Expected Outcomes:

- Increased funding for the HIV and AIDS Response (implementation and coordination) from domestic, external and other financial investments in HIV and TB from 60% to 90% of the NSP budget by 2023
- Increased domestic resources allocated for the HIV and AIDS response increased from 16% (of total contributions within and outside NSP) to 40% by 2023.
- Proportion of the budget allocated to prevention interventions increased from about 10% to at least 30% (Including prevention activities under Program Results 1, 2, 4,5, 6 and 7) by 2023

### Program Status

#### Progress:

#### Financial Landscape:

- Just about 70% of annual funding needs for HIV (Funding Landscape, 2018) has been available during the last three years. With growing needs under this strategic plan, this percentage of available funding falls to slightly annually by 2022/23. Even then, utilization / absorption of available funding has consistently fallen below 80% of the available funds. These trends are likely to continue unless both financial expansion and efficiency measures are implemented. Resource mapping and value for money audits have been planned to inform future program reviews.

National HIV Strategic Plan Funding Landscape (\$ Millions)						
Fiscal Year	2018/19	2019	2020	2021	2022/23	Total
Total NSP Resource Needs	188	204	218	227	236	1,076
Domestic Sources Total	36	47	47	45	45	220
External Sources Total	103	108	109	89	89	498
<b>All Sources Total</b>	<b>139</b>	<b>155</b>	<b>156</b>	<b>134</b>	<b>134</b>	<b>718</b>
% Funds available	74%	76%	72%	59%	57%	67%
Anticipated Funding Gap (\$ Millions)	49	49	62	93	102	358

- Domestic Financing: Commendably, government funds/ commits over 70% of the health sector budget. Government currently funds at least 70% of annual ART needs and provides about 30% of the available HIV program financing. There has been progress towards the government budget meeting Abuja Declaration goals from about 7% in the post-declaration years to at least 11% of GDP going into health sector funding currently. 15% of the recurrent budget (government revenue) is dedicated to the health sector, in the 2018-2019 budget. However, not all ministries allocate 2% of their budgets to HIV as required, and the large Social Assistance budget has not been adequately leveraged by the HIV Program.
- External Financing: While only about 70% of the funding is available, external partners provide slightly less than 70% of that available HIV budget. This amount has been growing from PEPFAR, which now provides

over 80% of the available external financing, while support to the HIV program from the Global Fund to fight AIDS, TB and malaria has halved between the last three implementation periods from about \$120 Million for 3 years in 2013-2015 to \$55 Million for the years 2018-2021.

- The rest of the budget is either unmet or may be traced through Out of Pocket spending, which is estimated to exceed 20% of domestic spending.

#### **Efficiency:**

- Utilization of available funding has consistently fallen below 80% of the available funds; still, this is an improvement from the 2011-2015 period when more than 30% of available financing from partners such as the Global Fund were returned to the donor.
- Tax and Public Financial Management systems have improved but can yet be strengthened to mobilize more funding and channel it faster.
- Optimal efficiency is yet to be achieved in the health system in the areas of procurement and supply chain management; health financing prioritization and utilization, allocation and public financial management; human resource management; service delivery and health information systems. Hard to reach areas face significant additional distribution and access costs in terms of availability of infrastructure and equipment.

#### **Challenges:**

- Over 30% NSP budget gap undermines attainment of strategic plan goals
- All sectors/ ministries are required to ring-fence at least 2% of their budgets for HIV and AIDS, but currently only a few contribute as stipulates while monitoring and financial channelling approaches are unclear, leading to a forfeiture of at least \$20 Million from various sectors annually;
- A systematically weakened NAC means that coordination and monitoring of financial and prioritization of spending has not been consistent
- Government directly supports about 11% of required HIV budget, excluding Human Resources and other health system support; while Two donors provide 49% of required HIV budget (including PEPFAR – 40% and Global Fund 9%)
- Small mix of partners funding TB response. Bulk of TB funding - about \$25 million over next three years-provided by two donors (World Bank \$15 million, including NRL, miners and other funding; with Global Fund supporting about \$10 Million.)
- Disaggregation of country into priority and sustenance/ maintenance districts undermining attainment of goals and quality of programs (HTS; Labs), especially in districts additionally funded exclusively by Global Fund.
- Prevention program is severely underfunded, with less than 15% of required budget available.
- Out of pocket financing for health is still high; at about 19% (World Bank GHO, 2015)
- Weak involvement of Civil Society and Community Systems undermining HIV spending capacity
- Inefficiency in programming; opportunities in cost reduction exist
- Transactional cost (time; expense; delays; resource requirements) of some external funding not commensurate with their proportional contribution to the budget; the country should consider an additionality approach or pooled funding of priorities;
- No recent value for money assessments (efficiency/ cost -effectiveness, equity, economy and effectiveness)
- No recent national expense tracking assessments
- There is still no sustainable mechanism such as an HIV Fund or national health insurance scheme to strategically channel public and private sector and out of pocket investments into the HIV program.

### **Result Area 8.1: Expanded financing for HIV Response**

**Strategy: Enhanced Fiscal space including through expanded financing, budget re-allocation and increased domestic resource mobilization**

- Expand available NSP financing by developing and approving a national financing/ resource mobilization strategy which includes acceleration of establishment of HIV Fund;
- Integrate HIV into Universal Health Coverage strategy
- Develop a public and private sector health subsidy/ insurance scheme under the Social Development/ Assistance sector
- Seek opportunities to ringfence funds for HIV and channel 2% earmarked funds through NAC;
- Mobilize additional investments from non-traditional external funders (PPPs for large infrastructure projects);
- Establish innovative financing mechanisms and increase private sector commitment;
- Increase external and private sector partnerships under NSP coordinating structures and provide social protection (and health insurance) subsidies to extremely poor and vulnerable populations, including women, orphans, the elderly, people living with HIV, among others.
- Encourage adoption of progressive tax systems

**Strategy: Increase absolute value of external and private funding for HIV (including from external partners, international foundations, private sector and civil society)**

- Increase external and private sector partnerships under NAC structures and provide social protection and health insurance subsidies to extremely poor and vulnerable populations, including women, orphans, the elderly, people living with HIV, among others.
- Develop a system of impact bonds for civil society and private sector implementers to be strengthened and ultimately reimbursed upon achieving verified NSP targets;
- Source short term technical support for resource mobilization and proposal writing to the HIV program and implementing partners including civil society to optimize funding from external sources; private sector and international foundations.
- Develop partnerships with Investment Guarantee agencies and mechanisms to mitigate international private sector investment risk and accelerate international PPP to invest in Lesotho's health facilities, infrastructure, equipment, training and quality assurance directly through guarantees by World Bank's Multilateral Investment Guarantee Agency (MIGA), China's SINOSURE, European Union trade guarantee mechanisms, US Government's Overseas Private Investment Corporation)
- Develop national partnerships with US Chapter 501 (3) (C) registered organizations (United States-registered tax exempt non-profit organizations) including those present in Lesotho, to jointly access a percentage of the \$8 Trillion international private foundation annual financial base.

**Result Area 8.2: Sustainability of the response with increased domestic financing**

**Strategy: Develop sustainable and integrated Universal Health Coverage, Social Assistance and HIV Financing Mechanisms**

- Gradually increase government allocation to HIV program
- Enforce compulsory government / line ministry contributions to HIV budget
- Expand integration of UHC and HIV financing into Environmental Impact Assessments for public and private capital projects and direct sectors to channel resultant financing through the AIDS Fund or National Health Insurance Scheme
- Establish HIV and UHC financing coordinating mechanisms under the executive (Office of the Prime Minister or Cabinet members) and include development partner/ donor coordinating structures in these structures

- Expand financing through budget re-allocation and increased domestic resource mobilization, including from private sector and individuals (for example, eventually developing a contribution mechanism while maintaining Out of Pocket expenditure at less than 20%)
- Convene an annual HIV Financing Conference
- Support finalization of the National Information System for Social Assistance (NISSA) to cover at least 95% of Lesotho, in order to more accurately forecast individuals in need of subsidy and social protection

### **Result Area 8.3: Increased Value for Money (Efficiency, Economy, Equity and Effectiveness)**

#### **Strategy: Institute Value for Money / efficiency audits on health programs and implement findings**

- Conduct value for money analyses including efficiency audits (Efficiency, Equity, Economy and Effectiveness) of allocations, transactional costs and expenditure on the HIV and TB programs at least once every two years;
- Reallocate financing to high impact and spending areas; match resource mobilization efforts to funders.
- Audit service delivery models, and efficiency of partners responsible for implementing each intervention in this strategic plan
- Adopt innovative ICT and digitize/ computerize the HIV program/ health sector including patient tracking through unique identifiers; HMIS/HRIS/LMIS/LOMSHA integration in DHIS2.

#### **Strategy: Reduce cost of public health purchases through strategic purchasing supported by appropriate changes in public finance rules and budget structure**

- Strengthen Public Financial Management to optimize UHC and HIV Financing and HIV program procurement of products and services; and strengthen districts and community capacity to more strategically expend;
- Strengthen MOH capacity to engage with ministries of finance and procurement management and oversight authorities and negotiate for more responsive Public Financial Management (PFM) systems and essential health commodity systems;
- Fully institute and implementation resource tracking/monitoring/mapping
- Track expenditures periodically to avoid wastage and inform future allocation processes
- Improve efficiencies in procurement of medicinal and health commodities
- Adopt contract bundling where equipment and reagent provision is contracted out together with obligation to maintain equipment; and payment premised upon uninterrupted equipment operation and results

#### **Strategy: Improve efficiencies in the health system**

- Develop and standardize a national and community health worker remuneration and incentive guidelines/framework for equitable distribution of health workforce and the right skills mix
- Prioritize HIV program staff needs based on 95-95-95, and gradually harmonize remuneration across development partners with MOH
- Link Human Resources for Health (HRH) information systems and integrate with the medicines logistics and financial management information systems.
- Develop master plans for streamlining infrastructure and increasing service delivery capacity
- Improve quality and reduce redundancies (e.g. unnecessary tests) by prioritizing improved management, availability, innovative capture and use of data; clinical guidelines; refresher trainings and financial incentives to prevent overuse and promote quality.

## 4. MANAGEMENT AND COORDINATION

### 4.1 Coordination of this Plan

The National AIDS Commission re-established under the Office of the Prime Minister in 2015/2016, exercises the overall legal mandate for coordinating the national response to HIV through implementation of this Strategic Plan. It exercises this mandate in partnership with other stakeholders through a multisectoral and decentralized framework. These include the Ministry of Health, Ministry of Local Government and Chieftainship and other non-state/ sectoral lead partners. It is envisaged that both coordination and management will be conducted in a participatory manner, within the existing National Coordination Framework (2016) which defines the roles of each stakeholder, sector and coordinating entity at national, district and health centre /community levels, premised on the Three Ones principles.<sup>14</sup>

Program Result Coordination: Program Results, monitored through indicators in the Results Framework are the main channels through which NSP interventions will be implemented. This approach responds to lessons and challenges from the previous strategic plan, which made it difficult for NAC to standardize reporting, enforce accountability from a large number of implementing partners funded differently and operating at national and decentralized levels. The approach will productively share tasks, risks, results and challenges with other stakeholders. Government and development partners have indicated sector leads for oversight and implementation of each of the eight Program Results. Civil Society and other sectors will build capacity to define Program Result leads.

#### Expected Outcomes:

- Strengthened and adequately resourced multisectoral structures that efficiently coordinate management, implementation, reporting and resource mobilization for the NSP
- Complementary community, civil society, key and vulnerable populations and PLHIV collaboration structures at national, district and community levels
- Successful and accountable delivery of each NSP goal and program result,
- Single, transparent and well enforced HIV/ Health information system capable of integrating data for planning, monitoring, reporting and using data at all levels in full compliance (At least 90% Timeliness, Consistency and Accuracy).

### 4.2 Policy, Governance, Advocacy and Resource Mobilization Structures

**The Office of the Prime Minister:** The Office of the Prime Minister (OPM) provides political leadership and good governance in the context of the national multi-sectoral HIV and AIDS response. It is responsible for advocating for improved political commitment, and sustainability of the response through adequate sustainable financing, national and community ownership. In addition, the office ensures an enabling social, policy and legal environment for the response.

**The Cabinet Sub-Committee on HIV and AIDS:** The Cabinet Sub-Committee on HIV and AIDS is chaired by the Deputy Prime Minister and comprises of Ministers of Health, Finance, Social Development, Gender, Education, and Local Government. The Committee reviews programmatic and management policy documents and proposals by NAC and advises the Prime Minister; Advocates for continued prioritization of HIV and AIDS response on the national social, economic and political agenda; Oversees NAC's compliance with the stipulations of the NSP, NAC Act, National HIV and AIDS Policy, other policies and laws; Advocates for sustainable financing of the national multi-sectoral response with Government and Development partners.

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<sup>14</sup> Office of the Prime Minister, National AIDS Commission (2016) National Coordination Framework.

#### **4.3 Roles of Structures for the Response:**

Stakeholders in the current response are clustered into public sector institutions, academia, media, private sector, organized labour, civil society, development partners, and beneficiary communities. Public Sector Institutions take the overall lead in coordination, collation of information and reports and churning them up the coordination hierarchy, to NAC.

#### **4.4 Roles of NAC under this NSP:**

Roles of NAC including the NAC Secretariat, as established under the NAC Coordination Framework are adapted here. NAC will coordinate, oversee and ensure prioritization of HIV prevention and treatment interventions, and strengthening of the enabling environment (Program Results 1 to 8) in collaboration with MOH, MLGC, MOSD, MOF and other sector leads; Steward mainstreaming in public and private sectors; providing a neutral leadership for the civil society response to HIV and AIDS; Coordinating with development partners on resource prioritization, mobilization and tracking; and lead on knowledge management and innovation. Furthermore, NAC will be expected to work with the cabinet subcommittee on AIDS and Ministry of Finance to ensure adequate domestic resource mobilization, including through channeling the 2% portion of budget from other ministries into HIV; work with the MOH to integrate HIV and TB fully into the Universal Health Coverage agenda towards 2030; regulate, monitor and oversee implementation of all aspects of this NSP, including all HIV programs in the country, using the Results Framework as a principal guide; collaborate with local and international agencies working on HIV and AIDS in the country, among other roles stipulated in the NAC Act. NAC will be revitalized through staffing at national level to better coordinate program results; strengthening of financial resource mobilization and management capacity; information system and research management.

Government and development partners have indicated sector leads for each Program Result. Civil Society and other sectors will define leads during 2018, to ensure seamless transition between coordination of implementation under the previous and current NSPs. Meetings for the structures will be jointly funded to ensure proper functioning of the system and collective achievement of each result.

#### **4.5 Public Sector Coordination and Roles of Government Ministries:**

Coordination at the National Level: Government institutions involved in the response include line ministries, parastatal organizations, and other semi-autonomous government agencies. This category also includes Cabinet, Parliament, and local authorities. The Ministry of Health has the mandate to coordinate and manage the health sector response to HIV and AIDS, particularly the biomedical interventions, as part of the national multisectoral response.

An Inter-Ministerial Committee on HIV and AIDS was established under the auspices of the Ministry of Public Service to support inter-ministerial coordination and networking. Sector institutions (government ministries and agencies) have appointed HIV and AIDS Coordinators / focal point persons, who facilitates HIV and AIDS workplace programmes.

Ministry of Health will continue to be the lead health sector agency for *implementation* of prevention, treatment and care interventions (Program Results 1, 2 and 3). Its roles will include regulation, formulation and review of health sector policies and guidelines on HIV prevention, treatment and care; strengthening, availing and quality assuring the health system including infrastructure and equipment, human resources at and linked to health facilities; pharmaceuticals, vaccines, health equipment and other technologies procurement and supply chain management; 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, key and vulnerable populations, among other roles.

The Ministry of Education and training will facilitate HIV and AIDS mainstreaming (delivery of all relevant interventions under Program Results 1 to 8), 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 menstrual hygiene kits; identification of SGBV survivors and other children in need of legal protection; among others.

The Ministry of Social Development is mandated to coordinate social assistance across the life-course stages. Through triangulation of the NISSA with the community information system in LOMSHA, MOSD will collaborate with HIV Program Result 5 implementers and be responsible for identification of the ultra-poor and poor PLHIV, and AGYW, orphans and vulnerable children (OVCs), elderly and child headed households and coordinate provision of social assistance under this Program Result to individuals. It will also identify individuals that qualify for other forms of social protection being provided by other ministries/ sectors to alleviate the social and economic impacts of HIV and AIDS for people living with HIV and those affected such as orphans and vulnerable children (OVC). MOSD will collaborate with NAC to coordinate identification and targeting of different levels of vulnerable individuals through NISSA and other means , will be responsible for ). HIV and AIDS sector coordinators are responsible for coordination of the sector responses.

The Ministry of Labour and Employment will be responsible for integrating all HIV program results 1-8 and policies in the workplace and surrounding communities, including in the formal sector and among migrant, factory workers, seasonal workers and the provision of social security to vulnerable individuals in collaboration with MOSD and other implementers.

Ministry of Finance will be responsible for the delivery of Program Result 8, in collaboration with NAC, under the oversight of the cabinet subcommittee on AIDS. It will enforce requirement for contribution of 2% of budgets by other ministries to HIV through various methods including through subtraction, earmarking and other methods to increase HIV financing.

The Ministry of Justice, Human Rights and Correctional Services will be responsible for implementation of Program Results 1 to 5 among prisoners, linking prisoners living with HIV to MOH, MOSD and MLGC structures, and collaborating with Ministry of Law and Constitution and the Ministry of Gender, Youth and Sports; and other stakeholders in the implementation of relevant aspects of Program Result 4.

Ministry of Agriculture and Food Security (MOA) will be responsible for training PLHIV through CAGs, AGYW and other vulnerable groups and communities to promote food security; providing nutritional counseling, measuring nutritional status and linking severely acute malnourished PLHIV and TB patients to relevant implementers (including MOSD, PEPFAR implementing partners) and health clinics, through Community Health Workers; and provision of seeds including those donated by the Food and Agriculture Organization (FAO) and other providers, to the most vulnerable. It will continue supporting supplementary and complementary feeding programs (including provision of super cereals to MAM), and assist PLHIV, OVCs and the elderly under Program Result 5 to prepare supplementary food provided by partners, while monitoring its correct use. The Ministry will also continue to conduct positive deviance studies to improve food security across the country, prioritizing the most vulnerable communities. The MOA will continue to avail/ second its human resources including District Agricultural Officers, nutritionists and Area Technical Officers throughout the country to promote nutrition and provide arbitrary assistance, among other interventions.

The Ministry of Local Government and Chieftainship is responsible for *coordinating* district and community-based HIV and AIDS interventions on behalf of government, under all Program Results (1 to 8), in collaboration with Ministry of Health DHMTs at district level and Health Facility Committees, Civil society and other partners. MLGC instituted the Gateway Approach which rolled out strategies to respond to HIV in a more coordinated manner and developed the Essential Services Package. MLGC was involved in community support; and oversaw District AIDS Committees and coordinators at community level. NAC will work with MLGC towards strengthening District and Community AIDS Committees to more efficiently coordinate the response on behalf of government, and other sectors. MLGC will continue coordinating with NAC through the office of the focal point for HIV and AIDS.

#### 4.6 Coordination at District and Community Levels:

**District AIDS Committees (DACs)**, under the auspices of the District Administrators within The Ministry of Local Government and Chieftainship coordinate at district level. The District Health Management Teams (DHMT) under the Ministry of Health are responsible for coordinating the decentralized health sector response. However, they work in collaboration with District and Community Councils that ensure the implementation of the Gateway approach.

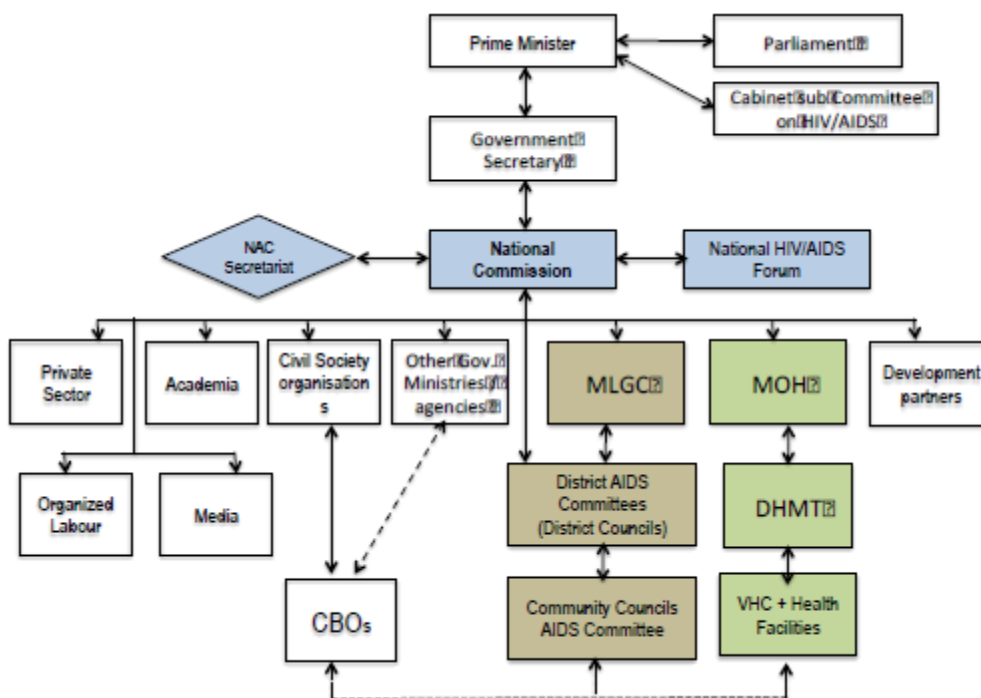
**Coordination at Community Level:** At community level coordination is facilitated by, Community Councils AIDS Committees (CCAC).

#### 4.7 Coordination among Non-State Actors - at National, District and Community Levels.

**Civil Society and Private Sector:** Civil Society Organizations include NGOs, Faith based organizations (FBOs), Organizations of people living with HIV and AIDS (including support groups), and community-based organizations (CBOs). Civil society organizations and the private sector are coordinated through umbrella organizations. Coordination between umbrella organizations will be strengthened under this plan, as part of Program Result 6.

**Development partners:** are coordinated through various forums including the Development Partners Coordination Forum (DPCF), National HIV and AIDS Forum, The Health Partnership Forum and the Joint UN Team on AIDS among others.

**Technical Working Groups:** At the interventions level, technical coordination, advisory, and progress reviews are performed through the Technical Working Group. These Technical Working Groups are coordinated under NAC, while the health system-specific groups convene under MOH, but still under NAC's coordination. These groups will be critical in guiding NSP operationalization and will be strengthened to reflect the desired program results and results areas of the NSP. The diagram illustrates the coordination framework and relationship between the different coordinating structures.



**National Coordination Framework for the Multisectoral Response.**

<b>LEVEL</b>	<b>Program Result 1:</b> 90% of people over 15 have accessed combination prevention by 2023	<b>Program Result 2:</b> Elimination of Mother to Child Transmission by 2023	<b>Program Result 3.: Test and Treat Cascade Fast Tracked to attain 95-95-95 targets by 2023</b>	<b>Program Result 4:</b> Gender and Human Rights Barriers removed	<b>Program Result 5:</b> Social Protection for 75% of PLHIV, at risk of and affected	<b>Program Result 6:</b> 40% community-led and sustainable response BY 2023	<b>Program Result 7:</b> Strengthened, people- centred, integrated Health System	<b>Program Result 8:</b> Increased efficiencies and financial investments in HIV and TB programs from 60% to 90% NSP budget by 2023
<b>OVERALL COORDINATOR OF NATIONAL HIV AND TB RESPONSE: NATIONAL AIDS COMMISSION</b>								
<b>PROGRAM RESULT COORDINATORS</b>	<b>NAC</b> - MOH -CSOs- UNFPA – PEPFAR (DREAMS); LCCM	<b>MOH-NAC-</b> CSOs- UNICEF	<b>MOH;</b> (SECTOR LEADS: LCCM, PEPFAR, NAC, CSOs, WHO)	<b>NAC</b> (SECTOR LEADS MGYSR, MLGC; UNDP; UNICEF, LCCM, CSOs)	<b>MOSD/ NAC</b> (SECTOR LEADS: MOA – FAO, MOSD)	<b>NAC</b> (SECTOR LEADS- CSOs and PVT-PEPFAR)	<b>MOH</b> (SECTOR LEADS: WHO LCCM PEPFAR CSO UNAIDS)	<b>MOF</b> (SECTOR LEADS- MOH-PEPFAR-LCCM-NAC- UNAIDS)
<b>National Level</b>	<b>Gen. Pop</b> MOH; NAC; CSOs <b>Key Pop</b> LCCM (PRs) <b>Vuln. Pop.</b> LCS & MOH	MOH; LCCM; Private Sector, Academia; Development Partners, Civil Society; Organized Labour; Media	<b>MOH,</b> Sector leads: NAC; LCCM; Office of First Lady; LCCM; MOSD; LCS; Academia; Private Sector	NAC, MGYSR, MLGC; Private Sector, Academia; Development Partners, CSOs, Labour; Media	NAC, Social Dev. & Min. of Police, Office of the First Lady; Pvt Sector; Acad; DPs; CSOs; Media; Org. Labour	NAC, MLGC Pvt Sector; Acad; DPs; CSOs;	NAC, MOH, MLGC, Inter-Ministerial Committee; Pvt Sector; Acad; DPs; CSOs	NAC, Inter-ministerial committee (Inc. OPM, Dev. Partners, LCCM; Pvt Sector; Acad; DPs; CSOs
<b>District Level</b>	<b>Gen Pop:</b> DHMT, IPs & MLGC <b>Key Pops:</b> DHMT, IPs/ CSOs <b>Vuln Pops:</b> MGYSR, CGPU, IPs, DHMT & MOET	MOH; IPs & DHMT; CGPU; MOET	MOH (DHMT), IPs & MLGC (NAC linkages); CSOs; MOSD	MGYSR, CGPU, MLGC; Min. of Law, CSO	Social Dev., WFP	MLGC (DA, DCS, TC)	MLGC, MOH	District Councils (Resource Mobilization & preparation of budget on HIV/AIDS specific interventions)
<b>Community Level</b>	<b>Gen Pop:</b> MOH (VHWs) & MLGC; Media <b>Key Pop</b> CSOs, MLGC <b>Vuln Pop</b> MLGC, MOET, CSOs & MGYSR	VHW and Health Facilities (MOH), MLGC; Academia; Private sector; CSOs, Labour; Media	VHW, Sputum collectors and HFs (MOH); MLGC; CSOs; SOCIAL DEVT; Academia; Private sector; Civil Society; Organized Labour; Media	MLGC; CSOs; VHW and Health Facilities (MOH); Academia; Private sector; Labour; Media	MLGC, CSOs; Academia; Private sector; Labour; Media	MLGC (CCS), CSOs; Academia; Private sector; Labour; Media	MLGC, VHW and H. Facilities; Academia; Private sector; CSO; Labour; Media	Community Councils (Resource Mobilization & preparation of budget on HIV/AIDS specific interventions); Media

## **4.8 Capacity Building Needs for Effective Coordination**

The above structures and entities will be strengthened to ensure compliance with the minimum standards set in this plan; and to define how information and evidence will be channelled, analysed and used to inform future policy decisions; and how major challenges in coordination will be addressed. The structures will be adequately financed to meet consistently as planned, and communicate both internally and externally.

### **4.8.1 NAC:**

To effectively coordinate this strategy NAC will need to be further revitalized through:

- Addition of strategic human resources at NAC Secretariat level to strengthen NAC's capacity to monitor and coordinate (harmonize) implementation of program Results 1 to 8 in partnership with the stated implementation lead partners from all other sectors, at national and decentralized levels.
- Adequate financial resources from domestic and other sources (at least 80% of the budget) to enable it to perform its core operations;
- Establishment of an information system/ dashboard integrating all HIV information and research to more ably provide multi-sectoral leadership in the context of HIV advocacy, policy and strategy development; integrating the health information system, and including subsidiary data sources such as NISSA and LOMSHA.
- Include executive representatives from Program Result implementing leads such as MOSD, MLGC, Ministry of Law and Constitution, among others, in the steering committee/ board of NAC and in each TWG and Program Result Coordination structures and orient them on the results of the new NSP.

### **4.8.2 Ministry of Local Government and Chieftainship**

To strengthen coordination at subnational level MLGC will be supported to:

- Update Terms of Reference of District Administrators to coordinate HIV and AIDS issues and lead the HIV response at district / decentralized levels
- Orient District Administrators and at least 10 Senior Information officers, community council secretaries, district council secretaries of MLGC on the expected NSP Program Results, Strategic Priorities, the SBCC strategy, coordination and Reporting processes.
- Disaggregate national and district level targets at community level and monitor the targets on a quarterly basis.
- Inspect community council activities through the inspection unit within the decentralization department of MLGC;
- Update training and M&E tool to include key aspects of HV NSP Results Framework; and include monitoring of coverage targets at community level;
- Revitalize Health Facility Committees (HFCs), monitor to ensure their meetings take place and monitor linkages between HFCs and community groups
- Link Social services committee members from MLGC to Program Result 5 coordinating structures
- Build capacity of staff at MLGC HIV and AIDS Unit at national level to better coordinate and link to NAC
- Rapidly assess and streamline MLGC structures at national, district and community level to align with the coordination needs of the HIV NSP
- Document and scale up community level best practices / signature processes ; and include findings of such documentation in efficiency audits to inform program implementation in collaboration with NAC and other stakeholders.

### 4.8.3 MOH

- Ministry of Health will require a HIV Coordination Manager to oversee, harmonize and report on implementation of Program Results 1 to 3,
- MOH will also require and a number of line officers to strengthen implementation of several Result Areas under these Program Results, including prevention (Condoms, VMMC, PrEP)

### 6.2.4 Civil society and Private Sector

The different capacity building needs for civil society have been outlined under Program Results 6 and in the National Operations Plan annexed to this document.

### 4.9 Risk Mitigation Plan

This table prioritizes the key risks and mitigation measures defined throughout the NSP development and multisectoral dialogue processes. It is the product of a risk, severity and impact analysis process with individuals. Other operational risks are addressed at intervention level.

Risk Category	Key Risk (+causality analysis; ranked by probability of occurrence and severity of effects)	Mitigation Measures	Timeline
Health services and health products quality risks	<b>Sample transportation and referral weaknesses; Delay in lab results</b> a. Inefficient referral system; b. Late arrival of samples, late results; c. Long laboratory response time; d. Quality of samples weak	Assess lab and develop lab systems strengthening plan a. Develop plan to improve referral network b. Purchase kits and packaging material for samples c. Expand electronic systems for referral d. Build capacity of laboratory staff	2018/19
Governance, Oversight and Management risks	<b>Weakened NAC due to insufficient financial and human resources; Weaknesses in coordination in reporting and compliance by implementers</b>  Low quality of and compliance in reports especially by externally funded implementers; Lack of a NAC-specific budget line Low compliance by line ministries with policy to earmark 2% of budget for HIV	<ul style="list-style-type: none"> <li>▫ Adequately finance NAC to coordinate the response</li> <li>▫ Monitor transfer of funding to NAC; advocate to OPM, MOF and donors for adequate funding and a NAC-specific budget line</li> <li>▫ Integrate and budget in the financial request the strengthening of NAC and Implementers</li> <li>▫ Budget for installation of NSP management dashboards/ Results Framework in DHIS 2 and establish its use</li> <li>▫ Strengthen enforcement of reporting compliance transparency and accountability policies within the coordinating structures</li> <li>▫ Adequately orient and incentivize community/ sector level</li> <li>▫ Link reporting requirements to NAC and MOH to job descriptions/ contracts across the health sector</li> </ul>	Institute Funding Monitoring System in 2018 and monitor throughout grant cycle
Health services and health products quality risks	<b>Interrupted services:</b> a. Lack of maintenance contracts b. Delayed implementation equipment procurement plans;	<ul style="list-style-type: none"> <li>a. Update the procurement plan annually</li> <li>b. Develop reagent rental contracts; Bundle equipment maintenance in contracts, with indicators of performance to ensure products always available and equipment always running</li> <li>c. Standardize and purchase laboratory equipment; advocate with MOF for caveats on procurement law for HIV program</li> </ul>	2018 and throughout implementation period
Governance, Oversight and Management risks	<b>Inadequate Coordination and Leveraging / Partnerships across sectors</b>	<ul style="list-style-type: none"> <li>(a) Strengthen data collection processes to manage quarterly reporting</li> <li>(b) Use DHIS 2 to facilitate reporting by NAC and Program Result coordinators and analyse information for decision-making</li> <li>(c) Inform NISSA and HIV information systems to enable integration of patients in need of support</li> <li>(d) Fund and conduct bi- annual value for money audits, joint annual reviews; quarterly district reviews and weekly management meeting</li> <li>(e) Properly institutionalize (aspects of the) gateway approach</li> <li>(f) Encourage development of District AIDS Plan aligned and operationalizing the NSP?</li> <li>(g) Clearly disseminate NSP to encourage district ownership</li> </ul>	

Programmatic and program performance	<p><b>Not achieving grant outcome and impact targets due to inadequate Coverage of Health Services</b></p> <p>(a) Human resource management issues; high turnover; low numbers of staff; uneven distribution and motivation.</p> <p>(b) Centralized Implementation;</p> <p>(c) Weak multi-sectoral engagement;</p> <p>(d) Poor understanding of efficient community engagement for prevention and treatment of diseases;</p> <p>(e) Low awareness of the needs and impact of the diseases by community leaders</p> <p>(f) Inadequate service delivery infrastructure</p> <p>(g) Inadequate community involvement</p>	<p>(a) Develop staff retention and development plan with performance based incentives and improved working conditions;</p> <p>(b) Strengthen NAC, civil society and MLGC to decentralize implementation and share responsibilities and targets with districts and communities</p> <p>(c) All prevention, treatment/ retention human rights, gender and care modules to sensitize duty bearers</p> <p>(d) Programs to review communication plans and make them culturally and community sensitive</p> <p>(e) Conduct leadership education programs;</p> <p>(f) Expand current service delivery systems e.g. health posts, lab, providers</p> <p>(g) Accelerate implementation of community engagement models in decentralization framework; strengthen CSOs and CSS under Program Result 6</p> <p>(g2) improve policy of community health workers engagement and remuneration.</p>	<p>Throughout period (a) HR Retention plan developed;</p> <p>(b) Financial decentralization plan</p> <p>(c) Develop Differentiated SBCC Strategy with targeted messaging</p> <p>(d) Update decentralization framework</p> <p>(e) Adequately fund and prioritize Program Result 6 implementation</p>
Health services and health products quality risks	<p><b>Inadequate quality of services</b></p> <p>(a) Low coverage of interventions impeding improvement of quality of diagnosis, especially TB, HIV and malaria.</p> <p>(b) Limited Coverage of interventions to improve the quality of treatment and disease prevention (VMMC, condoms, AGYW, etc)</p> <p>(c) Limited Coverage of interventions to improve the quality of management of resistance to HIV, TB</p> <p>(d) Inadequate adherence and retention in treatment, for PLHIV and MDR TB</p> <p>(e) Inefficient sample transport and long delays in delivering results to patients</p>	<p>(a) Develop Laboratory Systems Strengthening Strategy</p> <p>(b) Regular audit of case management and diagnosis</p> <p>(c) Adequately Fund M&amp;E Operational Plan</p> <p>(c2) Implement an integrated plan to improve the quality of services ; develop HIV DR Strategy</p> <p>(d) Develop an electronic patient tracking system, register and accelerate retention strategy for TB/HIV patients for use by health facilities and community workers; provide adherence support for HIV and TB patients; implement Social Protection under Program Result 5</p> <p>(e) Periodic M&amp;E of the network of laboratories and the transportation of samples to identify bottlenecks and take corrective measures.</p>	2018 and 2019
Financial and Fiduciary risks	<p><b>Low absorptive capacity</b></p> <p>(a) Lengthy verification, information and planning processes especially for variances</p> <p>(b) Informational gaps in planning and lack of knowledge on eligibility of some activities;</p> <p>(c) Lack of operational plan</p>	Stakeholders to anticipate and monitor donor verification process to include the time taken by MOF and donors to disburse, verify, revise and make corrections	Institute Funding Monitoring System in 2018 and monitor throughout grant cycle
Programmatic and program performance	<p><b>Inadequate M&amp;E data and issues in data quality; lack of baselines</b></p> <p>(a) Lack of information policy and M&amp;E Strategic Plan</p> <p>(b) Limited data analysis capacity, inferencing and use of strategic information for program planning</p> <p>(c) Inadequate quality of data, for decision-making</p>	<p>(a) Adequately finance implementation of the DIS and stakeholders will develop an information Policy and M&amp;E Strategic Plan</p> <p>(b) DIS and partners will implement a capacity building plan on data use;</p> <p>(ii) implement a supervision plan</p> <p>(c) Implement internal and external data quality audits</p>	Throughout Plan Period
Financing	Not all funding for prioritized populations and interventions may be received on time; and not all may be allocated to priority interventions	Focus on high impact and cost-effective interventions prioritized in this plan; Update MOF policies on pre-financing to allow pre-financed emergency procurements and services; and issuing of social impact bonds or pay for targets met, to civil society and private sector investors	
External Risks	<p>a) Changing weather patterns have resulted in food insecurity</p> <p>b) Macroeconomic fluctuations including in currency</p>	<p>a) Establish emergency health contingency budget</p> <p>a2) Prioritize PLHIV and affected populations under Program Result 5 in NISSA</p> <p>b) Earmark some HIV/ emergency funding in foreign reserves; adopt mechanisms to protect currency and contracts, such as forward / spot contracts with suppliers depending on economic trends</p>	During and after plan period

## 5. MONITORING AND EVALUATION

Currently, strategic information for HIV and TB is collected, stored, managed and shared through disparate systems. The principal mode is the Health Management Information System (HMIS), managed by the Ministry of Health, which collects data from a variety of sources within the health sector and processes it through the DHIS 2 software. Community and other non-health sector routine data is processed and managed through Lesotho Output Monitoring System for HIV and AIDS (LOMSHA), managed by the National AIDS Commission. In addition, development partners such as PEPFAR and Global Fund collect intervention data including ART, Key Populations and vulnerable groups through their own systems and process these internally. Civil society and other implementers also collect information on key populations and other areas. Beyond the health sector, other public-sector entities such as the Ministry of Social Development, Ministry of Agriculture, Ministry of Labour and Ministry of Finance, among others collect information including tiered data on individuals in need of assistance through the National Information System for Social Assistance (NISSA), those in need of or receiving welfare assistance, and other targeted benefits. These sources will initially be harmonized through a database and modules linking community, priority population, intervention, patient record/ tracking, human rights, value for money and other modules in the LOMSHA, NISSA and onwards to the DHIS 2 platform on a national scale. Data quality assessments, M&E supervisions and validations will also be standardized and conducted jointly.

**Health Information System scale up and sustainability plan:** MOH, NAC, PEPFAR, LCCM and other partners will collaborate to develop a Health Information System scale up and sustainability plan. Besides integration of data and patient tracking systems (using unique identifiers or blockchain technology for patient tracking, or both), computerization of the HMIS system will be expanded to all health facilities, and private facilities with a large volume of patients also linked to feed into DHIS 2. This will entail a nationwide capacity building process. Data and information sharing systems will be created at community, district and national levels based on the NSP Program Results coordination framework. An automated dashboard updating key indicators on a quarterly basis will be shared with all stakeholders through the ubiquitous DHIS 2, available on mobile phones, tablets and computers.

**Results Framework and Indicator Reference Sheet:** A Results Framework outlining baselines, annual targets and standardizing indicators to be collected is annexed to this plan.

**Monitoring and Evaluation Plan.** An M&E Plan developed to accompany this NSP Outlines Indicator Definitions, Reference Sheets and Measurement

- Describes data Management processes through the routine data reporting system
- Outlines purposes, strategies and plans for the collection, management, analysis and use of non-routine information from the joint AIDS/TB Program Reviews of 2018 to 2023; Evaluations, Surveys such as LePHIA and DHS; IBBS and Size Estimation of FSW, MSM and other populations; HIV Recency Testing, community participatory reviews, district reviews and partner reviews, among others.
- Guides on Data Quality Assurance Mechanisms and Related Supportive Supervision and Mentoring
- Outlines how M&E systems will be coordinated, within Program Results, accountability for results at each level
- Outlines which and how monthly, quarterly, semi-annual, annual and multi-year information products (reports, newsletters; dashboards, and other) / newsletters and reports will be disseminated, and their intended purpose and use at community, district and national level to improve the HIV/TB Program Performance.
- Describes the multisectoral review mechanisms at each level of the health system, that will assess sector and program performance against coverage and outcomes annually, and impact at the end of the strategy period
- Outlines how progress and performance will be assessed and how information will be used to improve policies and future implementation
- Describes processes to identify corrective measures and feed back to communities, facilities, districts, sectors and funders
- Estimates a budget for M&E and outline how it will be funded.

## 6. RESOURCE NEEDS ESTIMATES

Resource Needs Estimates were developed by finding the product of targets in the NSP 2018-2023 Results Framework for each intervention and prevailing Unit Costs / UEs, run through the Spectrum Resource Needs Model. During the five years between 2018 and 2023, Lesotho will require \$ 1.1 Billion US Dollars for the entire HIV response. This includes \$ 188 M required during 2018/19; \$204 M in 2019/20; \$ 218 M in 2020/21; \$ 227 M in 2021/2022 and \$236 M in 2022/2023. Resource needs will grow marginally by 8% and 7% between 2020 and 2021, and then grow on a reducing scale, at 4% from 2022. Following is a disaggregation of annual resource needs by Program Result and intervention.

TABLE: LESOTHO HIV NSP 2018 - 2023 COST ESTIMATES

	2018/19	2019/20	2020/21	2021/22	2022/23	Total
<b>Intervention</b>						
<b>Combination Prevention</b>	<b>21,732,130</b>	<b>24,165,374</b>	<b>27,569,560</b>	<b>29,196,387</b>	<b>30,861,687</b>	<b>133,525,139</b>
PICT/ Facility Based Testing	3,125,669	2,885,983	2,742,396	2,550,610	2,406,862	13,711,520
Community Based Testing including index and self	1,683,052	1,923,988	2,068,825	2,261,862	2,406,862	10,344,590
Social Behaviour Change Communication - (15-24 years)	-	386,840	1,555,889	1,588,975	1,622,766	5,154,470
Voluntary Medical Male Circumcision	4,969,644	4,970,936	4,972,228	4,973,521	4,974,814	24,861,142
Condoms	1,246,000	1,358,353	1,470,764	1,583,234	1,721,789	7,380,141
Gender Based Violence	510,421	515,692	519,697	521,742	522,534	2,590,085
Pre-exposure Prophylaxis (PrEP)	1,780,950	3,237,241	4,740,814	6,322,729	7,903,915	23,985,650
Adolescent Girls and Young Women (AGYW)	1,150,138	1,174,597	1,199,575	1,225,084	1,251,139	6,000,534
Female Sex Workers (FSW)	190,074	190,124	190,173	190,223	190,272	950,866
Men having Sex with Men (MSM)	608,637	850,331	1,373,865	1,374,222	1,374,580	5,581,636
Inmates	8,215	9,031	9,478	9,480	9,483	45,687
Mobile/Migrant Populations	764,090	870,656	952,354	952,601	952,849	4,492,550
eMTCT - Women receiving ARV prophylaxis	2,585,093	2,683,597	2,718,790	2,649,884	2,605,510	13,242,873
eMTCT - Infants Tested	3,110,148	3,108,004	3,054,711	2,992,219	2,918,313	15,183,394
<b>Treatment, Care and Support</b>	<b>70,780,584</b>	<b>76,741,973</b>	<b>81,021,422</b>	<b>84,349,585</b>	<b>87,431,564</b>	<b>400,325,128</b>
Antiretroviral Therapy	58,240,083	63,779,316	67,736,665	70,787,647	73,584,484	334,128,194
Treatment Monitoring (Viral Load)	2,610,688	2,706,489	2,781,003	2,855,899	2,951,400	13,905,479
Treatment Adherence Support - Nutrition	2,916,406	3,193,235	3,390,944	3,543,000	3,682,057	16,725,642
TB HIV Collaboration - IPT	7,013,407	7,062,934	7,112,810	7,163,039	7,213,623	35,565,813
<b>SUB-TOTAL</b>	<b>92,512,714</b>	<b>100,907,347</b>	<b>108,590,982</b>	<b>113,545,972</b>	<b>118,293,251</b>	<b>533,850,267</b>



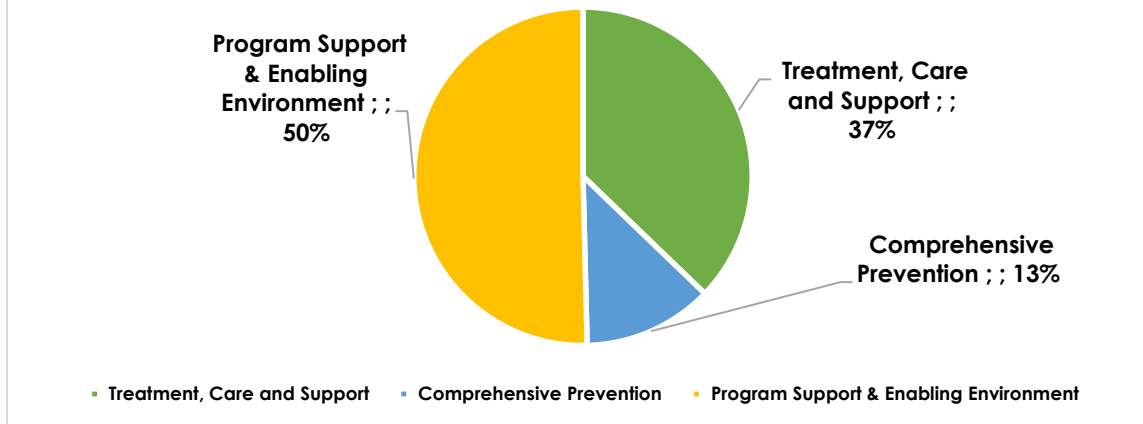
<b>Program Support &amp; Enabling Environment</b>	<b>96,327,767</b>	<b>103,467,805</b>	<b>110,003,496</b>	<b>114,219,840</b>	<b>118,259,630</b>	<b>542,278,538</b>
Human Rights and Gender Related Barriers to Access, Utilization and Delivery	1,850,254	2,018,147	2,171,820	2,270,919	2,365,865	<b>10,677,005</b>
Gender Norms	1,850,254	2,018,147	2,171,820	2,270,919	2,365,865	<b>10,677,005</b>
Socio-cultural barriers to HIV services	1,850,254	2,018,147	2,171,820	2,270,919	2,365,865	<b>10,677,005</b>
HIV-Sensitive Social Protection	4,625,636	5,045,367	5,429,549	5,677,299	5,914,663	<b>26,692,513</b>
Support Packages for Orphans and Vulnerable Children	17,691,960	17,696,560	17,701,161	17,705,763	17,710,367	<b>88,505,811</b>
Community Systems Strengthening	11,101,526	12,108,882	13,030,918	13,625,517	14,195,190	<b>64,062,032</b>
Health Management Information Systems	11,101,526	12,108,882	13,030,918	13,625,517	14,195,190	<b>64,062,032</b>
Procurement and Supply Chain Management	18,502,543	20,181,469	21,718,196	22,709,194	23,658,650	<b>106,770,053</b>
Laboratory Systems and Equipment	13,876,907	15,136,102	16,288,647	17,031,896	17,743,988	<b>80,077,540</b>
Program Governance, Policy and Coordination	12,026,653	13,117,955	14,116,828	14,760,976	15,378,123	<b>69,400,535</b>
Finance and Sustainability	1,850,254	2,018,147	2,171,820	2,270,919	2,365,865	<b>10,677,005</b>
<b>Total Millions of USD</b>	<b>188,840,481</b>	<b>204,375,152</b>	<b>218,594,478</b>	<b>227,765,812</b>	<b>236,552,882</b>	<b>1,076,128,805</b>

### **Analysis of Resource Needs for the HIV Response**

Of the required resources, \$542 Million (50%) will be mobilized or leveraged during the five years 2018-2023 to create an enabling environment through the health, social development, law, gender, local government, finance and other sectors. Health system support will include procurement and supply chain management, human resources, strengthening community systems, engaging civil society and key population networks; Gender and Human Rights program support; ensuring HIV -sensitive social protection and coordinating the entire NSP implementation across all sectors. Not all resources will be mobilized only through the HIV Program therefore since much of the funding can be leveraged through better integration and coordination with other sectors. To illustrate, by 2013 the Government of Lesotho was already spending \$197 Million, or 9% of her GDP on Social Assistance annually. Much of the \$115 Million required by the Social Protection Program Result for five years can be leveraged by ensuring that the National Information System for Social Assistance is informed by the HIV information system to prioritize ultra-poor and poor people living with HIV and most vulnerable groups covered in this NSP.

The HIV program would therefore add value by providing precise information, sharing its platform for coordination at the Office of the Prime Minister with MOSD, MLGC, MOA, and MOE to better coordinate social assistance; and by orienting, updating and informing stakeholders on the NSP and its M&E framework. Similarly, for Program Result 7, the MOH domestic budget would be expected to cover a significant portion of the identified needs, while leveraging on the HIV Program to raise additional funds for the latter's unmet priority needs.

## NSP Estimated Resource Needs: 2018/19 -2022/23



**Combination prevention (Program Result 1)** will account for \$133 M, (12%) of all resources. Differentiated HIV Testing Services (HTS) will account for a further \$24 M, representing 2% of total NSP costs. Of the HTS funding, community-based testing will account for \$14 M while Facility-Based testing will account for \$10 M.

**Treatment, care and support needs (Program Result 2)** will require \$ 400 M (37%) during the five years. This will include the cost of ART, viral load monitoring, adherence support and management of TB and other opportunistic infections.

**EMTCT (Program Result 3)** will require \$28 M over the next five years, amounting to 3% of total NSP costs between 2018 and 2023. \$15 M of this will fund Early Infant Diagnosis and \$13 M for ARV prophylaxis for expectant mothers ; Prong 1 and Prong 2 costs have been included as part of the combination prevention Program Result (1).

The five Program Results (4 to 8) dedicated to creating an enabling environment, will cost an estimated \$542 Million during the five years.

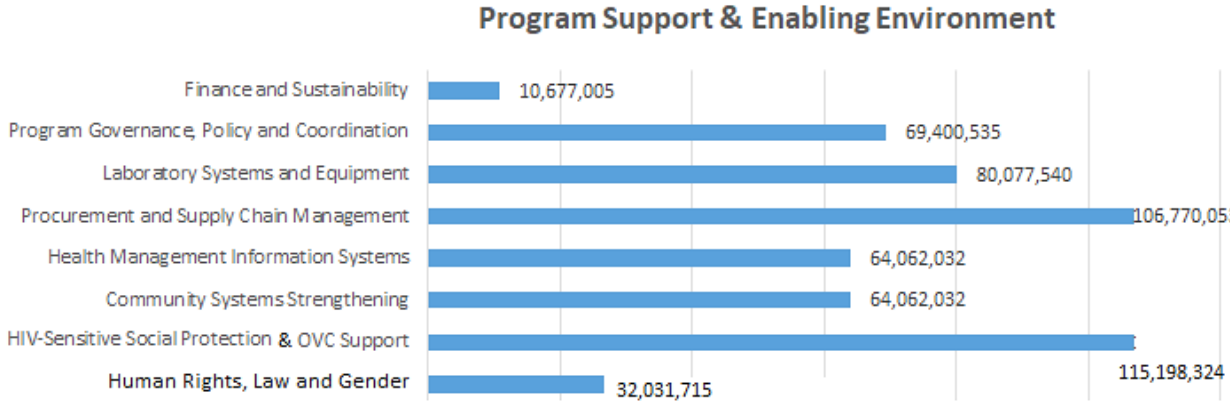
**Program Result 4** (Gender and Human Rights related barriers to service delivery, accessibility and utilization removed by 2023) will cost \$ 32 Million, or 3% of the total NSP five-year budget.

**Program Result 5** (Strengthening national social and child protection systems to ensure 75% of PLHIV, at risk of and affected by HIV including OVCs benefit from HIV-sensitive social protection by 2023) will cost \$115 Million or 11% of the total budget.

**Program Result 6** which includes activities to strengthen civil society engagement and strengthen community systems, towards ensuring that current CSO implementation improves from 30% to at least 40% of the response budget is community led and sustainable by 2023, will require an additional \$64 Million or at least 6% of the entire budget.

**Program Result 7** (Ensuring that the Health System is people-centred, and sustainably integrates HIV, TB, Hepatitis and other infections by 2023) , will require \$ 320 M, or at least 30% of the NSP five-year budget. This cost will include Human Resources and other service delivery (subsumed under Program Governance, Policy and Coordination- \$69M, (or 6% of NSP budget). It is estimated that at least 60% of this budget will be utilized at district level, for coordination, management and oversight purposes. Laboratory Systems (\$80M- 7%), Supply Chain Management (\$106M or 10%, of the budget, excluding costs of medicines, vaccines and other health products and commodities, which are included under Program Results 1, 2, 3, 4, 5 and 6 as required); and Health Management and Information System (\$64 Million- 6%).

**Program Result 8** (Increasing efficiencies and financial investments in HIV and TB programs to 90% of the NSP budget by 2023) will require \$11 Million, or 1% of the entire NSP five-year budget.



## ANNEX 1: RESULTS FRAMEWORK

Progress in implementing the strategic plan will be measured against the below results framework. The M&E Plan will be extended from the annual targets presented. Progress in implementing the strategic plan will be measured against the below results framework. The M&E Plan will be extended from the annual targets presented.

### The Goals of the Lesotho National HIV/AIDS Strategic Plan 2018 to 2023

1. Reduced new HIV infections from 13,300 in 2017, by at least 50% by 2023.
2. Reduced AIDS related deaths by 50% by 2023, from 4900 in 2017.
3. Mother to child transmission of HIV eliminated, from 11.3% to less than 5%, by 2023.

Results Level	Indicators	Disaggregation	Baseline	Data Source	Target 2018/19	Target 2019/20	Target 2020/21	Target 2021/2	Target 2022/3
Impact	1.1 Number of new HIV infections	All Adults: 15+	13,300	Spectrum Estimates	--	--	8,100	--	4,100
		Adults 15+: Male	5,900	Spectrum Estimates	--	--	3,500	--	1,800
		Adults 15+: Female	7,500	Spectrum Estimates	--	--	4,700	--	2,300
		Young People: (15-24)	5,000	Spectrum Estimates	--	--	2,500	--	1,250
	Number of AIDS-related deaths	All	4,900	Spectrum Estimates	--	--	3,600	--	2,800
		Adults 15+: Male	2,000	Spectrum Estimates	--	--	1,400	--	1,000
		Adults 15+: Female	2,000	Spectrum Estimates	--	--	1,600	--	1,300
		Young People: (15-24)	240	Spectrum Estimates	--	--	170	--	125
	% of people living with HIV in the reporting period with suppressed viral loads ( $\leq 1000$ copies/mL)	Adults (15-59)	67.70% (M=63.4%) (F=70.5%)	LePHIA Population survey	---	---	78%	---	85%
		Young People: (15-24)	51% (M=51.3%) (F=50.9%)	LePHIA Population survey	---	---	71%	---	85%
Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	All	86%	HMIS	90%	93%	95%	95%	98%	
Percentage of child HIV infections from HIV-positive women delivering in the past 12 months	--	11.30%	Spectrum Estimates	--	--	7.50%	--	<5%	

**Program Result 1: 90% of people aged 15 and over at risk for HIV have accessed combination HIV prevention by 2023**

<b>SBCC Result: Comprehensive knowledge about HIV and AIDS increased by at least 60% by 2023</b>									
Outcome	Percentage of women and men aged 15-49 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Adults (15 – 49): Male	31%	DHS Population survey	---	---	45%	---	60%
		Adults (15 – 49): Female	39%	DHS Population survey	---	---	50%	---	65%
		Young People (15 – 24): Male	31%	DHS Population survey	---	---	45%	---	60%
		Young People (15 – 24): Female	38%	DHS Population survey	---	---	50%	---	65%
Outcome	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Males	23%	DHS Population survey	---	---	15%	---	10%
		Females	5.30%	DHS Population survey	---	---	3%	---	1%
Coverage	% of young people aged 15 – 24 reached with HIV prevention programmes during the last 12 months (e.g. CSE, DREAMS)	Sex	TBD	LOMSHA	70%	75%	80%	85%	90%
Coverage	# of individuals (aged 10+ years old) reached with HIV prevention programmes during the last 12 months	Sex	N/A	LOMSHA	500,000	580,000	650,000	720,000	800,000
<b>Voluntary Medical Male Circumcision (VMMC)</b>									
<b>Result: Quality Male Medical Circumcision Scaled Up and 50% of males circumcised by 2023</b>									
Coverage	% of males aged 15-49 medically circumcised according to national standards	Young men (15 – 29)	29%	DHS Population Survey	---	---	55%	---	80%
		Adult men (15 – 49)	23%	DHS Population Survey	---	---	36%	---	50%
Coverage	Number of VMMCs per annum	All ages	34,157	HMIS	45,000	45,000	45,000	45,000	45,000
<b>Condoms and Lubricants – promotion and distribution</b>									
<b>Result: Condom use among general population engaged in risky sexual behaviour increased by at least 90% by 2023</b>									
Outcome	Percentage of adults aged 15–49 who had sex with a non-regular sexual partner in the past 12 months who report the use of a condom during their last intercourse	Adults (15-49): Females	76%	DHS	---	---	84%	---	90%
		Adults (15-49): Male	76%	Population Survey	---	---	84%	---	90%
Coverage	No of condoms distributed/sold per man (15-64)	Male Condoms	53	HMIS	55	57	60	60	60
Coverage	Number of male and female condoms distributed annually	Male Condoms	30 Million	NDSO issue records	32 Million	34 Million	36 Million	38 Million	40 Million
		Female Condoms	437,000		550,000	650,000	750,000	850,000	1,000,000
<b>Pre-exposure prophylaxis (PrEP)</b>									
Coverage	% and Number of people who received oral PrEP at	Young women (15 – 24)	TBD	HMIS	5,000	7,900	11,100	14,800	18,500

	least once during the last 12 months	(10% of 185,000 HIV-YW)							
		Discordant couple (80% of 38,000)	TBD	HMIS	6,000	12,000	18,000	24,000	30,000
		MSM (20% of 7,700 HIV-MSM)	TBD	HMIS	310	620	930	1,240	1,540
		FSW (50% of 1,800 HIV-FSW)	TBD	HMIS	180	360	540	720	900
<b>Key populations Results (MSM, SW, Inmates, Transgender)</b>									
<b>Result 1: Comprehensive knowledge about HIV and AIDS increased by at least 50% by 2023 for young people and key populations adopt safer sexual behaviour</b>									
<b>Result 2: Condom use among key populations engaged in risky sexual behaviour increased by at least 90% by 2023</b>									
<b>Result 3: HIV testing, and counselling services scaled up and at least 90% for key populations who know their HIV status by 2023</b>									
Outcome	Percentage of key populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	MSM	N/A	IBBSS	---	---	40%	---	50%
		FSW	N/A		---	---	40%	---	50%
		Inmates (Prisoners)	N/A		---	---	40%	---	50%
		Mobile/Migrant	N/A		---	---	40%	---	50%
Outcome	Percentage of key populations reporting use of a condom with their most recent partner	MSM	<a href="#">76%</a> [1] (Casual male partner)	IBBSS	---	---	85%	---	90%
		FSW	<a href="#">83.4%</a> [2] (Regular client)		---	---	85%	---	90%
		Inmates (Prisoners)	N/A		---	---	85%	---	90%
		Mobile/Migrant	N/A		---	---	85%	---	90%
Coverage	Percentage of key populations who received an HIV test in the last 12 months and who know the results	MSM	<a href="#">58%</a> [3] (Ever tested>1x)	IBBSS	---	---	85%	---	90%
		FSW	<a href="#">61%</a> [4] (Ever tested>1x)		---	---	85%	---	90%
		Inmates (Prisoners)	N/A		---	---	85%	---	90%
		Mobile/Migrant	N/A		---	---	85%	---	90%
Coverage	Percentage of key populations reached with HIV prevention programmes	MSM	<a href="#">48%</a> [5] (Received HIV prevention information between men in the past year)	IBBSS	---	---	85%	---	90%
		FSW	<a href="#">24%</a> [6] (Participated prevention)		---	---	85%	---	90%
		Inmates (Prisoners)	N/A		---	---	85%	---	90%
		Mobile/Migrant	N/A		---	---	85%	---	90%

**Program Result 2: Mother to Child Transmission Eliminated and 95% of children living with HIV on treatment by 2023**

**Elimination of Mother to Child Transmission (eMTCT)**

*Result 1: Mother-to-child transmission of HIV during pregnancy, child birth and breastfeeding reduced to less than 5% by 2023*

*Result 2: Access to lifesaving treatment for HIV+ pregnant women increased to 100% by 2023 and AIDS-related maternal deaths substantially reduced*

Coverage	Percentage of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission increased by 2023	---	66%	HMIS & Spectrum Estimates 2017	75%	80%	85%	90%	95%
Coverage	Percentage of infants born to women living with HIV receiving a virological test for HIV within 2 months of birth	---	93%	HMIS	95%	97%	98%	99%	100%
Coverage	Percentage of pregnant women who know their HIV status	---	93%	HMIS	95%	98%	100%	100%	100%
Coverage	Percentage of women accessing antenatal care services who were tested for syphilis	---	73%	HMIS	---	---	100%	100%	100%

**Program Result 3: Test and Treat Cascade Fast Tracked to attain 95-95-95 targets by 2023**

**HTS**

*HTS Result: HIV testing, and counselling services scaled up and at least 95% people who know their HIV status by 2023*

Coverage	% of women and men aged 15-49 years who received an HIV test in the last 12 months and who know their results	Adults (15 – 49): Male	36%	DHS Population Survey	---	---	85%	---	90%
		Adults (15 – 49): Female	58%		---	---	85%	---	90%
		Young People (15 – 24): Male	28%		---	---	85%	---	90%
		Young People (15 – 24): Female	54%		---	---	85%	---	90%
Coverage	% of women and men aged 15-59 years living with HIV who know their HIV status	Adults (15-59)	77%	LePHIA Population Survey	---	---	90%	---	95%
		Adults (15 – 59): Male	71%		---	---	90%	---	95%
		Adults (15 – 59): Female	82%		---	---	90%	---	95%

		Young People (15 – 24):	56%		---	---	90%	---	95%
		Male							
		Young People (15 – 24):	63%		---	---	90%	---	95%
		Female							
<b>ART</b>									
<b>Result 1: At least 95% of Adult and Children living with HIV who know their status receiving antiretroviral treatment by 2023</b>									
Outcome	<b>95-95-95</b> % of all people living with HIV who know their HIV status, % of all people with diagnosed HIV infection who received antiretroviral therapy and % of all people receiving antiretroviral therapy who have viral suppression	All	77-90-88	LePHIA	---	---	90-90-90	---	95-95-95
		Adults (15-59):	71-89-88	Population Survey	---	---	90-90-90	---	95-95-95
		Male							
		Adults (15 – 59):	82-91-88		---	---	90-90-90	---	95-95-95
		Female							
		Young People (15 – 24)	60-88-78		---	---	90-90-90	---	95-95-95
Outcome	Percentage of adults and children living with HIV infection receiving antiretroviral therapy at the end of the reporting period	All	62%	HMIS & Spectrum Estimates	72%	81%	83%	88%	90%
		Adults (15-59):	53%		63%	73%	79%	88%	90%
		Male							
		Adults (15 – 59):	68%		72%	81%	83%	88%	90%
		Female							
		Young People (15 – 24):	<a href="#">56%<sup>[7]</sup></a>		63%	73%	79%	88%	90%
		Male							
		Young People (15 – 24):	<a href="#">63%<sup>[8]</sup></a>		72%	81%	83%	88%	90%
		Female							
		Children (<15)	60%		67%	74%	80%	84%	90%
<b>Tuberculosis</b>									
<b>Result 2: TB deaths in people living with HIV reduced by 75% by 2023</b>									
Outcome	Percentage of HIV-positive new and relapse TB patients on ARV therapy during TB treatment	Adults (15+):	91.70%	HMIS	93%	95%	95%	96%	97%
		Male							
		Adults (15+):	92.20%						
		Female							
		Children:	89.10%						
		<15							
Coverage	Percentage of people living with HIV newly enrolled in HIV care started on TB preventive therapy	Adults (15+):	TBD	HMIS	75%	80%	90%	90%	95%
		Male							
		Adults (15+):	TBD						
		Female							
		Children:	TBD						



		<15							
Coverage	Percentage of people living with HIV who are screened for TB in HIV settings	All People	79%	HMIS	79%	85%	90%	95%	100%
<b>Program Result 4: Structural Barriers (Gender and Human Rights Related Barriers to service delivery, accessibility and utilization removed by 2023)</b>									
Outcome	% Of women and men aged 15-49 with accepting attitudes to PLHIV	Adults (15- 49):	36%	DHS 2014	---	---	75%	---	90%
		Male							
		Adults (15-49):	46%	Age; Gender	---	---	75%	---	90%
		Female							
Outcome	Proportion of women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	Adults (15-49):	62%	Gender link GBV Indicator Study 2014	---	---	80%	---	90%
		Female							
Outcome	Lesotho Gender equality index (value)	---	0.962	Human Development Report 2016	0.962	0.962	0.962	0.999	0.999
Outcome	Existence of an enabling policy and legal framework that promotes and protects human rights	---	4.73	2017 Sustainability Index	---	---	6	---	7
Coverage	Proportion of sexual and gender-based violence cases prosecuted successfully	---	TBD		---	---	---	---	95%
<b>Program Result 5: 75% of PLHIV, at risk of and affected by HIV and in need benefit from HIV-sensitive social protection by 2023</b>									
Outcome	Current school attendance among orphans and non-orphans aged 10–14	---	82%	2016 Census Preliminary Report/ Population Survey	---	---	90%	---	95%
Coverage	% of people living with, at risk of and affected by HIV and in need benefit from HIV-sensitive social protection	---	TBD	DHS	---	---	60%	---	75%
Coverage	% Of vulnerable children 0-17 years who received basic external support	---	TBD	Population Survey DHS Population Survey / NISSA	---	---	60%	---	75%
<b>Program Result 6: At least 20% of the HIV/TB response is community-led and sustainable by 2023</b>									
Outcome	Community systems strengthened	---	3.2	2017 Sustainability Index	---	---	6	---	8
Outcome	Percentage of HIV funding channeled through community-based organizations	---	TBD	NASA Resource Mapping	---	---	15%	---	20%

				Expenditure Tracking					
Coverage	Percentage of CSOs submitting reports on time within LOMSHA	---	---	LOMSHA	---	---	50%	---	75%
<b>Program Result 7: Health System is people-centred, and sustainably integrates HIV, TB, Hepatitis and other infections by 2023</b>									
Outcome	Health systems strengthened	---	4.81	2017 Sustainability Index	5	6	7	8	8
Outcome	% of women attending antenatal care (at least four visits) –(includes women reached in both facilities and at communities by mobile clinics)	---	70.1	UNICEF (2015) 2008 – 2012 data	---	---	80%	---	90%
Outcome	The national M&E system is functional	---	5.48	2017 Sustainability Index	8	8	8	8	8
Coverage	% of NSP M&E framework indicators that have baseline values	---	80%	NSP	---	---	90%	---	100%
Outcome	Proportion of women living with HIV 30–49 years old who report being screened for cervical cancer	Women (30 – 49 years)	TBD	HMIS	---	---	50%	---	80%
Coverage	% of health facilities reporting no stock out of ARVs, IPT, test kits, reagents	ARVs	97.20%	Global Health Supply Chain monitoring report for 2017	99%	100%	100%	100%	100%
		HIV Test Kits	83.60%	Health facility, Hospital	97%	99%	100%	100%	100%
		Viral Load Reagents	77.80%		80%	85%	96%	100%	100%
Coverage	Percentage of health facilities timely submitting reports within HMIS	---	90%	HMIS	95%	95%	95%	95%	95%
<b>Program Result 8: Increased efficiencies and financial investments in HIV and TB programs from 60% to 90% of the NSP budget by 2023</b>									
Coverage	% of HIV Program (NSP) Budget funded by the Public sector (GoL)	---	11%	Annual National Budget	---	---	13%	---	15%
Coverage	% of NSP budget funded (from all sources)	---	60%	Funding landscape Analysis	70%	75%	80%	85%	90%

[1] Estimates of HIV prevalence, risk behavior, and population size. January 2015. Baltimore: USAID

[2] [ibid](#)

[3] [ibid](#)

[4] [ibid](#)

[5] [ibid](#)

[6] [ibid](#)

[7] [Lesotho Population Based HIV Impact Assessment \(LePHIA\), 2017](#)

## LIST OF ANNEXES

ANNEX 2: NATIONAL OPERATIONS PLAN  
ANNEX 3: NATIONAL MONITORING AND EVALUATION PLAN  
ANNEX 4: RESOURCE NEEDS ESTIMATES FOR THE NSP

### OTHER SUPPORTING AND RELATED NATIONAL AND SECTOR DOCUMENTS:

MOH PROCUREMENT AND SUPPLY CHAIN MANAGEMENT STRATEGY  
2018-2021 MOH COMMODITY FORECASTS AND QUANTIFICATION  
2018 HIV ESTIMATES AND PROJECTIONS  
MINISTRY OF SOCIAL DEVELOPMENT – NATIONAL SOCIAL PROTECTION POLICY AND STRATEGY;  
NATIONAL INFORMATION SYSTEM FOR SOCIAL ASSISTANCE  
MINISTRY OF LOCAL GOVERNMENT STRATEGY  
NATIONAL AIDS COMMISSION – NATIONAL COORDINATION FRAMEWORK  
NATIONAL TUBERCULOSIS STRATEGIC PLAN 2018/19-2022/23  
EMTCT STRATEGIC PLAN  
NATIONAL ACTION PLAN ON HIV AND LAW  
NATIONAL STRATEGIC PLAN FOR INTEGRATED EARLY CHILDHOOD CARE AND DEVELOPMENT  
DECENTRALIZATION POLICY AND PRIMARY HEALTH CARE REVITALIZATION ACTION PLAN  
INCLUSIVE FINANCE STRATEGY OF LESOTHO  
NATIONAL STRATEGIC DEVELOPMENT PLAN  
NATIONAL HEALTH SECTOR STRATEGIC PLAN  
OTHER NATIONAL AND SECTOR STRATEGIES  
HEALTH SECTOR STRATEGIC PLAN