GLOBAL AIDS RESPONSE PROGRESS REPORT 2015

FOLLOW-UP TO THE 2011 POLITICAL DECLARATION ON HIV/AIDS

INTENSIFYING EFFORTS TO ELIMINATE HIV/AIDS

Ministry of Health

LESOTHO COUNTRY REPORT

Reporting Period: January – December 2014

FOREWORD

In 2001, United Nations Member States unanimously adopted the Declaration of Commitment on HIV/AIDS during the General Assembly Special Session on HIV/AIDS (UNGASS). Built upon this declaration followed by the 2006 Political Declaration on HIV/AIDS, in 2011 the UN Political Declaration on HIV and AIDS set 10 targets related to the global AIDS response to be achieved by 2015.

Member States are requested by UNAIDS to present an annual report describing their country progress towards achieving the 10 targets. The information provided by country reports represents the most comprehensive data on both the status of, and response to the AIDS epidemic locally, regionally and globally, and allows for yearly monitoring of the progress towards the 10 targets. As a Member State, Lesotho has submitted its progress reports regularly, and is now submitting the 2014 Country AIDS Progress Report with the leadership of Ministry of Health, technical guidance and support from the UN family, and input from various stakeholders in the HIV response.

Lesotho today is still faced with a high burden of HIV and TB, poverty, mortality and youth unemployment. The Government and its Development Partners have continued to make huge investments and provision of resources in the Health sector including the HIV and TB programmes in order to address the health sector challenges. Furthermore, the Ministry of Health recently developed the Health Sector Strategic Plan including TB and HIV plans, HMIS Strategic Plan, Research and Evaluation Agenda and the HIV M&E Plan. These key national guiding documents are intended to reshape and standardise our implementation of strategic information-related activities, according to national and international standards.

We must now put all our efforts, energy and resources into implementing these strategies and plans. There is a saying that *"What Gets Measured, Gets Managed. And, What is Managed, Gets Measured"*. It is for this reason that Ministry of Health is further strengthening the coordination and implementation of the strategic information activities to become more robust, engaging and results-oriented. In this regard, I call upon all partners and stakeholders to play an active role in making this vision a reality. To do this, we must all work together in a harmonized and coordinated manner to avoid duplication of efforts. We also need more time for constructive dialogues and sharing of experiences on issues of implementation especially as we embark on Fast Tracking the HIV response in the fragile window of next five years (2016-2020) and Ending AIDS by 2030.

Finally, we will all be judged by our acts, not our words. I therefore wish to call on all stakeholders' and partners' continued commitment, technical and financial support in order to collectively achieve the health goals and objectives, especially the Millennium Development Goals (MDGs) and Post 2015 Strategic Development Goals (SDGs).

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Dr 'Molotsi Monyamane
Honourable Minister of Health

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BCC	Behavioural Change Communication
CD4	T-helper Cell
CPT	Co-trimoxazole Preventive Therapy
CSO	Civil Society Organization
DNA	Deoxyribonucleic Acid
EID	Early Infant Diagnosis
FSW	Female Sex Worker
GF	The Global Fund
HIV	Human Immune-deficiency virus
HTC	HIV Testing and Counselling
LDHS	Lesotho Demographic and Health Survey
LENASO	Lesotho Network of AIDS Service Organization
LENEPWHA	Lesotho Network of People Living With HIV and AIDS
M&E	Monitoring and evaluation
MOET	Ministry of Education and Training
MOH	Ministry of Health
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NAS	National AIDS Secretariat
NSDP	National Strategic Development Plan
OVC	Orphans and vulnerable Children
PCR	Polymerase Chain Reaction
PEPFAR	President Emergency Plan for AIDS Relief
PLHIV	People Living with Human Immune Deficiency Virus
PMTCT	Prevention of Mother to Child Transmission
PSI	Population Service international
SADC	Southern African Development Community
STI	Sexually Transmitted Infection
TB	Tuberculosis
UNAIDS	United Nations Programme on HIV/AIDS
UNESCO	United Nations Education, Scientific and Cultural Organization
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

ACKNOWLEDGEMENT

The 2015 Country AIDS Progress Report is a product of collaborative efforts by different stakeholders in the multi-sectoral HIV response. The Ministry of Health would like to acknowledge all individuals and institutions that contributed in one way or another to the successful development of this progress report at different stages.

Special appreciation go to the SI Technical Working Group consisting of various stakeholders drawn from various government departments, the civil society and multilateral agencies, who provided technical guidance and quality control; the consultant, Mr John Nkonyana, who collected, collated and consolidated valuable input from various stakeholders to draft this report.

Over and above, the Ministry of Health would like to recognise the unflinching and continued technical and financial support from the UN Family, particularly the UN Joint Team on AIDS.

Highlights of Key Achievements

Programmatic

- Scale-up of voluntary medical male circumcision nation-wide
- Implementation of Viral Load testing for HIV
- Implementation of Provider Initiated HIV Testing
- Piloting of Performance Based Funding in two districts
- SRH/HIV Pilot Project has shown an increase in the uptake of key services
- About 65,000 vulnerable children direct beneficiaries under Child Grants Programme
- Over 250,000 pre and primary school going children benefited from the school feeding programme

Guidelines and Policy

- Development of strategic plan for Social and Behavioural Change Communication
- Formally rolled out revised ART guidelines based on 2013 WHO Recommendations
- Review of HTC guidelines and standard operating guidelines
- Development and implementation of schools HIV and AIDS Schools Curriculum
- Development of 2015-2020 National Sexual and Reproductive Health Strategic Plan
- Development of 2015-2020 National Health Strategy for Adolescents and Young People
- Draft School Feeding Policy available
- Social Protection Bill approved by cabinet

Strategic Information

- Conducted PrePex acceptability and safety study
- Conducted VMMC Mid-Term Review
- Conducted Lesotho Demographic Health Survey 2014
- Updated National HIV Estimates and Projections
- Setting of 90-90-90 targets
- Conducted Annual Joint Review including HIV and TB
- Conducted a study for Examining Factors Associated with HIV-Related Risk Behaviours, HIV Prevalence, and Population Size Estimates of Two Key Population-Men who have Sex with Men (MSM) and Female Sex Workers (FSW)
- Conducted Resource Mapping and Financial Gap Analysis for HIV Response
- DHIS2 being Piloted for HIV and TB data

Table 1: Status on targets and elimination commitments of 2011 UN Political Declaration on HIV/AIDS

Target and Indicators	2009	2014
Target 1. Reduce sexual transmission of HIV by 50% by 2015		
General population		
1.1 Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	All - 35.6% M-28.7% F-38.6%	All - 35.5% M-30.9% F-37.6%
1.2 Percentage of young women and men who have had sexual intercourse before the age of 15	All - 12.2% M-22.1% F-7.8%	Awaiting 2014 LDHS results
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	All - 10.8% M-44.8% F-25.9%	All-12.3% M-26.7% F-6.6%
1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	All - 46.4% M-52.3% F-37.5%	All - 60.9% M-65.3% F-53.9%
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	All - 36.9% M-24.0% F-42.0%	All - 51.8% M-36.4% F-58.0%
1.6 Percentage of young people aged 15-24 who are living with HIV	All - 9.3% 15-19: 3.5% 20-24: 16.3%	Awaiting 2014 LDHS results
Sex workers		
1.7 Percentage of sex workers reached with HIV prevention programmes	No data	No data
1.8 Percentage of sex workers reporting the use of a condom with their most recent client		64.9%
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results		68.7%
1.10 Percentage of sex workers who are living with HIV		71.9%
Men who have sex with men		
1.11 Percentage of men who have sex with men reached with HIV prevention programmes	No data	No data
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner		62.2%
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results		13.6%
1.14 Percentage of men who have sex with men who are living with HIV		32.9%
Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015		
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	No data	No data
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse		
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected		
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results		
2.5 Percentage of people who inject drugs who are living with HIV		

Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths		
3.1 Percentage of HIV-positive pregnant women who receive antiretroviral medicine to reduce the risk of mother-to-child transmission [1]	>95%	72.0%
3.1a Percentage of women living with HIV who are provided with antiretroviral medicine for themselves or their infants during the breastfeeding period (formerly indicator 3.8)	No data	No data
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	37.50%	55.9%
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	9.5%	5.9%
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015		
4.1 Percentage of adults and children currently receiving antiretroviral therapy	All - 23% Adults -23% Children - 19%	All - 35% Adults -35% Children - 30%
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	80%	79%
Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015		
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	28%	70%
Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$22–24 billion in low- and middle-income countries		
Domestic and international AIDS spending by categories and financing sources		Domestic -26% International - 74%
Target 7: Eliminating gender inequalities		
7.1 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	No data	No data
Target 8: Eliminating stigma and discrimination		
8.1 Discriminatory attitudes towards people living with HIV - whether would you buy fresh vegetables from a shopkeeper who has the AID Virus	All - M - 68.9% F- 79.4%	Awaiting 2014 LDHS results
Target 9: Eliminate Travel restrictions		
Travel restriction data are collected directly by the Human Rights and Law Division at UNAIDS and no reporting is therefore needed.	Not Applicable	Not Applicable
Target 10: Strengthening HIV integration		
10.1 Current school attendance among orphans and non-orphans aged 10–14	Total=0.98 M=0.94 F=1.01	Total=0.92 M=0.90 F=0.95
10.2 Proportion of the poorest households who received external economic support in the last 3 months	No data	No data

1. PMTCT includes all regimen until 2009 but only effective regimen (excluding single dose Nevirapine) starting 2010

Table 2: Key HIV and TB Indicators for 2009 - 2014

INTERVENTION	INDICATOR	2009	2010	2011	2012	2013	2014
PMTCT	Number of pregnant women living with HIV who received antiretrovirals for preventing mother-to-child-transmission	6,434	8,047	12,090	9,997	8,218	8,065
	Estimated percentage of pregnant women living with HIV who received antiretrovirals for preventing mother-to-child-transmission	58	72	>95	89	73	72
ADULT ART	Reported number of adults receiving ART	60,064	74,563	77,622	86,537	96,392	105,635
	Estimated ART coverage of adults living with HIV	23	28	28	30	33	35
PAEDIATRIC ART	Reported number of children receiving ART	3,985	4,812	5,028	5,246	5,201	5,687
	Estimated ART coverage of children living with HIV	19	23	24	26	26	30
ALL ART	Reported number (All ages) receiving ART	64,049	79,375	82,650	91,783	101,593	111,322
	Estimated ART coverage (All ages) living with HIV	23	28	28	30	33	35
TB/HIV	Percentage of TB Cases tested for HIV	70	84	82	81	88	93
	Percentage of TB - HIV co-infection	85	77	77	76	75	74
	Percentage of TB and HIV co-infected on CPT	91	96	95	90	97	98
	Percentage of TB and HIV co-infected on ART	28	27	25	40	53	72
HIV TESTING & COUNSELLING	Number tested for HIV & received results	221,616	256,526	274,240	310,059	337,546	553,243
	Number tested for HIV, received results & positive	40,196	41,301	40,871	38,771	43,836	55,089
	Percentage of HIV Positivity	18	16	15	13	13	10

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Tables and Figures

1. Status at Glance

The Lesotho National Response Status Report for 2015 was jointly developed by the Ministry of Health with the support of the UN Joint Team on AIDS using an inclusive process involving stakeholders from the public sector, civil society, and private sector and other development partners to the extent possible.

The HIV epidemic in the country remains generalized, affecting more females than males. There is a notable high prevalence among MSM and FSW according to the most recent studies. The prevalence varies among with some more affected than others. Incidence and AIDS related mortality have both been slowly declining.

Multi-sectoral coordination of the AIDS response weakened for some time due to the closure of the National AIDS Commission (NAC) in 2012. There is now a firm commitment by the Government of Lesotho to re-establish the NAC by the end of the year. The Government of Lesotho however remains committed to achieving zero new infections, zero HIV related deaths and zero HIV stigma and discrimination. The required environment has been facilitated through development of the required policy to support the multi-sectoral response in line with the High Level Meeting targets by 2015. Progress towards achieving major HLM targets seems to be mostly off track, and there are major challenges with respect to HTC, ART (including paediatric ART coverage) while PMTC coverage is also slowly declining.

The HIV response in Lesotho still largely remains externally donor funded with the Global Fund, PEPFAR and Government of Lesotho being the major financiers. Care and Treatment interventions account for the largest share of expenditure. The financial gap of the HIV response between available resources and costing remains huge, and has major implications towards achieving the 90-90-90 targets by 2020.

Table 3: Performance on impact indicators – HIV Estimates 2014

Impact indicators	2012	2013	2014
Deaths averted by ART	9500	9400	9300
Infections averted by PMTCT	1700	2000	2200
Life years gained by ART and PMTCT	56000	69000	78000
Deaths averted by PMTCT (0-4)	1000	1000	1000
HIV incidence rate	2.1	2.1	2.0
Annual HIV related deaths	9 000	9 000	9 000
Total AIDS orphans	78 000	76 000	74 000
Number of new child infections due to MTCT	2000	1800	1600

Source: 2014 UNAIDS Estimates and Projections

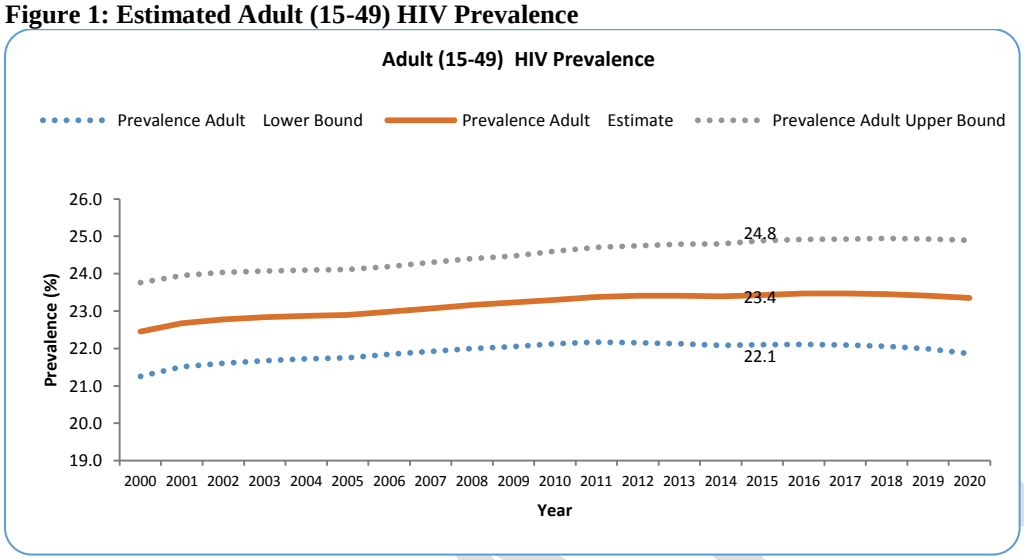
Table 4: Overview of performance on core indicators

Year	2012	2013	2014
Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission.	89%	73%	72%
Number of Adults and children who were tested and received results	310059	337546	553243
Number of males medically circumcised according to national standards	10410	37975	36245
Percentage of eligible adults and children currently receiving antiretroviral therapy.	Adults- 29% Children- 24%	Adults – 31%, Children–24%	Adults – 35%, Children–30%
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.	72%		79%

2. Overview of HIV Epidemic

Lesotho is facing a generalized epidemic which affects different sub-populations through various modes of transmission. According to LDHS 2004[1] and 2009[2] the prevalence is around 24% and 23% respectively. The latest HIV estimates[3] also show that the HIV epidemic stabilized at 23%, though still at a very high level.

Figure 1: Estimated Adult (15-49) HIV Prevalence



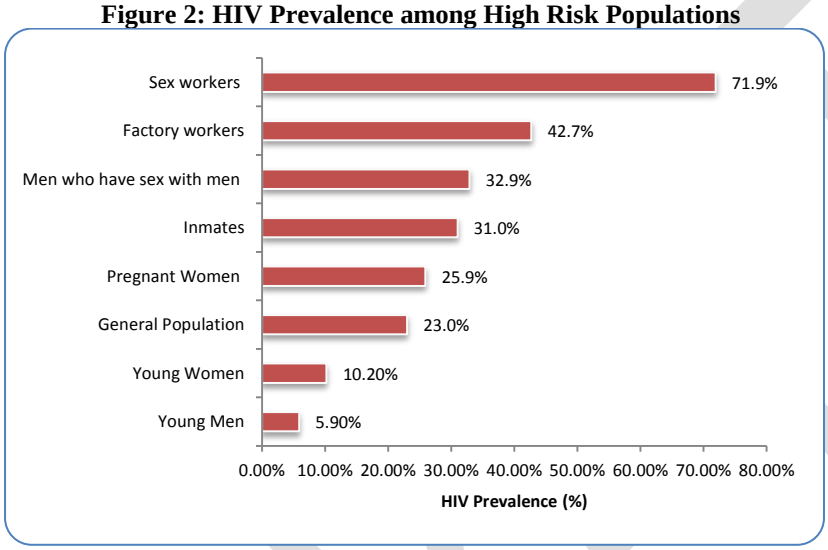
The urban areas carry more burden than rural with prevalence of 27% and 21% respectively. In this scourge, women are more affected by the epidemic with prevalence of 27% while among men the prevalence is 18% according to the LDHS 2009. Estimated HIV prevalence for 2014 is 23.4% and is projected to remain stable for next few years. However, new HIV data from the 2014 LDHS will confirm this assumption. The prevalence among pregnant women attending ANC was 28% in 2009, 24% in 2011 and 26% in 2013 (ANC Sentinel Surveillance 2013). Syphilis prevalence was 2% in 2009, 3% in 2011 and 3% in 2013 ANC sentinel surveillance. Prevalence of syphilis in urban area (3%) was slightly higher than that of rural (2%). The 2011 survey also revealed that ANC clients with a positive Syphilis test had higher HIV prevalence of 38.8% in 2011 and 40% in 2013. Among syphilis none-reactive clients the prevalence was 23.9% in 2011 and 25% in 2013[4]. Traditional high risk populations – MSM, sex workers and inmates - have HIV prevalence ranging between 31% and 72%.

[1] Lesotho Demographic and Health Survey 2004
[2] Lesotho Demographic and Health Survey 2009
[3] Lesotho HIV and AIDS Spectrum Estimates Report 2015
[4] Lesotho HIV Sentinel Surveillance 2013

3. Epidemic Drivers and Factors Influencing the Spread of HIV

The prevalence varies among different subgroups as may be seen in figure 2 below. HIV prevalence among sex workers is estimated to be 3 times higher than for the adult population (72% compared to 23%), largely because of widespread violence, criminalization, stigma and discrimination, lack of funding and targeted programmes; HIV prevalence among MSM is estimated to be 1.4 times higher than for the adult population (33% compared to 23%); and prevalence of HIV in prison populations is estimated to be 31%1.3 times higher than in the general population (31% compared to 23%). Nearly one-in-three (31%) of the estimated 2500 inmates are living with HIV.

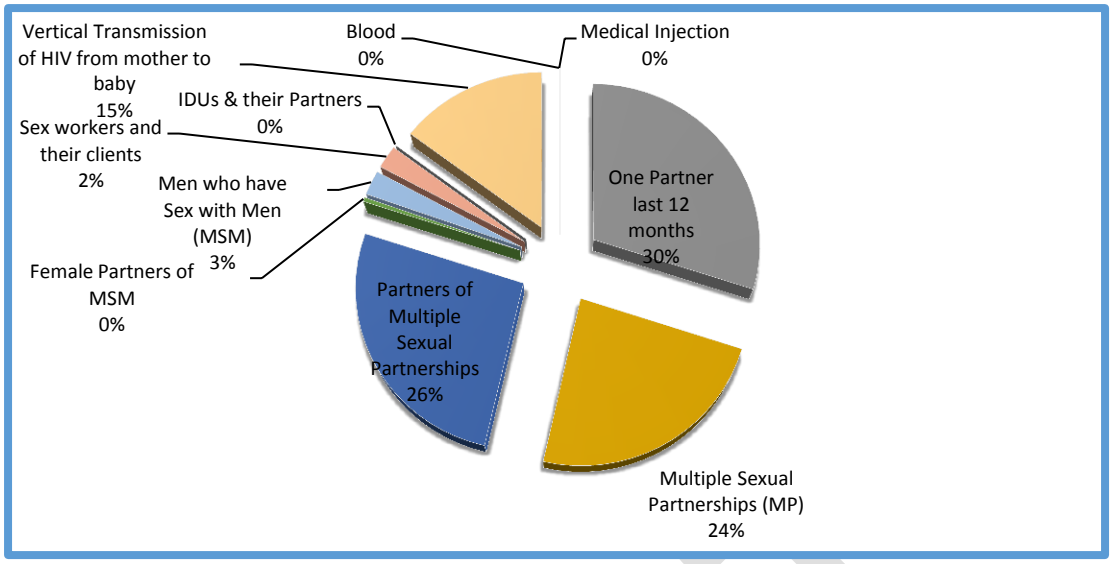
Figure 2: HIV Prevalence among High Risk Populations



As may be noted in Figure 3 below the 2010 Modes[5] of Transmission study revealed that most new infection were from exposure to Low-risk heterosexual sex which contributed 30% of the new infections, Casual heterosexual sex 50%, and key populations 5%. Vertical transmission of HIV from mother to baby accounts for 15%. There were an estimated at 314 000 PLHIV consisting of 295 000 adults and 19 000 children were in urgent need of antiretroviral therapy by the end of 2014.

Figure 3: Sources of New HIV Infections

[5] HIV Modes of Transmission study 2010



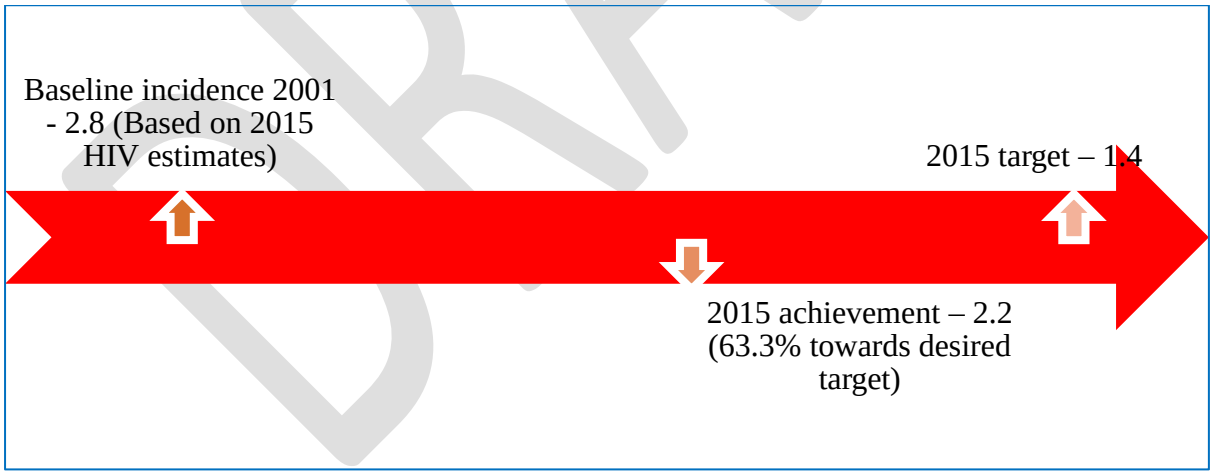
The epidemic is mostly heterosexual and the risk factors include both cross border and internal migration, high risk sex.

4. Status of the Implementation of the High Level Meeting Targets

4.1 Reduce Sexual Transmission of HIV by 50 % by 2015

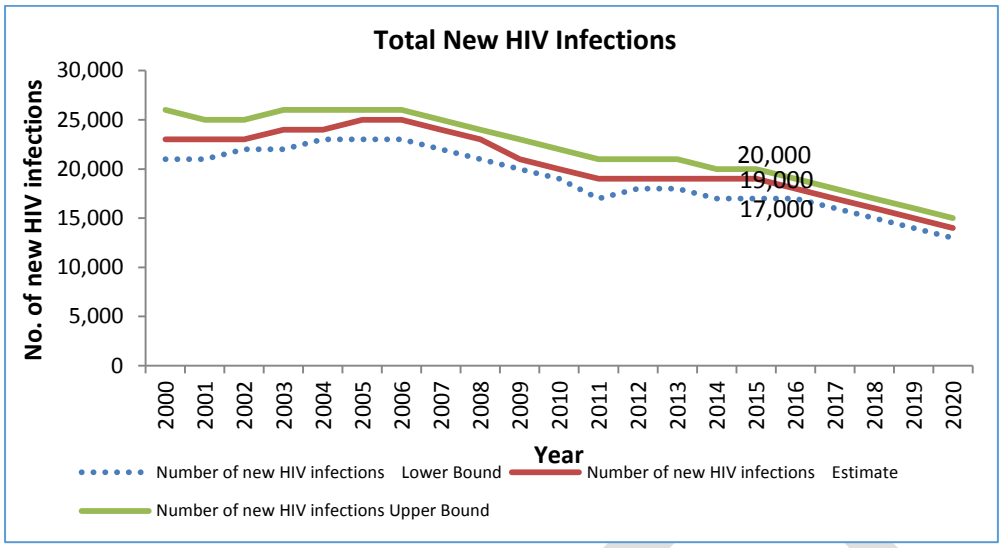
Progress towards the desired target is illustrated below with the trends in incidence rate.

Figure 4: Progress towards target of reduction of new infections



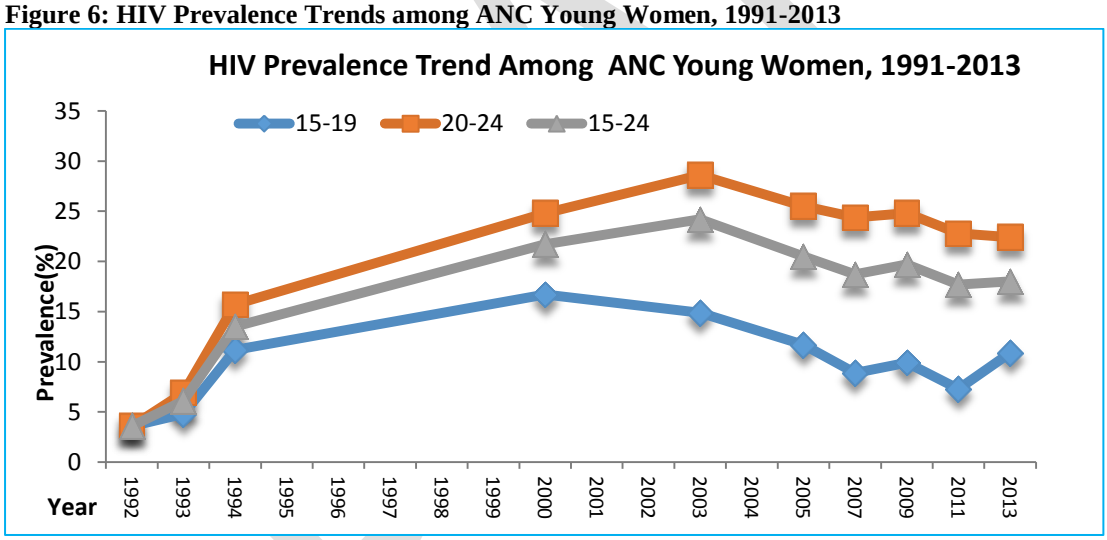
Lesotho is currently not on track to realize the set target of reducing HIV incidence by 50% by 2015. 2014 national HIV estimates show that new infections are declining slowly as shown in the figure 4 below. Adult HIV incidence has only declined by 29% between 2001 and 2014.

Figure 5: New HIV Infections



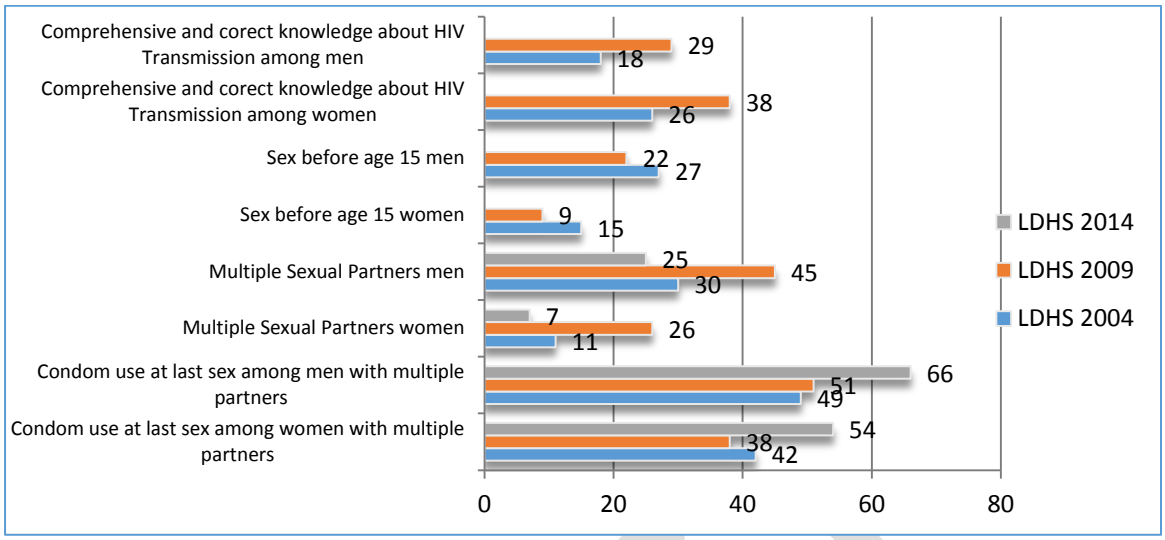
Trend from ANC Sentinel Surveillance 2013 (Figure 5) continue to show stabilization of HIV prevalence among young pregnant women. HIV prevalence rapidly increased between 1992 and 1994, thereafter increased gradually until peaking in 2003 before showing signs of decline onwards up to 2013.

Figure 6: HIV Prevalence Trends among ANC Young Women, 1991-2013



Key factors associated with reduction in new HIV infections from Figure 6 shows the following, among others, as significant: declining multiple sexual partners, increase in knowledge about HIV, increasing condom use during last sexual intercourse with persons having multiple partners and declining proportion having sex before age 15

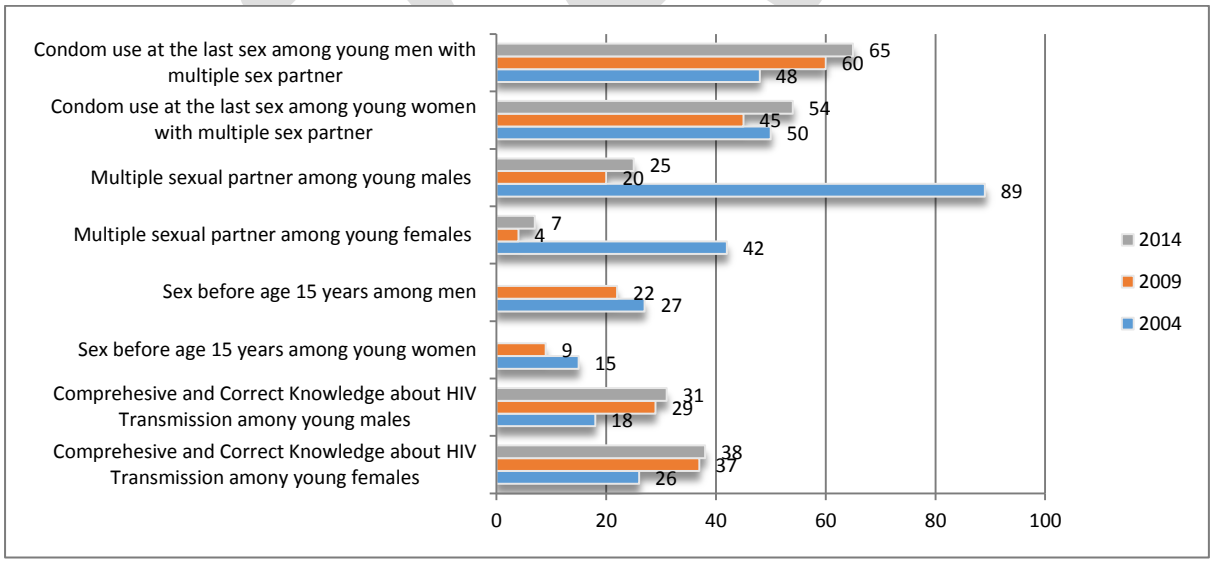
Figure 7: Factors associated with Reduction in new HIV infections



(LDHS 2015 data on sex before 15 and comprehensive knowledge not yet available)

Outcome results for the reduction of sexual transmission among 15-24 year old shows that comprehensive knowledge on HIV has always been low and shown very small improvement in the last LDHS 2014 surveys. Multiple sex partnership has shown very dissimilar results among both women and men. Condom use during last sex among young people with multiple sexual partners has always been higher in young males than females and has been steadily improving among both over time.

Figure 8: Outcome results for the reduction of sexual transmission among 15-24 year



(LDHS 2015 data on sex before 15 not yet available)

4.1.1 HIV Testing and Counselling (HTC)

Significant gains have been seen over time with respect to implementation of HTC as between 2009 and 2014 LDHS there was tremendous decline in the proportion of people who had never tested for HIV from 63% to 35% among men and from 34% to 15% among

women. The 2014 LDHS also shows that 63% men and 84% of women had ever tested for HIV and received. These are the highest ever reported figures in the past three surveys.

In Lesotho, the HIV testing services have been given a brand name of "Know Your Status" after a nationwide campaign that was inaugurated by His Majesty by openly testing for HIV in 2008. In the period under review, HTC services were strengthened through review of the HTC guidelines to include pediatric counseling and testing, Provider Initiated Testing and Counseling, couple testing and subsequent testers. The standard operating guidelines were also reviewed to encompass the changes brought about by the changing ART parameter for enrollment to ARV. Government implemented door to door campaign to reach more couples in HIV testing. HTC services were constantly challenged by test kits stock-outs and shortage of human resource in the period under review.

4.1.2 Social and Behavioural Change Communication (SBCC)

In the period under review the National Social and Behavioural Change Communication strategy was reviewed. The purpose of this strategy is to use social behaviour change to hasten awareness and demand for HTC services which are an entry into the HIV and AIDS services. The strategy seeks to address promotion and adherence to TB and HIV treatment. According to 2014 Stigma Index study, in Lesotho, like in other countries, people living with HIV experience stigma and discrimination. This was found to be one of the major barriers to accessing treatment for HIV affected people. Stigma and discrimination was also isolated in a study conducted among MSM and FSW. The country is strengthening strategies for SBCC delivery which include interpersonal communication, peer education, media, community dialogues and conversations aimed at improving personal risk perceptions and promotion of risk reduction strategies. In this initiative, MSM and sex workers and their clients, girls, women, Youth in the general population, Persons with Disabilities (PWD), inmates, PLHIV, migrant workers), ex-miners and mobile populations are prioritized.

4.1.3 Key Populations

a. Female Sex Workers and Men-who-have sex with Men

In period under review, a study was conducted among MSM and Sex-worker from two industrialized sites in Lesotho-Maseru (318) and Maputsoe (211). The study revealed that many of MSM had tested for HIV more than once (56% in Maseru and 61% in Maputsoe). HIV prevalence among MSM was 31% and 35% in Maseru and Maputsoe respectively which was much higher than the national prevalence. Stigma and human rights abuse are common among them through verbal abuse blackmail and physical aggression. They reported in this study to be afraid to access health services because of stigma.

In Maseru, 410 FSW participated in the study while in Maputsoe there were 334. Most of them had tested for HIV more than once (55% in Maseru and 68% in Maputsoe) Among FSW in Maseru the HIV prevalence was 73% while in Maputsoe it was 70% it was much higher than the National average. They reported harassment among them in form of forced sex, police intimidation and physical aggression. They were also afraid to access health services because of stigma.

In Lesotho MSM and FSW have been prioritized, with the support Government, NGOs and CBOs. MSM, FSW and LGBTI have been supported through an organized association which facilitate advocacy among others. These studies have assisted to measure the magnitude of the HIV and STIs related stigma and discrimination among some of these key population groups in Lesotho. The major challenge is that while these groups are expected to access services like the rest of society stigma and discrimination frequently hinder them. The related law for protection of these vulnerable subgroups needs to be considered.

The proportion of the female and male population 15-49 that are female sex workers and MSM is 1.24% and 2.16%, respectively (2015 MoH/PSI, BBSS)

b. Inmates

In Lesotho the Provision of health services among inmates in the correctional service is comprehensive and includes among others HIV and TB services. Nearly one-in-three (31%) of the estimated 2500 inmates are living with HIV. HIV services comprise of prevention, care and support. There is continuity of care as AIDS patients are provided with ART during their incarceration period and on discharge they are transferred to the neatest health facility or one most suitable to them. The correctional services, concerned about treatment defaulting among ex-inmates resulting from stigma from HIV and incarceration conducted a study among ex-inmates to determine magnitude of the problem. Prevention services for inmates include condom distribution, HTC and peer education by educators who are identified from among the inmates. Established within correctional services throughout the ten districts are health units run by nurses who provide relevant services for continuity of care. Clients are referred to hospitals throughout the country as necessary.

4.1.4 High Risk and Vulnerable Populations

a. Adolescents and Young People

Between LDHS 2004 and LDHS 2009 there was notable decline in the prevalence of HIV among young people 15-24 years from 11% to 9%. At the time of reporting LDHS 2014 prevalence data was not yet available. Comprehensive knowledge of HIV prevention seems to be static where 39% in women and 29% in men were found to have comprehensive knowledge in 2009 LDHS, while the 2014 LDHS showed 38% and 31% for women and men respectively. Lesotho needs to decide on strategic choices to mitigate HIV prevalence among young women and girls to mitigate their vulnerability and risks of acquiring HIV.

Further, recent data – both the country HIV estimates as well as the Key Indicator Report of the Lesotho DHS summarizes an alarming situation for adolescents. Prevalence among adolescent girls aged 15-19 is estimated at 4.1% and for boys 15-19 at 2.9%. About 2000 new HIV infections occur annually among adolescents aged 15-19. By age 19, nearly 40% of adolescent girls have started child-bearing. Unmet family planning amongst 15-19 year old girls is the highest amongst any cohort. Similar age and gender disparities exist across other indicators including reported condom use, awareness of status after taking an HIV test, and comprehensive knowledge.

b. Addressing the needs of Women and Girls

In Lesotho, according to LDHS surveys, school attendance has always been highly favouring girls than boys. The 2014 LDHS was not different. The net attendance ratio in primary school

education was 98% for females and 93% for males, while the literacy rate among 24 to 25 years olds showed 99% among young women and 91% among men. In the period under review the Education Sector Policy on HIV and AIDS was developed. The policy provides guidance to the Education Sector on HIV and AIDS. It applies to learners, employees, managers, employers and other providers of education and training in all formal and non-formal learning institutions at all levels of the education system. Government also undertook comprehensive review of the curriculum using UNESCO's International Technical Guidance on Sexuality Education. The revised Life-skills Education (LSE) incorporates gender-transformation, comprehensive sexuality education that is scientifically accurate, age-appropriate, and culturally relevant for grades 4 (9 year olds) to Grade 10 (15year-olds).

Revised National Action Plan for Women and Girls and HIV AIDS 2012-2016 was implemented during the reporting period. This plan seeks to reduce women and girls' vulnerability to HIV through active policy engagement; creative HIV prevention strategies; enhance equitable access to quality health and HIV services; social protection of vulnerable households including girl-child headed households; facilitating the achievement of sustainable economic empowerment; food and nutrition security for women and girls affected and infected with HIV; and addressing gender injustices that perpetuate women and girls in vulnerable situations. Efforts have been undertaken to tackle alleviation of social, cultural and economic imbalances that position girls and women to be vulnerable to HIV infection and increase gender equity in HIV/AIDS programs and services.

c. Preventing Stigma and Discrimination Towards People Living with HIV

In the period under review major progress was achieved when the Stigma Index study was implemented. PLHIV experience stigma in various forms, many of them (41%) report experiencing gossip about them. There were those who were verbally insulted, harassed and threatened (27%). Some 16% reported to have been excluded from social gatherings. Physical harassment was reported in about 15% of the sample.

The high knowledge the society has about HIV and PLHIV shown in the DHS surveys has only very slowly translated into change in attitude and behaviour particularly towards PLHIV, this is shown by stigma experienced PLHIV. The support provided for PLHIV has capacitated them in various ways. Many of them believe they have ability to influence local government policies affecting PLHIV; while some believe have a hand in influencing in influencing national programs and projects intended to benefit people living with HIV.

In the period under review the Lesotho Network of People Living with AIDS (LENEPWHA) implemented an initiative of linkages with people taking treatment in health centres in selected districts to reduce defaulting from ART. The organization continues to strengthen the support group in the villages to ensure compliance to ART to minimise the virus developing resistance. LENEPWHA views one of the greatest challenges to be that of people who are affected but remain in denial for their status. LENEPWA as an organization is completing 10 years this year. The organization has engaged in extensive advocacy during this period of 10 years anniversary.

d. People with Disabilities

The Lesotho National Federation for the Disabled (LNFOD) conducted a situational analysis in 2008 to find out the Disabled People Organizations' (DPO) capacity in identifying's key HIV

and AIDS national response activities and development of appropriate standards to deliver and improve them. The finding revealed that People With Disabilities (PWD) are still marginalized by cultural understanding that they are not affected by HIV, this may a result in mistaken assumptions in sexual practices among PWDs; thus limited HIV education is provided to them.

While Government Ministries, DPOs and LNFOD have executed advocacy for PWD, there is recommendation for mainstreaming of disability into HIV and AIDS response among government agencies and CBOs. There is need for capacity building through training to equip PWD.

e. Migrant Workers

HIV prevalence among the estimated 50,000 factory/migrant workers is 43%. The Southern African Development Community protocol addresses communicable diseases with specific attention to HIV and TB; it calls for the member states collaboration in the management of communicable diseases particularly HIV/AIDS and TB. Lesotho is one of countries that exports labour to the South African mines. Management of HIV/AIDS and TB among mine workers is a collaborative effort between the Ministry of Health and the mine workers recruiting agency "Employment Bureaus for Africa" (TEBA). The collaboration is weak and does not yet provide access to treatment irrespective of the country in which the client is. The collaboration between South Africa and Lesotho needs to be strengthened to include all workers in South Africa to ensure treatment continuity when the person is in Lesotho or South Africa.

f. Herd Boys

Herd Boys are amongst the most disadvantaged young people, particularly as regards access to formal education. Extreme poverty contributes significantly to the decision to take up herding of livestock as a full-time occupation. Besides being deprived of formal education, they often miss opportunities of vocational training, access to health services and life skills training afforded to their peers in mainstream schools. The herd boys are often young boys who are at exploratory age. The NGOs working with Ministry of Education, Local Government, Traditional Authorities, affected communities and key stakeholders implemented provision of basic education to the herd boys in selected mountain areas for 550 herd boys in 12 schools. The herd boys were also availed livelihoods and survival training as well as Sexual and Reproductive Health Training and HIV testing and counselling. In this remote area 800 herd boys and community member were tested and got their results.

4.1.5 Condom Promotion

The LDHS 2014 Key Indicator showed that 92% of women and 88% of men know that consistent use of condom is a means of preventing HIV infection. About of 99% of women and 87% of men know that limiting sexual intercourse to one faithful and uninfected partner can reduce chances of contracting HIV. Eighty six per cent of women knew that both using condoms and limiting sexual intercourse to one faithful and uninfected partner can reduce chances of contracting HIV, this was an improvement over a period of about 10 years where in 2004 and 2009 the figures were at 71% and 81% respectively. Among men in 2014 about 81% showed knowledge in this parameter, this was tremendous improvement from 60% in 2004 and 72% in 2009.

In the past 10 year the trends of sexual intercourse with 2 or more people among women has fluctuated at 11%, 29% and 7% in 2004, 2009 and 2014 respectively, with the lowest figure reported in 2014 while among men it was at 29%, 45% and 27% in the above years respectively. Condom use has been improving steadily more so among men than women. Among women it was 42%, 38% and 54% in 2004, 2009 and 2014 respectively; while among men it showed consistent improvement of 46%, 52% and 65% in 2004, 2009 and 2014 respectively.

Free issue condoms are procured by Government procedures with partners such as UNFPA support. Government also undertakes distribution to the health facilities where they are subsequently distributed to the strategic points such workplace, community-based outlets as well as in service delivery points as outpatients HTC, VMMC, SRH, STI ART, PMTCT and in outreaches. Population Services International (PSI) has been undertaking social marketing of condoms in collaboration with UNFPA. Consistent and correct condom use is being promoted through health promotion media to diverse population groups.

4.1.6 Voluntary Medical Male Circumcision (VMMC)

VMMC has been adopted as a key strategy for primary prevention of HIV infection in Lesotho. During the reporting period the services were routinely provided in 16 hospitals and selected health centres. The VMMC services have been provided throughout the country through mobile campaigns which are conducted in health centres. The table below depicts annual circumcised men by age. About 56% who came for circumcision services were tested for HIV and received the results. Most people who accessed the services were in the age group of 15-19. The mean HIV prevalence among those who were tested was 4%.

Table 5: VMMC 2012-2014 by Age Groups

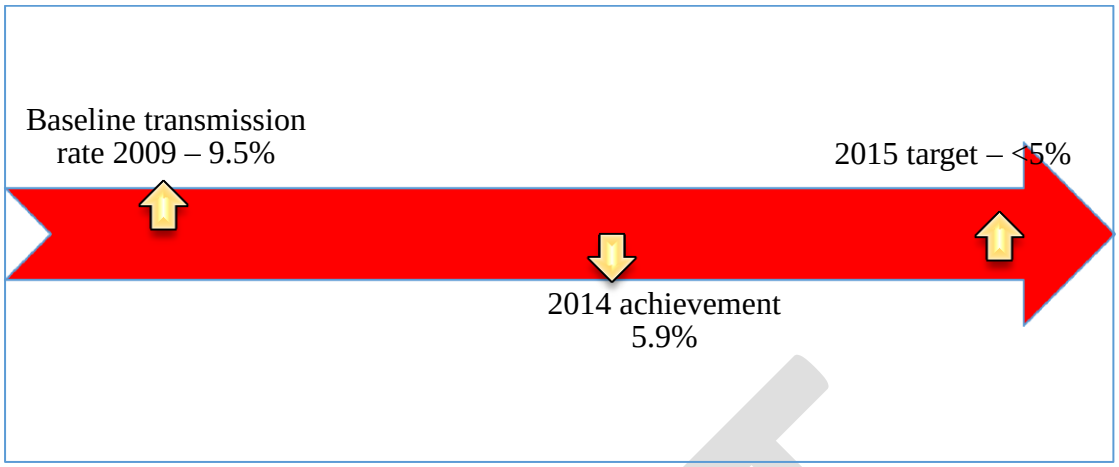
	<1	1-9	10-14	15-19	20-24	25-49	50+	Total
2012	0	23	647	4624	3191	1905	20	10410
2013	34	35	8151	14896	7089	7528	242	37975
2014	33	104	14714	10057	4721	6322	294	36245
Total	**67**	**162**	**23512**	**29577**	**15001**	**15755**	**556**	**84630**

The program provides a chance for men who have never tested for HIV to be able to test. The program is challenged by frequent shortage HIV test kits. Mid-Term Evaluation of Medical Male Circumcision was conducted in 2014. Acceptability and Safety Study for PrePex device was conducted in 2014 with main purpose to provide an alternative to surgical circumcision. The country is in the process of addressing issues around task shifting to ensure accessibility of VMMC services. New strategies need to be devised for reaching men particularly older men who have not been coming to facilities in significant numbers.

4.2 Eliminate New HIV Infections among Children by 2015 and Substantially Reduce AIDS Related Maternal Deaths

Progress towards the desired target is illustrated below with the trends in MTCT rate

Figure 9: eMTCT Progress



According to the National HIV Estimates, the HIV transmission from mother to child in 2012 was 3.5%; this performance has slowly been declining overtime to 5.8% and 5.9% in 2013 and 2014 respectively. The declining PMTCT coverage from 89%, 73% and 72% in 2012, 2013 and 2014 respectively undermines the gains that had been earlier noted. The new infections averted by PMTCT have been on the increase from 1700 to 2000 and 2200 in 2012, 2013 and 2014.

Table 6: Selected eMTCT Indicators

Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths1			
Indicator	2012	2013	2014
3.1 Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission.	89%	73%	72%
3.2 Percentage of infants born to HIV-positive women receiving. a virological test for HIV within 2 months of birth	50.7%	57.5%	55.9
3.3 Percentage of child infections from HIV infected women delivering in the past 12 months - Mother-to-child transmission of HIV (modelled).	3.5%	5.8%	5.9%
3.4 Percentage of pregnant women who were tested for HIV and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status	73%	73%	72%
3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	7%	6%	6%
3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	29%	26%	41%
3.7 Percentage of infants born to HIV-infected women (HIV-exposed infants) who received antiretroviral prophylaxis to reduce the risk of early mother-to-child-transmission in the first 6 weeks	96%	No new data	No new data

Source: PMTCT Programme Data and Estimates and Projections

The Global Plan focuses on reaching pregnant women living with HIV and their children in low and middle income countries-throughout pregnancy, breastfeeding and beyond-with global targets to (i) reduce the number of new childhood HIV infections by 90% (Reduce AIDS related infant deaths by > 50% and provide ART to all children) and (ii) Reduce the number of HIV-related maternal deaths by 50% - Reduce HIV incidence among women 14-59 yrs by 50%;

Reduce MTCT to 5%; 90% mothers receive ARVs for PMTCT; 90% breastfeeding mother infant pairs receive ARV for PMTCT; 90% of pregnant women in need of ART for their own health. The table below shows the status updates towards the Global Plan targets.

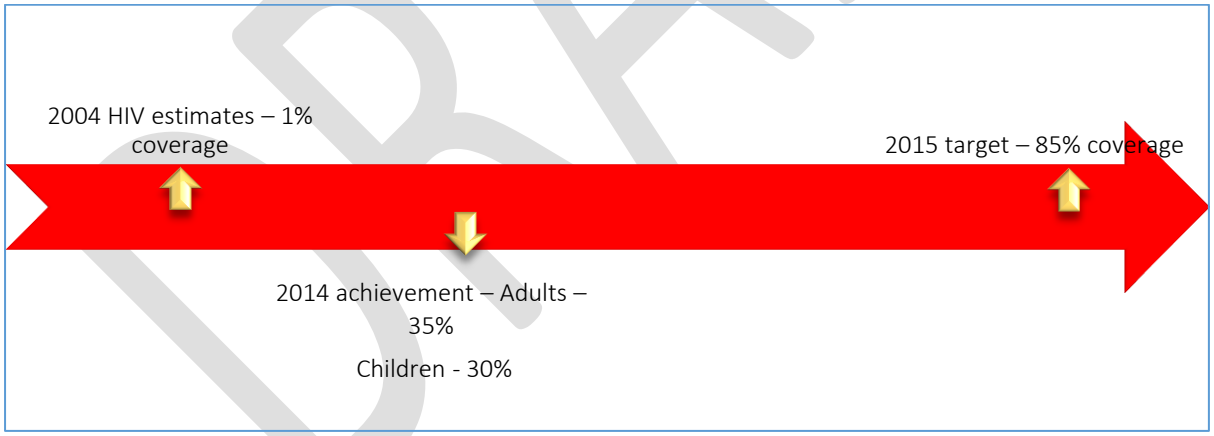
Table 7: Global Plan on eMTCT Indicators

Global Plan Towards the Elimination of New HIV Infections Among Children by 2015 and Keeping Their Mothers Alive				
		2004	**2014**	**Target in 2015**
Target 1	**Reduce the number of new childhood HIV infections by 90%**			
	Reduce AIDS related infant deaths by > 50%	860	260	<430
	Provide ART to all children	<1%	30%	100%
Target 2				
	Reduce HIV incidence among women 14-59 yrs by 50%	3.30%	2.40%	1.15%
	Reduce unmet family planning need to zero	31%	18%	0%
	Reduce MTCT to 5% at 6 weeks	19.20%	5.90%	5%
	90% mothers receive ARVs for PMTCT	4%	72%	90%
	90% breastfeeding mother infant pairs receive ARV for PMTCT	0%	69%	90%
	90% of pregnant women in need of ART for their own health	0%	26%	90%

4.3 Contribute to Reaching 15 Million People Living With HIV with Life Saving Anti-Retroviral Treatment by 2015

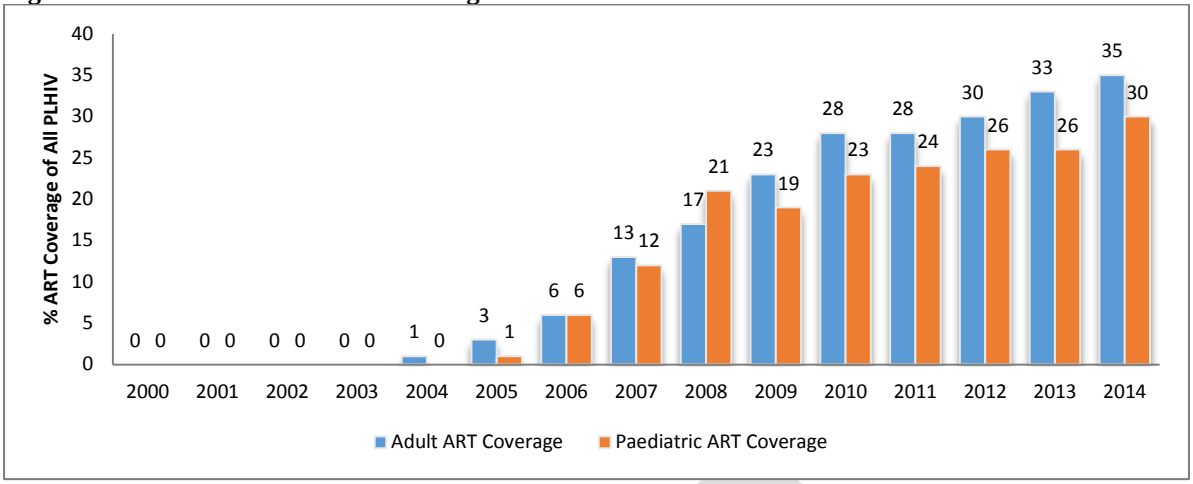
Progress towards the desired target is illustrated below.

Figure 10: ART Progress Towards Target



Lesotho is at the moment not on track to achieve the target. The number of facilities providing ART service was 207 at end of 2013; the expected number to provide ART was 240 in 2014 ART providing facilities were 217. Factors that limit some facilities from providing ART include inadequate space and staffing. Some facilities in private practice open and close erratically and sometimes lack necessary licensure.

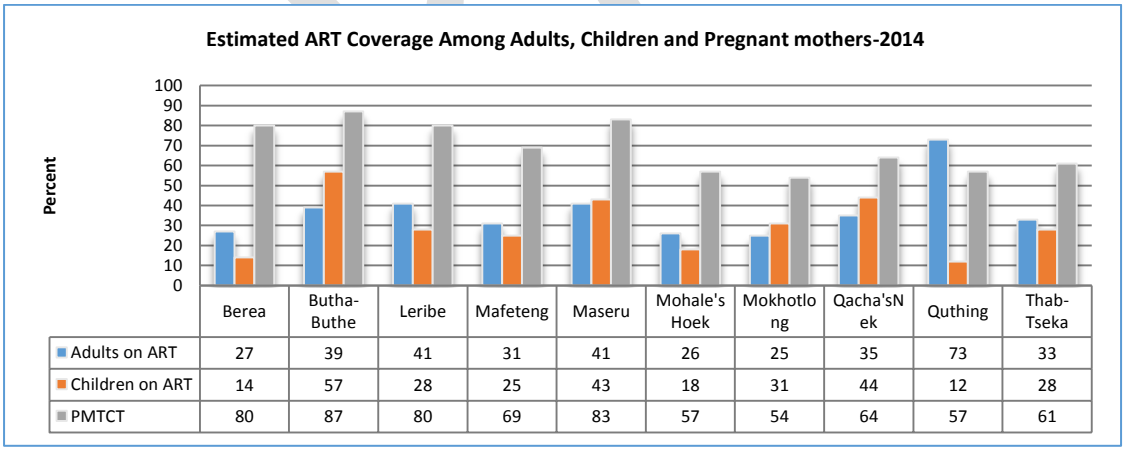
Figure 11: Adult and Child ART Coverage



Estimated total number of people in need of ART in 2014 consisted of 227000 adults, 10000 children and 11 000 pregnant women. Although there was a total of 5652 newly enrolled on ART in 2014 not much difference was noted on the coverage because the denominator expanded subsequent to adjusting of the cut-off point to CD4 count of 500µl.

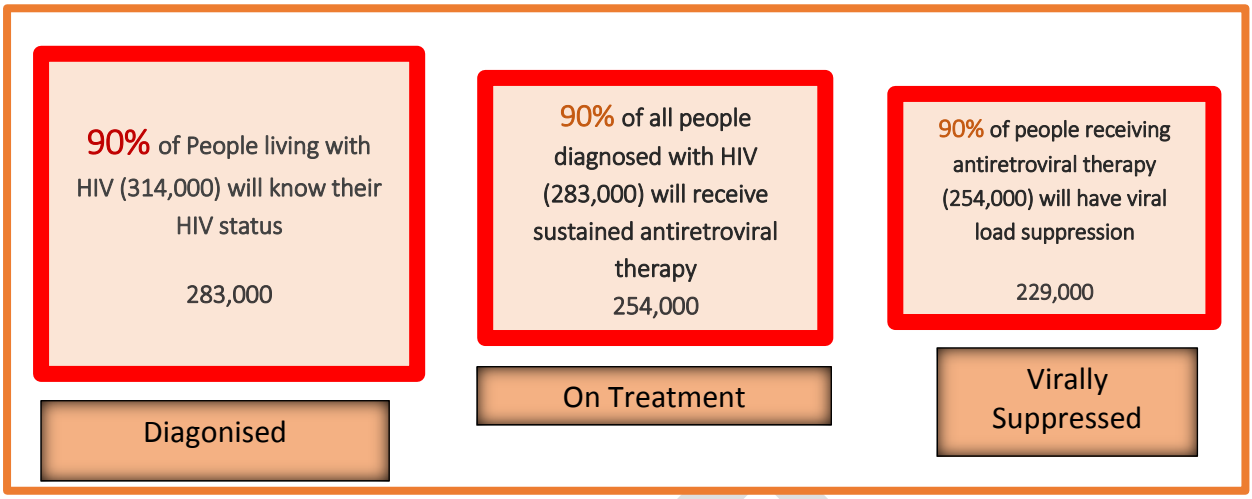
Regarding achievement of desired target of 85% of people living HIV to be on ART, the country is off target. Figure 10 below shows an estimated ART coverage by district in 2014 among Adults, children, and pregnant mothers. Adults and children coverage is lower than half in all districts except Butha-Buthe while coverage among pregnant mothers is higher in the districts of Butha-Buthe, Maseru, Berea and Leribe.

Figure 12: ART Coverage by District



	Berea	Butha-Buthe	Leribe	Mafeteng	Maseru	Mohale's Hoek	Mokhotlong	Qacha'sNek	Quthing	Thab-Tseka
Adults on ART	27	39	41	31	41	26	25	35	73	33
Children on ART	14	57	28	25	43	18	31	44	12	28
PMTCT	80	87	80	69	83	57	54	64	57	61

Figure 13: Lesotho's Bold Targets of 90-90-90 to Reduce HIV Infection and AIDS Death by 2020



According to the 2014 national estimates, there are currently 314000 PLHIV in Lesotho. It is purposed that by 2020 there will be 283,000 of them who will have been tested and know their positive HIV status. It is also set that 90% (251,100) of people who are diagnosed HIV will receive sustained antiretroviral therapy. It is also determination that 90% (229,000) of people receiving antiretroviral therapy will have viral load suppression. Extensive measures are required to ensure realization of these ambitious targets.

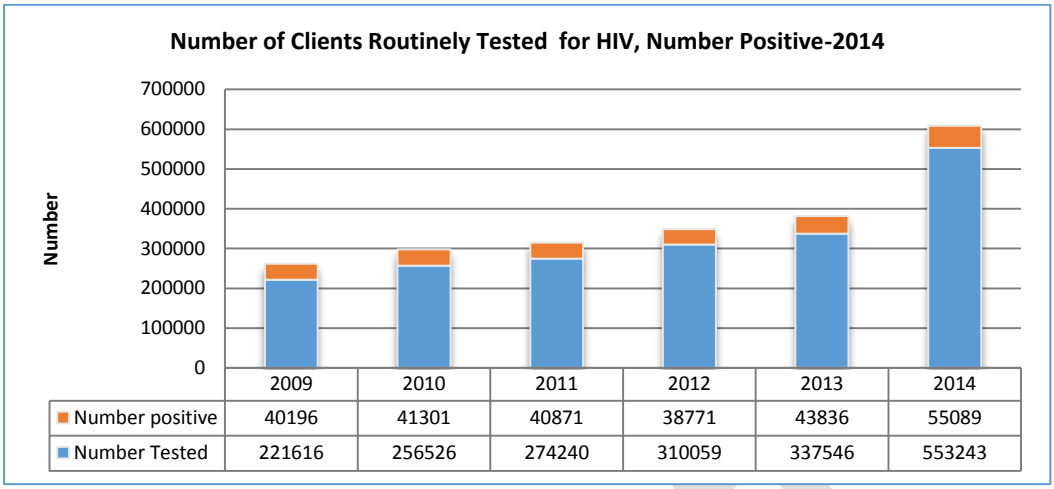
4.3.1 90% of all people living with HIV will know their HIV status:

LDHS 2014 shows that the proportion of young men (15-24 years) who never tested (35%) is more than twice (15%) that of women who never tested.

In 2013 and 2014 there were about 337546 and 553243 people respectively who tested for HIV; according to routine data it is known that on average about 60% of them were repeat testers. In the respective years 43836 and 55089 were found to be HIV positive. HIV testing has been prioritized as a gateway to treatment, prevention of mother-to-child transmission, and treatment of opportunistic infections. The HIV positivity yield has always been small. Only 40% of the people who test are new. In order for the country to reach the targets HTC services need to be strengthened to reach more people who test for HIV for the first time.

During the period under review there were frequent stock-outs for HIV test kits. Procurement of test kits was also overwhelmed by Voluntary Medical Male HIV testing demands. It was noted that this stock-outs were not due to shortage in funding but rather weak procurement system. Efforts are already under way to strengthen forecasting and procurement system. HTC services are available for all citizens including key populations nation-wide through fixed and mobile units. Lesotho implemented Provider Initiated Testing and Counseling as well mobile testing campaigns. These initiatives are challenged by inadequate human resources to meet daily service delivery demands. There are also inadequate skills in the management of pediatric HIV to cover the whole country.

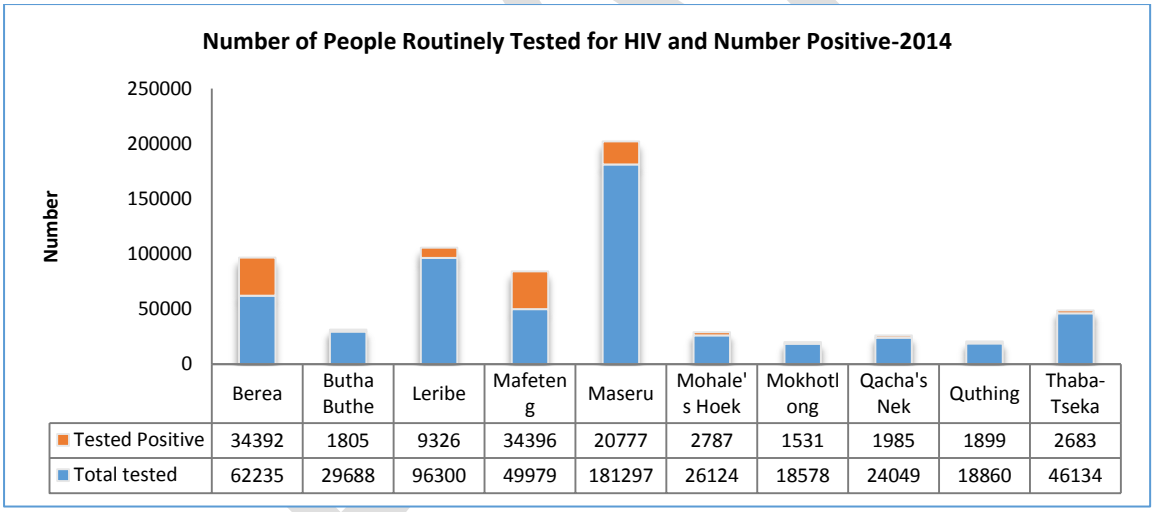
Figure 14: HIV testing in Lesotho, 2009-2014



	2009	2010	2011	2012	2013	2014
Number positive	40196	41301	40871	38771	43836	55089
Number Tested	221616	256526	274240	310059	337546	553243

In the period under review most people tested were from most fairly accessible districts of Maseru, Leribe and Berea. Districts which yielded most positives were Mafeteng and Berea. Maseru yielded fewer positive in proportion to a high number of people tested. There is need to strength HTC services to reach difficult to reach districts and improve coverage in all districts.

Figure 15: HIV testing in Lesotho Districts 2009-2014

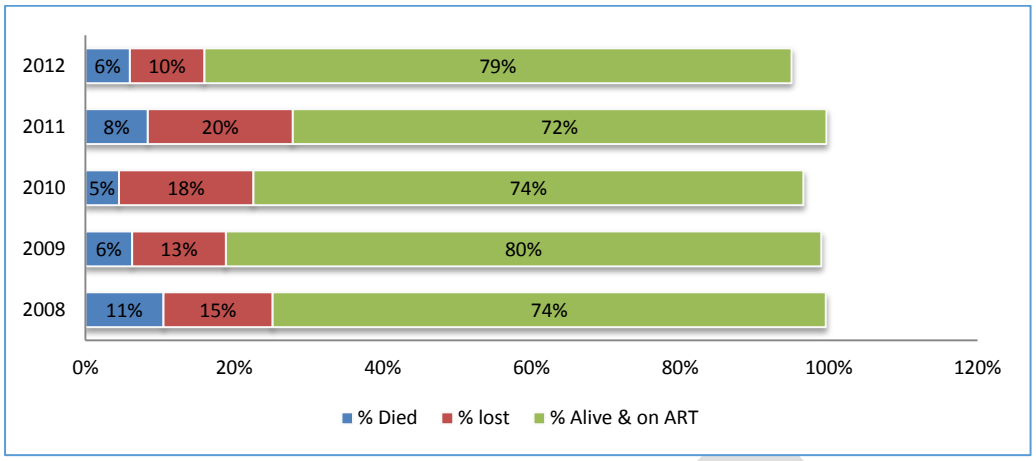


	Berea	Butha Buthe	Leribe	Mafeteng	Maseru	Mohale's Hoek	Mokhotlong	Qacha's Nek	Quthing	Thaba-Tseka
Tested Positive	34392	1805	9326	34396	20777	2787	1531	1985	1899	2683
Total tested	62235	29688	96300	49979	181297	26124	18578	24049	18860	46134

4.3.2 90% of all people diagnosed with HIV will receive sustained antiretroviral therapy.

The trends in the proportion of people alive and on ART in the last 12 months ranged between 70 and 80% between 2008 and 2012. Loss to follow was about 20% with the lowest figure (10%) reported in 2012 while percentage of those who died is always below 10%. These denote very high losses of people on treatment. It is hoped that implementation of Performance Based Funding at facility level will enhance support for the village health workers and improve retention of people on ART and as result reduce death.

Figure 16: National ART Cohort Outcomes 2011-2012



4.3.3 90% of all people receiving antiretroviral therapy will have durable suppression.

Lesotho implemented viral load monitoring for patients on ART in 2014. The initiative is at its basic phase not yet scaled-up to the districts. A total of 2219 viral load test have be conducted. The coverage is still very low.

Table 8: Scale-up of viral load support system

	Jan	Feb	Mar	Apr	May	Jun	Jul	Au	Sep	Oct	Nov	Dec	Total
VL*	665	459	176	166	170	132	285	463	657	1134	1279	805	**6391**
EID	1233	484	748	0	480	1320	2525	2083	1320	1112	1132	1077	**13514**

Note: VL numbers include MoH Lab and MSF

Regarding Early Infant Diagnosis (EID), in order to facilitate early intervention and reduce infant mortality, exposed infants are tested through DNA-PCR from as early as two months of birth. A total of infants born to HIV-positive women receiving virological test for HIV within 2 months of birth constituted 51.7%. The positivity rate was 2.9%. About half of HIV positive pregnant women giving birth in the last 12 months was lost to follow-up.

While it is known that most maternal deaths and neonatal deaths occur during the 48 hours post-delivery; there is an obvious gap that exists in the postnatal services in Lesotho where LDHS 2009 and 2014 showed that, at least 42% and 39% of women respectively did not attend post-natal services. It may also be construed from this data that, these women do not access family planning services and some HIV prevention services. Some of the challenges in paediatric HIV management include loss-to-follow-up related to stigma, non-integration of HIV infected children into Under-5 clinics services, delays in receiving DNA PCR results, and challenges related to infant nutrition among exposed infants.

Blood screening for infection is mandatory for all blood donated. In the period under review, all (100%) of blood donations were screened for ABO and RhD grouping using Automated blood grouping machine and micro plate method as a backup; HIV Ag/Ab Combo by ELISA; HBsAg by ELISA; HCV by ELISA; Syphilis by RPR and ELISA. The table below shows that HIV prevalence among blood donors was about 3%.

Table 9: Trends in the Selected Laboratory Blood Tests

Year	Blood Donor	HIV	HBsAG	HCV	Syphilis
2011	132	3.3	0.9	0.9	0.7
2012	119	3.1	0.9	0.9	0.4
2013	123	3.2	1.1	0.9	1

4.4 Reduce tuberculosis deaths in people living with HIV by 50% by 2015

In the period under review there has been a noticeable improvement in the proportion of TB patient who were tested for HIV. The trends in TB patient HIV positivity show that more than three quarters of TB clients are also HIV positive. TB remains one of the major opportunistic infections in Lesotho. There are weak synergies between TB and AIDS treatment; this is indicated by low coverage of ART among TB positive clients. Efforts are underway to improve TB/HIV coordination. In the year under review the TB program integrated co-management of TB and HIV patients in the health system. All co-infected patients were treated under one roof. There is need to strengthen proactive screening of HIV clients for TB.

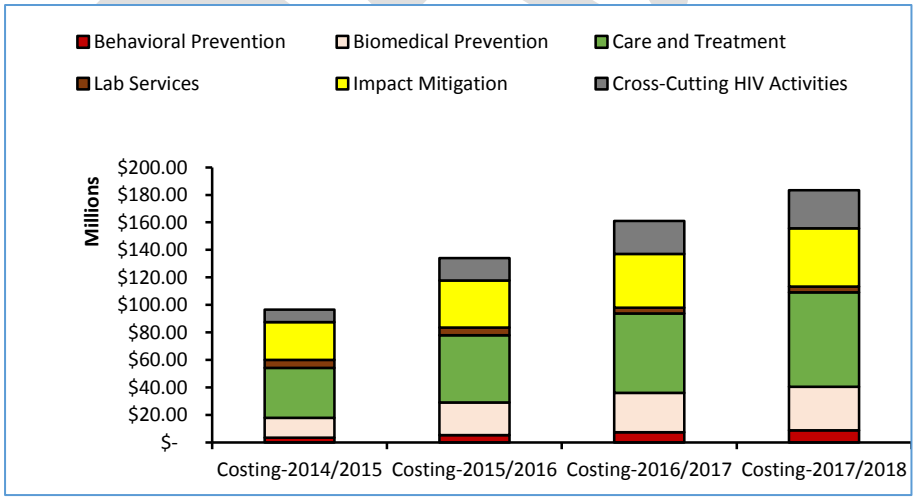
Table 10: TB HIV 2011-2014

Area	Indicator	2011	2012	2013	2014
TB/HIV	% of TB patients tested for HIV	82%	81%	88%	93%
	% of TB patients who tested HIV positive	77%	76%	75%	74%
	% of HIV Positive TB on CPT	95%	90%	97%	98%
	% of HIV Positive TB patients on ART	25%	40%	53%	72%
	Number of TB Mortality Cases	7500	7100	6900	6800

4.5 Close the global AIDS Resource gap by 2015 and reach annual global Investment of US$22-24 billion in low and middle-income countries

4.5.1 Resources Needs disaggregated by Sub-Programs

Figure 17: Resources Needs disaggregated by Sub-Programs

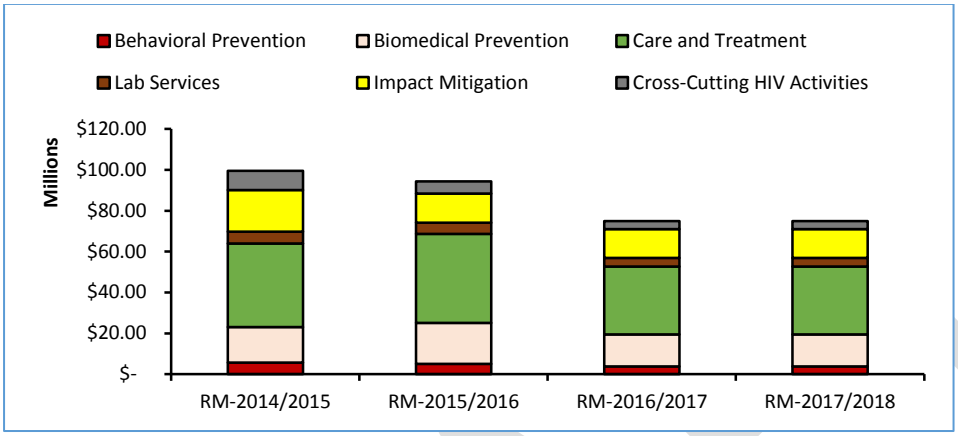


Between 2014/15 and 2017/18, the HIV response in Lesotho will cost an estimated US$593 million in Lesotho, ranging from US$97million in 2014/15 to US$191million in 2017/18. Across the years, care and treatment accounts for the largest share at 36% while behavioural prevention accounts for less than 5 %.

4.5.2 Available Financial Resources disaggregated by Sub-Programs

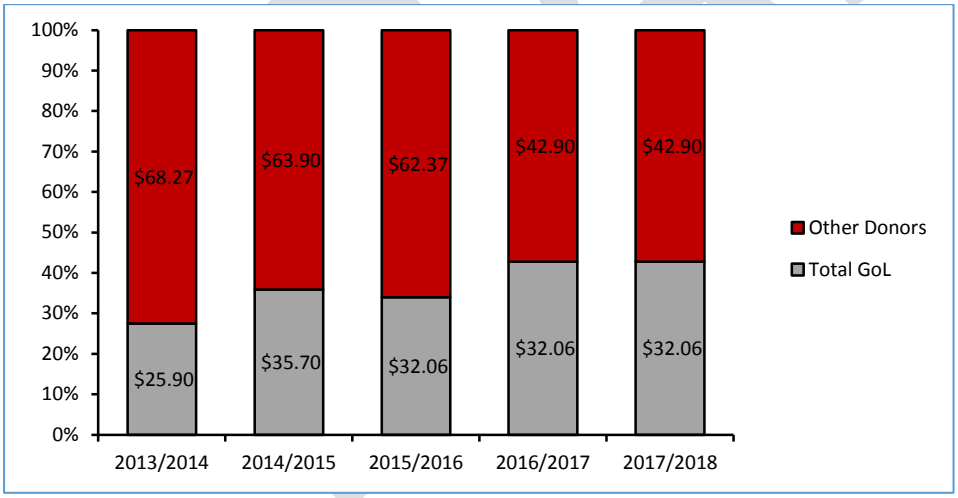
Between 2014/15 and 2017/18, the available financial resources for HIV response in Lesotho is estimated to be US$344 million in Lesotho, leaving a total gap of US$249 million of unfunded programmes. The available financial resources are estimated to decline by 25% from nearly US$100million in 2014/15 to about US$75million. The largest anticipated unfunded programmes across the years are impact mitigation and care and treatment.

Figure 18: Available Financial Resources disaggregated by Sub-Programs



4.5.3 Government contribution as a percentage of National HIV/ADS response

Figure 19: Government contribution as a percentage of National HIV/ADS response



According to the 2013/2014 Resource Mapping, the Government of Lesotho (GoL) contributed about 26% of financial resources towards the national HIV response. On average, GoL is expected to increase its share of contribution to the HIV response up to 32%. The other major financiers of the HIV response in Lesotho are the Global Fund, PEPFAR, EU and the UN family.

4.6 Strengthening HIV Integration

4.6.1 Orphans and Vulnerable Children

Lesotho has just developed two important documents to define social welfare services. National Social Welfare policy overall objective is to promote interventions that are preventive, protective and transformative in orientation, to improve the welfare of the people, particularly vulnerable groups. The policy contributes to Lesotho's Vision 2020 and the National Strategic Plan (NSDP) of preventing and reducing the economic and social vulnerabilities of the most disadvantaged segments of the society. The other document is the National Social Protection Strategy. Section 26 (2) of Lesotho Constitution stipulates that " the state shall take appropriate measures in order to promote equality of opportunity for the disadvantaged groups in the society and enable them to participate fully in all spheres of public life". It is under this clause that the country advanced to establish formal social protection programs which is one of the first in sub-Saharan Africa. The policy seeks to integrate core programs aimed at reducing vulnerability; establish strong linkages with other ministries and stake-holders among others. The NSDP envisions transformation of "Social Welfare" to "Social Development" with a purpose of improving quality of life of all Basotho people through interventions that address poverty, deprivation, vulnerability and inequality in a comprehensive and holistic manner.

The population of Lesotho is mostly constituted by young people. A situational analysis study conducted in 2011 which assessed 1,072,974 children found that 363,526 (34%) were orphans. The study also estimated that 10% of Basotho were vulnerable, and around 3% were most vulnerable.

To date the Child Grants Program (CGP) is currently active in 43 councils across all 10 districts of Lesotho. The number of households currently receiving the grant is 25,600. This means that approximately 65,000 children are directly benefiting from the grant. Through GFCU OVC bursaries have been provided to 15 000 children. Major commitment was demonstrated by Lesotho Government when it assumed responsibility for provision of both Child Grants and Bursaries.

In 2014, about 200,000 primary school children and 50,858 pre-primary ones were supported through the school feeding programme. Also, MoET was assisted to draft a school feeding policy which lays the foundations of a national government-owned school feeding programme in Lesotho. Further, on the policy and legal environment, the government through MoSD was supported to start Conditional Cash Transfer (CCT) pilot in six (6) community councils covering approximately 6000 households. In addition, the MoSD was supported in the piloting of an integrated social safety nets in 3 community council covering a total 2,371 households. It is anticipated that through this process four primary social safety nets (Old Age Pension, OVC Bursary, Public Assistance and the CGP) will be integrated in an effort to improve efficiency and reduce overlaps. Ministry of Labour and Employment also developed the Social Protection Bill that has been currently approved by cabinet and is awaiting for final approval by Parliament

Children living with HIV have been supported around the country through camp gatherings for psychological support and adherence to ART; in 2012 there were276 children reached, in 2013 about 419, and in 2013 there were 490 children reached among selected communities

who dwell far from the health facilities. The children's care givers were supported through caregivers 'clubs that convened monthly particularly in hard to reach areas.

4.6.2 Sexual and Reproductive Health and HIV Linkages Project in Lesotho

The Kingdom of Lesotho is among the seven Southern African countries (Botswana, Malawi, Namibia, Swaziland, Zambia and Zimbabwe) that the European Union is supporting the MOH to implement a project linking HIV to sexual and reproductive health through UNFPA and UNAIDS. The overall aim of the project is to support the seven countries in addressing barriers to efficient and effective linkages between HIV and SRHR policies and services as part of strengthening health systems and to increase access to and use of a broad range of quality services and achieve the goals of universal access to reproductive health (MDGs 3, 4 and 5) and HIV prevention, treatment, care and support (MDG 6) by 2015, while making relevant linkages with the education, gender and legal sectors.

According to UNFPA and UNAIDS, the benefits of SRH and HIV integrated are multi-fold. SRH services can provide a platform for reaching clients with crucial HIV prevention, care, and treatment interventions – helping them to understand their risks for HIV and make informed decisions about their sexual and reproductive health. At the same time, HIV services can provide an effective entry point for addressing the unmet family planning needs of female clients living with HIV and can increase access to and uptake of key SRH services such as cervical cancer screening and antenatal care.

The project has three broad specific objectives of:

i. supporting seven countries in Southern Africa to allow full integration of HIV/AIDS and SRHR in national health and broader development strategies, plans and budgets;
ii. enabling three countries in Southern Africa to link efforts on integration of SRHR and HIV better and scale them up effectively;
iii. Stimulating formulation and dissemination of lessons learned in the Southern Africa region, formulate best practices and facilitate South-South cooperation in this field.

The project is a catalytic initiative which seeks to demonstrate the benefits of linking and integrating SRH and HIV services, and can equally be shown through uptake of services. In Lesotho, the project was piloted in three initial sites of SDA, LPPA Clinics and Mafeteng hospital in 2012. For the purpose of this report, data from LPPA clinic has shown an increase in the uptake of SRH and HIV services since the start of the project:

- ☑ The number of male and female clients accessing **HTC** increased from 3170 in 2012 to 8,114 in 2013 and down to 6,972 in 2014
- ☑ The number of clients accessing **ART** increased from 1625 in 2012 to 5520 in 2014
- ☑ The number of female clients screened for **cervical cancer** increase from 629 in 2012 to 877 in 2013
- ☑ The number of clients provided **with STI management** increased from 1281 in 2012 to 2753 in 2014
- ☑ The number of male and female **family planning** clients increased from 26,959 in 2012 to 29203 in 2013.
- ☑ The number of **new family planning acceptors** increased from 3647 in 2012 to 4839 in 2014
- ☑ The number of **VMMC** clients increased from 412 in 2012 to 1,199 in 2014

Two key national strategic documents were also drafted:

i. 2015-2020 National Sexual and Reproductive Health Strategic Plan

ii. 2015-2020 National Health Strategy for Adolescents and Young People

5.0 Coordination of the National Response

The government of Lesotho undertook restructuring of NAC since 2009 to 2011 to strengthen the coordination and management of the national response to HIV and AIDS. The review process aimed at restructuring the National AIDS Secretariat (NAS) to make it more effective and efficient in its role of coordinating and managing multi-sectoral engagement on HIV and AIDS. It is the priority of the new government to reinstitute NAS as soon as possible. The new Government of Lesotho has prioritized HIV/AIDS response in the key priorities that are set to bring a noticeable difference during the next five years while Government is in power. These augers well for development of policies to facilitate fast-racking the HIV response in Lesotho.

6.0 Monitoring and Evaluation

During the period under review, key strategic information activities were undertaken. These were

i. Setting of the national 90-90-90 targets from 2015 – 2030
ii. Conducted Annual Join Review of the health sector including HIV
iii. Conducted VMMC Mid-Term Review
iv. Conducted HIV Drug Resistance and Early Warning study
v. Conducted Resource Mapping and Financial Gap Analysis for HIV Response
vi. Conducted a study for Examining Factors Associated with HIV-Related Risk Behaviours, HIV Prevalence, and Population Size Estimates of Two Key Population-Men who have Sex with Men (MSM) and Female Sex Workers (FSW) in Lesotho
vii. Conducted 2014 Lesotho Demographic and Health Survey including HIV testing
viii. Disseminated key strategic information from the 2013 HIV ANC Sentinel Surveillance, Lesotho GAP report, ART Cohort and programme data
ix. Review of the national data collection tools in lieu of upgrading indicators and reports in HMIS
x. Piloting of the DHIS2 with HIV programme

7.0 Best Practice – VMMC Scale-up in Lesotho

Male circumcision is associated with lower risk of HIV transmission from women to men. Lesotho is a traditionally circumcising nation with very strong cultural ties which seek to protect the highly secretive traditional practice (initiation school) which provide for rites of passage. The VMMC program developed an innovative initiative of branding VMMC to “Rola Katiba” (“take off your hat”) to ensure that VMMC was perceived as different from traditional initiation. The initiative yielded positive results as the program got to be accepted by communities with very strong culture of initiation throughout the country. This is considered to have been a good practice because it provided transformation for the Lesotho HIV response using VMMC.

The program has managed to rapidly scale-up of VMMC in 3 years achieving nearly 85,000 MCs by the end of 2014 compared to less than a 1000 in 2012 when it was initiated. About 30% of the national target of nearly 317,000 has been reached so far. In the Eastern and

Southern African region, most VMMC programs have had a slow start of a couple of years prior to taking off rapidly. According to the 2014 LDHS, 27.7% of men age 15-49 reported to have been medically circumcised.

Lesotho MOH delayed the start of the VMMC program to ensure challenges related to the misunderstandings with the culture of initiation were alleviated. The communication brand "Rola Katiba" managed to raise demand and discuss benefits of VMMC without being in conflict with cultural sensitivities of traditional circumcision but rather complementing it with the medical approach

The program expanded reach of service by involving multiple stakeholders and organization. The program is designed to fit various age groups. Beyond providing the partial protection, the VMMC program has been a gateway for clients to test and access STI treatment. Linkages to care and treatment are also reinforced which is not negligible in a population where males HIV treatment rates remain lower than female.

8.0 Major Challenges

The following challenges were experienced in 2014:

i. Continued lack of a NAC posed a challenge for the coordination of the multisectoral response
ii. Low ART coverage among adults and children with limited skills in implementing paediatric ART.
iii. Slow scale-up of viral load testing for HIV
iv. Low coverage of HTC testing in many districts particularly hard to reach districts.
v. Low post natal care leading to ART defaulting among of women post-delivery and loss to follow-up of exposed infants
vi. High HIV prevalence and stigma toward MSM and FSW and subsequent low access of health services among them.
vii. Weak linkages between Health and Community systems affecting quality of services

9.0 Future priority Actions

The next five years post 2015 are critical and will determine the future of the HIV response for Lesotho. There is still an opportunity to change the situation and reverse the trend by fast tracking and scaling up the HIV response through multi-sectoral coordination and action. Leadership, commitment, ownership and coordination at all levels of the national response are absolutely essential for an effective national HIV and AIDS strategy. The following strategic actions would be useful in moving forward at an accelerated pace:

a. Support a sustained, nationwide campaign on HIV Prevention, particularly behaviour change among adolescents and young people

b. Provide leadership and designate champions for the response especially eliminating new HIV infections in children and eliminating stigma and discrimination

c. Government consideration, approval and implementation of the recommendations of the 2012 Independent Sector Institutional Assessment (ISIA) report

d. Re-establishment of a National AIDS Coordinating Authority for multi-sectoral coordination and accountability of response

e. Increased and sustained advocacy and community mobilization by traditional, religious and political leaders to create demand for HIV and TB services at district, community and family levels. This should also include addressing issues of stigma and discrimination at the community level.

f. Decentralize and scale up interventions using innovative approaches

g. Conduct sub-national estimates and projections

h. Fast tracking and scaling up the HIV response by prioritizing high TB and HIV burden locations and high risk population groups.

i. Localize epidemic in each community - identify context specific key populations and respond with tailored responses;

j. Strengthen partnerships for the response

k. Increased access to services and fast tracking spending to boost implementation of plans and strategies.

l. Mobilise and allocate resources efficiently in programmes with high investment returns

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