Message from the Country Director

Welcome to The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) Lesotho program 2013 annual report. Through this report we share our achievements, performance, and organization’s position for 2013, hold ourselves accountable and transparent to our funders and the Government of Lesotho, including Lesotho’s Ministry of Health (MOH). We also provide an opportunity for stakeholders to review our performance, program, future plans, and priorities.

I am extremely happy with the progress we made in 2013. I am particularly thrilled about EGPAF’s contribution to the provision of comprehensive HIV services in Lesotho, as well as our contribution to improving programs through research and evaluation.

I wish to thank the MOH, our donors, and our partners, without whom we would not have realized the many achievements highlighted in this report. To the staff of EGPAF, I want to thank you for your invaluable support and commitment. You greatly contributed to all of our achievements, and I have no doubt your continued commitment and support will be critical to the elimination of pediatric HIV in Lesotho in the years to come.

Let us all continue to advocate for individuals affected by and infected with HIV as we aim to keep mothers, their children, and families safe and alive.

In solidarity,

DR. APPOLINAIRE TIAM
Country Director
EGPAF-Lesotho
List of Abbreviations

AIDS: acquired immunodeficiency syndrome
ALFA: Association Lesotho Alliance to Fight AIDS
ANC: antenatal care
ART: anti-retroviral therapy
ARV: anti-retroviral drugs
COE: center of excellence
DCC: district clinical coordinators
DHIO: district health information officer
DHMT: district health medical team
EID: early infant diagnosis
EIT: early initiation on treatment
EGPAF: Elizabeth Glaser Pediatric AIDS Foundation
EMR: electronic medical record
FHD: family health days
HIV: human immunodeficiency virus
HPV: human papilloma virus
HSS: health systems strengthening
IPT: isoniazid preventive therapy
JHU: Johns Hopkins University
LENASO: Lesotho Network of AIDS Service Organizations
LTFU: loss to follow-up
M&E: monitoring and evaluation
MNCH: maternal, neonatal, and child health
MOH: Ministry of Health
NAC: National AIDS Commission
NCD: non-communicable disease
NGO: non-governmental organization
NVP: Nevirapine
OGAC: Office of the US Global AIDS Coordinator
OI: opportunistic infection
OPD: outpatient department
PEP: post-exposure prophylaxis
PEPFA: U.S. President’s Emergency Plan for AIDS Relief
PHDP: positive health, dignity, and prevention
PHFS: Partnership for HIV-Free Survival
PITC: provider-initiated HIV testing and counseling
PLHIV: people living with HIV
PMD: partnership for management development
PMTCT: prevention of mother-to-child transmission of HIV
PSI: Population Services International
PSS: psychosocial support
QI: quality improvement
SCS: strengthening clinical services
STI: sexually transmitted infection
TA: technical assistance
TB: tuberculosis
USAID: United States Agency for International Development
VHW: village health worker
VMMC: voluntary medical male circumcision
WHO: World Health Organization
# Table of Contents

**Message from the Country Director** ................................................................. i

**List of Abbreviations** .................................................................................. ii

1. **Overview** ................................................................................................. 2
   1.1 Lesotho ..................................................................................................... 3
   1.2 The Elizabeth Glaser Pediatric AIDS Foundation ..................................... 3
   1.3 EGPAF-Lesotho ....................................................................................... 3
   1.4 EGPAF Lesotho’s Strategic Approach ....................................................... 4

2. **Maternal, Neonatal, and Child Health Services** ...................................... 6
   2.1 PMTCT ..................................................................................................... 7
   2.2 Reproductive Health: Focus on Cervical Cancer Prevention and Treatment... 10
   2.3 Pediatric Care and Treatment ................................................................. 11
   2.4 Nutrition .................................................................................................. 13

3. **HIV Services for Adults** ......................................................................... 14
   3.1 HIV Testing and Counseling ................................................................... 15
   3.2 Adult Care ............................................................................................... 17
   3.3 Adult Treatment ...................................................................................... 17
   3.4 TB and TB/HIV Co-Infection .................................................................. 18

4. **Health Systems Strengthening** ............................................................... 20
   4.1 Health Service Delivery ......................................................................... 21
   4.2 Health Workforce .................................................................................... 21
   4.3 Health Information Systems ..................................................................... 22
   4.4 Access to Essential Medicines ................................................................ 22
   4.5 Health System Financing ......................................................................... 23
   4.6 Leadership and Governance .................................................................. 23

5. **Community Initiatives** ........................................................................... 24

6. **Research and Evaluation** ....................................................................... 26

7. **Looking Ahead** ....................................................................................... 28

**Finance** ....................................................................................................... 30

**Acknowledgement** .................................................................................... 30

**References** .................................................................................................. 31
1. Overview
1.1 LESOTHO

The HIV/AIDS epidemic has had a devastating impact on Lesotho; the country has the second-highest HIV prevalence in the world.1 AIDS is the number one cause of death among a population whose average life expectancy averages 41 years; the disease’s impact on individuals, families, and communities cannot be overstated.2

Lesotho’s first AIDS case was reported in 1986. By 1996, HIV prevalence had skyrocketed to an alarming 26% among pregnant women ages 20 to 24 (up from just 3.9% in 1992). Since 2005, there has been no significant change in Lesotho’s national adult (15 to 49 years) HIV prevalence, which has remained steady at 23%, however, prevalence among pregnant women is still high (25.9%).3 The 2011 incidence of new HIV infections was approximately 17,500, and the number of AIDS-related deaths was estimated at 8,500.4

1.2 THE ELIZABETH GLASER PEDIATRIC AIDS FOUNDATION

The Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) is a leader in the global fight to eliminate pediatric AIDS. Since 2000, EGPAF, through support from the U.S. government, multilateral donors, and private donors, played a key role in supporting local governments and partners in the scale-up of comprehensive HIV prevention, care, and treatment services in areas of the world most affected by HIV and AIDS.

EGPAF has developed implementation-and solution-oriented technical expertise that now supports 6,800 health care facilities and their surrounding communities worldwide in the following impact areas:

- HIV/AIDS clinical services
- Health systems strengthening and capacity building
- Evidence-informed policy and advocacy
- Community engagement
- Monitoring and evaluation (M&E)
- Research, innovation, and implementation science

EGPAF pursues its mission through a three-pronged approach focused on program implementation, research, and advocacy. Program implementation entails provision of comprehensive programmatic, technical, and operational assistance to host governments, ministries of health, and local organizations to improve the capacity to deliver high-quality services and ensure program sustainability. EGPAF’s research efforts focus on operations research, clinical research, program evaluation, and building the capacity of host government institutions to conduct research and utilize findings to improve program performance. EGPAF also engages in advocacy at the global, regional, and national levels.

EGPAF currently supports programs in 12 countries across sub-Saharan Africa. EGPAF’s country programs are supported through a global network of technical, programmatic, and operational staff based in the United States, Switzerland, and regional posts across sub-Saharan Africa.

1.3 EGPAF-LESOTHO

EGPAF-Lesotho began its collaboration with the MOH in 2004, and established a country office in 2006. EGPAF’s role in rapid expansion in site coverage and service availability has established the organization as a key HIV service implementation partner.
In 2007, EGPAF-Lesotho was supporting implementation of HIV services in 17 health facilities; by 2009, EGPAF had expanded its support to 103 health facilities.

Prior to the U.S. President’s Emergency Fund for AIDS Relief (PEPFAR) partner rationalization in December 2013 (in which it was recommended that only one U.S. government partner per district provide a standard package of comprehensive HIV services in that district—see more details on page 9), EGPAF was supporting 200 health facilities in provision of adult antiretroviral therapy (ART) which represents 90% of facilities in the country, 208 providing adult care (93% facility coverage), 167 providing pediatric ART (75% facility coverage), 196 who provide pediatric care (88% facility coverage), and 198 (100% facility coverage) for provision of prevention of mother-to-child HIV transmission (PMTCT) services.5

As of December 31, 2013, EGPAF-Lesotho had:

- Supported MOH facilities to:
  - Provide PMTCT services to 144,000 women;
  - Enroll more than 215,000 clients into HIV care and support programs, including more than 10,000 children under the age of 15;
  - Start 86,000 individuals on ART, including 4,500 children under the age of 15 years and 9,400 pregnant women;
  - Trained over 2,800 health care workers;
  - Strategically participated in the development and revision of more than five national guidelines; and
  - Implemented six research studies to inform program implementation.5

### EGPAF-Lesotho Partners in Service Implementation

**In 2013, EGPAF worked with three strategic sub-grantee partners in Lesotho:**

1. Apparel Lesotho Alliance to Fight AIDS (ALAFA), which focuses on increasing uptake of HIV/AIDS services among members of Lesotho’s apparel industry through training and appropriate linkages and referrals. ALAFA supported the roll-out of the 2013 revised national PMTCT guidelines recommending lifelong ART initiation among all HIV-positive pregnant and breastfeeding women (Option B+) and trained nurses in provider-initiated HIV testing and counseling (PITC).

2. Baylor International Pediatric AIDS Initiative (Baylor) supports pediatric HIV clinical care at a center of excellence (COE), four satellite COEs, hospitals, and health centers. Baylor supports health worker capacity-building in psychosocial support (PSS) of HIV-affected/infected children, adolescents, and families and provides targeted TA in pediatrics to the MOH. Baylor’s medical officers provide side-by-side mentorship to health workers on pediatric HIV care to health centers, ART corners, and filter clinics. Baylor has a robust training program with focuses health worker training on PMTCT, pediatric HIV care, and adolescents living with HIV.

3. Lesotho Network of AIDS Service Organizations (LENASO) is the national umbrella body for HIV non-government organizations. LENASO strengthens links between health facilities and communities, promotes access and use of clinical services, and encourages community ownership. LENASO’s district community coordinators provide leadership for community activities which complement and bolster clinical objectives. EGPAF worked LENASO to better provide critical linkages between communities and the health care systems.

### 1.4 EGPAF-LESOTHO’S STRATEGIC APPROACH

EGPAF uses a “district approach” staffing structure, which allows for side-by-side capacity building within the existing MOH structure, to address human resource constraints in the national program, and provide continual mentorship. In 2013, within each of the 10 districts nationwide, EGPAF’s district clinical coordinators (DCC) provided direct technical assistance (TA), supportive supervision, and mentorship to district hospital staff. The DCC bolstered the HIV/AIDS program efforts of health facilities and provided direct
service support when needed. EGPAF nutrition officers are located in four districts, as part of the Partnership for HIV-Free Survival (PHFS) initiative through the United States Agency for International Development (USAID) bilateral award. EGPAF’s 17 ART/maternal and child health (MCH) integration nurses stationed at all hospitals in the country provided direct MCH/ART integration services and served as mentors for other hospital staff on EGPAF’s model of PMTCT, ART, MCH, and pediatric HIV service integration. EGPAF supported logistics and transportation within the MOH system through the staffing of a driver and provision of a vehicle in each district across the country.

EGPAF supports Lesotho’s central MOH, district health medical teams (DHMTs), health facilities, and communities. EGPAF-Lesotho’s key program strategies include:

- TA at each level of the national health system on the provision of quality integrated, comprehensive, and family-centered HIV/AIDS prevention, care, and treatment services;
- Capacity building at the district, facility, and community levels through the training of health care workers and community representatives;
- Active case finding and PITC of women, partners, children, and outpatient department (OPD) patients;
- Integration of PMTCT and treatment of HIV for mothers and children up to 24 months of age with other routine health services;
- Active follow-up with HIV-positive women and their HIV-exposed infants after delivery to provide all necessary prevention, care, and treatment services for mother-baby pairs;
- Community mobilization, outreach to hard-to-reach areas, and strengthened referral linkages to promote increased uptake and adherence to HIV/AIDS services; and
- Strengthening health systems through supportive supervision and mentorship, addressing challenges in human resources, developing national guidelines and materials, participating in national technical advisory committees and working groups, and implementing M&E activities.

Changes to TA Approaches in Lesotho

PEPFAR support to the national HIV care and treatment program in Lesotho was initiated in 2007, and was followed by a rapid scale-up of facility coverage for PMTCT and ART services from 2007 to 2011. The number of individuals receiving HIV treatment under PEPFAR support has continued to rise. During this phase of rapid expansion, PEPFAR-funded implementing partners providing complementary services expanded not only to the same 10 districts across the country, but also into the same facilities, with each implementing partner focused on specific technical areas (e.g., PMTCT, care and treatment, and tuberculosis [TB]/HIV). This resulted in multiple implementing partners operating with a degree of synergy, however, encountering some challenges related to coordination, demands for and accuracy of service reports, and possibly less than maximally-efficient use of resources.

In July 2013, a U.S. interagency task team from the Office of the U.S. Global AIDS Coordinator (OGAC) conducted a review of Lesotho’s care and treatment portfolio. Among the group’s recommendations was the rationalization of USG-supported services, meaning that moving forward, only one implementing partner per district should be providing a standard package of comprehensive HIV services. Expected results include a reduction in duplication of efforts, harmonization of reporting structures, and improved resource efficiency. The overall aim of district rationalization is for U.S. government implementing partners to work more effectively and efficiently.

EGPAF was assigned six districts (Mokhotlong, Butha Buthe, Maseru, Mafeteng, Mohale’s Hoek, and Thaba Tseka) and on December 1, 2013 began supporting a comprehensive package of HIV services: HIV testing and counseling; care and support; PMTCT, early infant diagnosis (EID) and testing, and care of HIV-exposed infants; adult and pediatric ART, including early infant treatment; tuberculosis (TB)/HIV; TB; health systems strengthening functions/laboratory (especially supply chain management and logistics); and M&E. EGPAF achieved a seamless transition in geographic and programmatic scope thanks to a precise internal strategy, rapid transition of staff and sub-grantee activities, and visits to district health teams with other stakeholders for proper handover. EGPAF classified sites within the six districts into three categories (high-performing sites, average-performing sites, and low-performing sites) and is using a different balance of direct implementation and TA for each category. EGPAF also restructured the technical team into three district teams - each responsible for two districts and each based in Maseru, but spend about 75% of their time in the field.

This report details EGPAF-Lesotho’s 2013 achievements and challenges organized by technical area: maternal, neonatal, and child health (MNCH) services, comprehensive HIV services for adults, health systems strengthening (HSS), community initiatives, and research and evaluation. The majority of these achievements occurred prior to the PEPFAR-recommended changes in implementation of TA.
2. Maternal, Neonatal, and Child Health Services
2.1 PMTCT

HIV prevalence among antenatal care (ANC) attendees in Lesotho was an estimated 25.7% in 2007, 27.7% in 2009, 24.3% in 2011 and 25.9 in 2013.3 Annually, nearly 15,000 HIV-positive women deliver children, and, without PMTCT interventions, 3,750-6,000 children could become perinatally infected each year.4 The Progress Report on the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping their Mothers Alive categorized Lesotho as one of six priority countries with a "slow decline" (poor performance) in new pediatric HIV infections, citing the following:

- 3,700 new pediatric HIV infections occurred in 2012.
- There was a 17% decrease in new pediatric infections from 2009-2013.
- Four out of 10 pregnant women living with HIV did not receive antiretroviral medicines for PMTCT.
- Eight out of 10 women or their infants did not receive antiretroviral medicines for PMTCT.6

Changes in Lesotho’s National PMTCT Guidelines

In 2006, the MOH approved policies for routine opt-out HIV testing and counseling at ANC and provision of the minimum package of ARV prophylaxis to HIV-positive pregnant women at their first ANC visit. The MOH’s PMTCT and Pediatric HIV Care and Treatment Scale up Plan for 2008-2011 called for 100% PMTCT coverage by 2011 through a district approach. Through decentralization of PMTCT services to health centers, facility coverage has increased from 37 health facilities in 2006, to 136 in 2007, and to 205 by the end of 2011, representing 100% coverage of all eligible health facilities.

The MOH has called for the elimination of MTCT and pediatric HIV, echoing the global call for countries to reduce MTCT rates to less than five percent. PMTCT guidelines for Option A including use of the *Mother Baby Pack* (a take-home pre-packaged PMTCT medicine pack) were implemented country-wide from 2006 to March 2013. In April 2013, the MOH initiated the implementation of PMTCT Option B+: lifelong ART for all HIV-positive pregnant women nationwide.

Until December 1, 2013, EGPAF and its sub-partners supported the provision of comprehensive and integrated PMTCT services in 198 health facilities in all 10 districts of the country. In 2013, EGPAF focused on ensuring PMTCT service quality and increasing population coverage, service uptake, and efficiency. EGPAF played a leading role in the national implementation of Option B+, including leading national trainings of health workers, revising the national PMTCT guidelines, and providing onsite support and mentorship in PMTCT delivery. EGPAF is co-chair of the MOH’s national technical working group on PMTCT.

One of the key components to successful roll-out of Option B+ and the ongoing provision of quality PMTCT services is the integration of HIV services into MNCH service settings. This service integration ensures that every HIV-positive pregnant woman and subsequently her HIV-exposed baby receives HIV care, treatment, and MNCH services from the same health professional in the same room – a strategy EGPAF has coined “walking through one door.”
Successful HIV/MNCH service integration addresses challenges surrounding the provision of comprehensive and timely PMTCT services (including initiation on ART under Option B+), EID, and early initiation of infants on treatment.

EGPAF staffed nurse-midwives tasked with MNCH/PMTCT/ART integration at 15 hospitals, one filter clinic, and one health center in 2013. These staff members are trained to initiate infants on ART and follow them through all components of MNCH until the child is 24 months of age. They coordinated EID activities among the site staff, supported infant treatment, followed-up with HIV-exposed infants, provided PSS, strengthened MNCH services, and championed overall efforts of integration and elimination of pediatric HIV. These nurses also served as resource persons and mentors when new staff members were hired into MNCH. Through the integration of ART in MNCH setting, EID/early infant treatment has been successfully scaled up in all hospitals, resulting in greater numbers of infants and young children tested early and initiated quickly on treatment. Service integration was also invaluable in the national roll-out of Option B+, as staff in MNCH had already been initiating women on ART within the MNCH setting and the appropriate infrastructure was already in existence.

The following steps summarize EGPAF’s innovative approach to MNCH/HIV service integration, which has been adopted nationwide:

- Group counseling is given to all pregnant women and their partners during the first ANC visit
- After the group counseling, HIV testing and counseling is provided to the pregnant women and their partners
- A “Family Book” is filled in by staff, which links HIV-positive women to other family members for active case finding of HIV-positive family members
- All routine MNCH services are offered (including screening and identification of high risk pregnancy, screening and testing for STIs, blood pressure measurements, urine tests, and counseling on delivery and birth spacing)
- All women are given mother-baby packs, with the type of pack depending upon their HIV status
- HIV-positive women are all initiated on ART at MNCH (not sent to a general ART clinics)
- ANC visits (at least four during pregnancy) are encouraged, per MOH guidelines
- All women are encouraged to deliver at health facilities
- After birth, HIV-exposed infants are initiated on nevirapine (NVP) within the maternity ward
- HIV-exposed infants and mothers are offered post-natal care services at MNCH at seven days and six weeks post-partum
- Blood is drawn for DNA PCR testing from all HIV-exposed infants at six weeks of age
- All HIV-positive children under two years of age are initiated on ART at MNCH, irrespective of CD4 counts
- The mother-baby pair is followed at MNCH until the baby is 24 months of age, at which point the mother is referred to general ART and HIV-positive children are referred to general ART; HIV-negative children are followed for other health services in under-5 clinics
- PITC, especially for children, is promoted at every interaction with the hospital system under-5 clinics, pediatric wards, OPDs, and Nutrition Corners)

**Figure 1. PMTCT cascade from 2008 to 2013**

- **Know HIV Status**
- **HIV-Positive**
- **ARVs for PMTCT**
- **Supported Health Facilities**

![PMTCT cascade from 2008 to 2013](image-url)
In 2013, EGPAF began work on two program evaluations to evaluate the effectiveness of the MOH PMTCT program in selected EGPAF-supported health facilities. To increase community demand for services, decrease loss to follow-up (LTFU), and better track mother-baby pairs, EGPAF worked with the Strengthening Clinical Services (SCS) sub-partner LENASO to strengthen community-clinic linkages and trained over 2,500 village health workers (VHW) to strengthen community-level support for PMTCT services.

To improve quality service delivery of Option B+ in the district of Thaba Tseka, EGPAF provided onsite training to 183 health workers from August to September 2013. One hundred women at these health facilities were initiated on ART in the two months after the training (with six women declining). In the two months before the training, 52 women were initiated on ART (with 18 declining) at the same health facilities.

![Figure 2. Percentage of HIV-pregnant women who received ARV for PMTCT](image)

![Figure 3. Pre-training test scores compared to post-training test scores and enrollment on Option B+ in Thaba Tseka District](image)
One of EGPAF’s major reproductive health accomplishments in 2013 was cervical screening provision through the Senkatana Center of Excellence at the Botshabello Hospital in Maseru. Cervical cancer is the most common cancer in Lesotho, and the national incidence rate (38.4/100,000 in 2013) is among the world’s highest. It is the leading cause of cancer death among women in Lesotho; 40% of all women who are diagnosed with cervical cancer in Lesotho present with advanced disease. Women infected with HIV have a higher prevalence of infection with human papilloma virus (HPV) and are more likely to develop persistent infection with multiple HPV types, as well as have a higher incidence and prevalence of pre-invasive lesions of the cervix, possibly more rapid progression to cervical cancer, and a higher incidence of cervical cancer. The rate of cervical dysplasia is higher among HIV-positive women.

Prior to 2013, there were no organized cervical cancer screening activities in Lesotho. In 2011, the MOH identified the need to create a comprehensive and cost-effective national cervical cancer screening program to reduce the incidence of cervical cancer and associated morbidity and mortality through implementation of evidence-based strategies for early detection and treatment of pre-cancers. Senkatana was chosen as the site for this program. In response to the MOH-identified need, EGPAF submitted an implementation plan in late 2011. Senkatana was launched as Lesotho’s first organized cervical cancer screening center on January 22, 2013. Senkatana staff members are now offering cervical cancer screenings, diagnoses, and pre-cancer early treatment services, along with referrals to higher institutions. Senkatana offers a walk-in program for cervical cancer screening with no appointments required.

EGPAF has engaged in the following activities in support of the project:

- Procurement and installation of two rooms for service provision and training;
- Procurement of medical supplies for cervical cancer program delivery;
- Development of national guidelines, job aids, and standard operating procedures for cervical cancer screening;
- Development of a national cervical cancer training manual;
- Successful advocacy for the placement of MOH nurses at the center;
- Staff capacity building and training; and
- Development of cervical cancer program monitoring tools.

Onsite staff support is provided by EGPAF’s reproductive health director (gynecologist), reproductive health technical advisor, PMTCT officer, and PSS counselor. From February 2013 to February 2014, a total of 2,003 women were offered screening using a combination of visual inspection with acetic acid (VIA) and pap smears. VIA is the preferred screening method because of its low cost, easy use, and the immediate availability of the results. Post-menopausal women are offered pap smears primarily because of the limitations involved in using VIA among this population. One challenge identified in 2013 was the delay in processing pap smear results in the country; EGPAF is working to improve turnaround time in 2014. Although the recommended cervical cancer screening interval is five years, HIV-positive women are screened annually.

EGPAF has developed a public awareness program for cervical cancer prevention for education and mobilization of corporate agencies and institutions. In 2013, six sessions were conducted with several agencies. In preparation for the nationwide scale up of organized cervical cancer screening, EGPAF trained a total of 62 health care workers in comprehensive prevention of cervical cancer using EGPAF-developed training materials. Five of the trainees are nurse tutors from various nursing colleges in Lesotho.

### Table 1. Health workers trained on comprehensive cervical cancer prevention

<table>
<thead>
<tr>
<th>SITE NAME</th>
<th>NUMBER OF STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senkatana</td>
<td>16</td>
</tr>
<tr>
<td>Maseru District</td>
<td>16</td>
</tr>
<tr>
<td>Berea</td>
<td>3</td>
</tr>
<tr>
<td>Leribe</td>
<td>4</td>
</tr>
<tr>
<td>Botha Bothe</td>
<td>5</td>
</tr>
<tr>
<td>Mokhotlong</td>
<td>2</td>
</tr>
<tr>
<td>Qacha’s Nek</td>
<td>2</td>
</tr>
<tr>
<td>Quthing</td>
<td>2</td>
</tr>
<tr>
<td>Mohale’s Hoek</td>
<td>2</td>
</tr>
<tr>
<td>Mafeteng</td>
<td>3</td>
</tr>
<tr>
<td>Thaba Tseka</td>
<td>7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>
Table 2. Detection rates of lesions among screened population

<table>
<thead>
<tr>
<th></th>
<th>Incidence among screened population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number screened</td>
<td>2,003</td>
</tr>
<tr>
<td>Pre-cancer lesions</td>
<td>178</td>
</tr>
<tr>
<td>Invasive cancer of cervix</td>
<td>41</td>
</tr>
<tr>
<td>Number of breast lesions/lumps</td>
<td>33</td>
</tr>
<tr>
<td>Treatment for pre-cancer lesions</td>
<td>178</td>
</tr>
</tbody>
</table>

EGPAF also held consultative meeting with DHMT and hospital management teams on scaling up organized cervical cancer screening nationwide. The 62 trained health workers will serve as mentors for district teams and will work with Senkatana staff to start screening in their districts and train additional care providers. Clients from health centers will be referred to hospitals for treatment. The program is also serving as a pre-service and in-service health workers: 15 students from the Paray School of Nursing have undergone rotational clinical attachments over one month time periods. The program also received 35 delegates from Swaziland in 2013 on a learning tour about cervical cancer prevention.

Among the 2,003 women screened, 1,559 had VIA and 444 had pap smears conducted. The majority of the clients (77%) had never had a screening for cervical cancer in the past. Clinical breast examination was offered to all women screened for cervical cancer and self-breast examination was taught. The detection rates and treatment services provided are detailed in the tables below. Invasive cancers were referred to the national hospital for further management.

Of the pre-cancer lesion treatments provided, 70% were loop excision of the transformation zone and 30% were cryotherapy. To complement the cervical cancer screening activities at Senkatana, EGPAF has also supported the development of the country’s HPV vaccine guidelines and has provided logistics support for national HPV vaccination rounds.

### 2.3 Pediatric Care and Treatment

Lesotho has approximately 40,000 children living with HIV, 22,000 of whom are in need of treatment as per the current pediatric ART guidelines. The country as a whole is still lagging in reduction of new pediatric infections, and reoccurring commodity stock-outs have challenged treatment scale-up. In July 2009, the MOH revised and completed its National ART Guidelines for the treatment of adults and children, restating their goal to achieve universal access to treatment, as well as prevention, care and support, for all Lesotho by 2010.

The guidelines indicate that all children less than five years of age should be initiated on ART.

One of the three objectives of EGPAF’s SCS Project is that 90% of facilities offer HIV care for children; another is that 90% of facilities offer pediatric ART initiation. With much effort, nearly 80% of Lesotho’s facilities are now providing pediatric care and treatment. Prior to implementing partner rationalization on December 1, 2013, EGPAF was supporting 167 health facilities for pediatric ART (75% coverage). A total number of 4,578 new children have been initiated on ART through EGPAF’s support (Figure 4).
In the last five years, 6,584 children have been cumulatively enrolled on treatment (with about 5,000 still active on treatment) by all partners in Lesotho working to scale up pediatric HIV treatment – in particular EGPAF and Baylor (Figure 5).

In 2013, EGPAF supported the MOH to scale-up comprehensive pediatric treatment services through the development of pediatric treatment-related strategic plans (including the development and costing of the PMTCT and pediatric AIDS elimination plans), guidelines, training materials, and job aids. EGPAF also supported facilities and health workers for pediatric HIV treatment services through TA, mentorship, and supportive supervision, and provided a higher-level TA to the MOH and DHMTs through participation in national technical working groups.

Frequent rotation and shortages of health staff continued to present challenges in 2013, as new staff are often uncomfortable with pediatric treatment initiation. EGPAF advocated for special consideration for MNCH staff to remain longer within the unit. EGPAF and Baylor also trained health workers to provide quality services, building their capacity to initiate new pediatric patients on ART.

Fully integrated PMTCT and pediatric treatment within the MNCH setting at all district hospitals and filter clinics is a critical component of EGPAF’s program. EGPAF’s MNCH/PMTCT/ART integration nurses at all major hospitals in Lesotho coordinated the initiation of infants on ART and appropriate follow-up until children reach 24 months of age. This approach resulted in greater numbers of infants and young children tested early and initiated quickly onto treatment in 2013. The approach was also integral to the roll-out of Option B+ beginning on April 1, 2013.

One of EGPAF’s aims under SCS was to link identified HIV-positive children to treatment within seven days and to increase the proportion of all HIV-positive children less than 24 months of age on treatment in MNCH. EGPAF supported the timely delivery and distribution of DNA/PCR results through 3G technology to fast-track the turnaround time of positive results to health facilities and, subsequently, parents/caregivers which led to reduction of overall turnaround time of results from twelve weeks to four weeks.12 For children identified as HIV-positive when they were >24 months, EGPAF appropriately linked them to ART Corners and Baylor COE and SCOEs for treatment initiation. EGPAF also worked with SCS sub-partner LENASO and leveraged ongoing MOH and Global Fund VHW activities to better track mother-baby pairs.

To improve psychosocial well-being among children infected with HIV, EGPAF continued to roll out and train health workers on play therapy for children. EGPAF worked with SCS sub-partners to hold support groups for children living with HIV (Ariel Clubs) and adolescents living with HIV (Teen Clubs).
2.4 NUTRITION

It is estimated that 39% of children in Lesotho younger than five years suffer from stunted growth, 13% are underweight, and four percent are acutely malnourished. The additional burden of HIV among children corresponds to an increase in the proportion of HIV-positive children admitted for severe malnutrition. Evidence suggests that HIV prevalence is especially high (28.7%) among undernourished children in countries with a high malnutrition burden, such as Lesotho. HIV/AIDS is also associated with an increased burden of under-nutrition even among children on ART. Many severely undernourished children die at home. Even when hospitalized, fatality rates can be high. Infrastructure challenges in Lesotho affect access to facilities and the space needed for nutrition activities, and some health workers are reluctant to engage in nutrition activities due to competing priorities.

Nutritional care and support (including counseling, education, information-sharing, and provision of food), is a fundamental component of a comprehensive package of care and support for all people living with HIV (PLHIV). EGPAF has initiated and scaled up strategic nutrition interventions with the goal of preventing malnutrition among pregnant women, lactating mothers, and children under five through the integration of nutritional supportive counseling into MCH services. Additional key activities include linking PITC, EID, and early initiation on treatment to nutrition services to improve the health of mother-baby pairs and improve family nutrition status by equipping mothers and caregivers with appropriate health and nutritional skills. EGPAF is a leading provider of technical support to the MOH Nutrition Unit.

Nutrition corners are part of a larger effort by EGPAF and the PEPFAR PHFS initiative in three districts to reduce malnutrition, especially among HIV-positive women and children. Also through PHFS, EGPAF successfully conducted nutrition sensitization meetings with DHMTs, followed by district nutrition work plan development. EGPAF has sensitized 399 health workers on nutrition assessment, counseling, and support and conducted onsite training for 286 health workers on infant and young child feeding and the integrated management of acute malnutrition.

One of the key SCS nutrition program strategies was the establishment of nutrition corners; EGPAF established 34 nutrition corners in facilities in Mohale’s Hoek, Thaba Tseka, and Butha-Buthe districts. Nutrition corners are identified spaces (integrated into MNCH services at hospitals and health centers) where nutritional counseling, HIV testing and counseling, and coaching of mothers and caregivers in appropriate health and nutritional skills take place. Mothers and caregivers attend cooking demonstrations to learn about healthy eating and food preparation skills using locally available food. EGPAF provides regular supportive supervision and mentoring to nutrition corner staff, with enhanced direct support to three district hospitals.

EGPAF has scaled up nutrition corners from four hospitals in 2010 to 12 hospitals and two filter clinics in 2013. This year, 1,425 children have been provided with services and 146 children graduated from nutrition corners with improved nutritional status. Nutrition corners are integral to the identification of children under five years of age and their caregivers for PITC, as these clients often present first with signs of malnutrition without having been tested for HIV as an underlying cause. Nutrition corners help EGPAF identify HIV-exposed children who are still breastfeeding and HIV-positive children who are younger than two years of age to ensure that they are receiving, and are retained in, optimum care for HIV prevention, care, and treatment.

Monthly growth monitoring sessions were used to identify under-nourished children who have low weight-for-age and weight-for-height. Caregivers and parents whose children do not nutritionally improve in three consecutive visits are given one-on-one counseling, while parents/caregivers who have children with swift improvement are invited to talk to the group about their experiences as “positive deviants”. In an effort to engage mothers and caretakers, nutrition corners hold graduation events for children who have been successfully rehabilitated within a 6-12 month period.

Of the 293 children (mean age of 30 months) enrolled in four nutrition corners in 2013, 170 (58%) had unknown HIV status. All 170 were tested for HIV at the nutrition corners, and 10 (5.9%) were confirmed HIV-positive. Eight out of 10 of the HIV-positive children presented with moderate under-nutrition, and all 10 children were enrolled into HIV care and treatment programs (six at ART sites and four within MNCH sites). Of the total 293 enrolled children, 165 (56%) presented with moderate under-nutrition and were eligible for rehabilitation with therapeutic food (Plumpy’nut). These 165 children were seen every two weeks for a period of four months for monitoring by nurses and screening for improvements in nutritional status. Over the four months, 94 (57%) of the 165 children improved significantly from moderate under-nutrition to normal weight/height distribution.

Nutrition corners are part of a larger effort by EGPAF and the PEPFAR PHFS initiative in three districts to reduce malnutrition, especially among HIV-positive women and children. Also through PHFS, EGPAF successfully conducted nutrition sensitization meetings with DHMTs, followed by district nutrition work plan development. EGPAF has sensitized 399 health workers on nutrition assessment, counseling, and support and conducted onsite training for 286 health workers on infant and young child feeding and the integrated management of acute malnutrition.
3. HIV Services for Adults

(Photograph: EGPAF)
3.1 HIV TESTING AND COUNSELING

Key elements of Lesotho’s national response have included educational programs, impact mitigation for affected families, and care and treatment for opportunistic infections (OIs). The first national strategic plan for AIDS was published in 2000, and the Lesotho AIDS Program Coordinating Authority was established the following year (later replaced by the National AIDS Commission [NAC]). Significant national-level commitment and leadership were demonstrated in 2003 when King Letsie III called HIV/AIDS a national disaster and helped to launch the Know Your Status campaign, which aimed at testing every Basotho over the age of 12.

The HIV epidemic in Lesotho continues to be fuelled by the inter-relationship of several behavioral and structural drivers. These include multiple concurrent partnerships, inadequate levels of HIV testing and counseling and personal knowledge of HIV status, low frequency of condom use, challenges in getting youth and adolescents to change sexual behavior patterns, high rates of alcohol abuse, and low demand for voluntary medical male circumcision. The structural barriers include socio-cultural factors for women and girls (e.g., poverty and inequality, and difficulties accessing health care services).

Although general HIV testing and counseling was not an official component of EGPAF’s PEPFAR-funded program until the implementing partner rationalization on December 1, 2013, EGPAF had engaged in testing campaigns throughout the year, especially community-level outreach and HIV testing and counseling within the PMTCT setting. EGPAF was cognizant that a successful HIV program needed to have a robust testing strategy in place, as HIV testing and counseling is the entry point and gateway to HIV prevention, care, and treatment services. The overall goal of EGPAF’s testing strategy was to identify as many people with HIV infection as possible and link them to services, using PITC to reach pregnant women, children, and families of PLHIV. In 2013, 21,529 women and over 2,000 men were provided with HIV testing and counseling within PMTCT at EGPAF-supported health facilities.

Family Health Days

For many reasons, it is still a challenge for a number of people to access health services offered at conventional health facilities. Additionally, non-communicable diseases (NCDs), such as diabetes mellitus, hypertension, and non-HIV related cancers are often not a major focus of the national health system. Following discussions with the MOH and USAID, EGPAF initiated Family Health Days (FHD), mobile health interventions which bring HIV prevention, care, and treatment services to remote areas, as well as to identify and appropriately manage NCDs while providing a package of primary health care services at community level. The campaigns were intended to mobilize communities and families to access integrated health services. Prior to the actual campaign days, consensus meetings and community awareness activities were conducted to mobilize community members to join the events. District FHD rounds targeted the general population (especially in hard to reach areas where there exists high demand for HIV testing and counseling services and low immunization coverage) and communities with large numbers of people eager to come to specific service delivery points. FHDs were conducted by multi-disciplinary teams composed of medical doctors, nurses, counselors, community health workers, social workers, and nutritionists. Overall, the prevalence of hypertension was 24.2% and that of diabetes mellitus was 3.1%.16

At FHDs, rapid HIV testing was performed on adults and children aged 18 months and above. Patients who tested positive were appropriately counseled and enrolled in care at the closest facility using an assigned VHW. For children aged nine to 18 months, rapid HIV testing is offered according to national guidelines. For children aged less than nine months, HIV test samples were transported to the laboratory for DNA/PCR testing and results returned to facilities nearest to the testing sites using EGPAF’s 3G transmission system.
Caregivers of HIV-positive infants were immediately reached by VHW and community focal persons, and asked to come back to clinics for counseling, discussion of HIV test results, and enrollment of the infant into ART clinic services. Over 2013, EGPAF conducted FHD in all 10 districts, including HTC and community-based HIV care and support. The HIV prevalence among adults was 5-7% at the community level (including 1% among adolescents and less than 0.5% among children).

There are gaps in accessing and providing quality adolescent reproductive health services (ARHS) at health facilities. However, at the community level, there is a great potential for integrating, scaling-up and sustaining ARHS, as was discovered during adolescent-focused FHDs conducted in two districts in 2012. In 2013, EGPAF, the MOH, and UNICEF collaborated on another ARHS project, with an overall objective to integrate ARHS into all FHD. The project used the first day of each round of FHD as a special emphasis day for adolescent-friendly services. Overall, a total of 3,462 clients were offered HIV testing and counseling and other services; out of these, 1,813 (52%) were adolescents. Of the 1,813 adolescents tested for HIV, 28 adolescents (1.5%) tested HIV-positive and were enrolled into care at the nearby health facilities. Overall, 127 clients tested HIV-positive with adolescents accounting for 22% (28/127).5

Also in 2013, EGPAF procured two mobile clinics. These clinics will become active in 2014 and will provide comprehensive health services to hard-to-reach communities in two districts.
3.2 ADULT CARE

At 23.7%, Lesotho’s overall HIV prevalence is the second-highest in the world. One of the three objectives of the SCS project was that 90% of health facilities offer HIV care for adults. A total number of 16,193 new HIV-positive adults were enrolled in care since the inception of SCS. Prior to implementing the PEPFAR-recommended partner ratiornalization, EGPAF was supporting adult HIV care services in 208 health facilities across Lesotho. After December 1, 2013, EGPAF continued to support the provision of comprehensive HIV care and support in over 140 health facilities in six districts.

In 2013, EGPAF conducted trainings and mentorship activities of health workers in comprehensive HIV care and treatment, routine screening and treatment of PLHIV for OIs and sexually transmitted infections (STIs), SRH services, nutritional care and support, and PSS. Using a family-centered approach, EGPAF supported health workers to offer routine screening and treatment of PLHIV for OIIs and STIs according to national treatment guidelines. EGPAF began work on the integration of HIV and STI services under the USAID-funded PSI Letlama Project until May 2013, and then transitioned this work to the SCS Project.

PSS and counseling are important aspects of care for patients with any chronic illness, including HIV. Lesotho has been rolling out ART services since 2004, but continues to face challenges in provision of adequate PSS services. EGPAF has a full-time PSS counselor providing TA to the MOH, who has worked with staff at the Senkatana Center of Excellence to establish a space where other PSS counselors from across the country can come for rotations. The EGPAF PSS counselor has also worked closely with the MOH to establish a PSS task team. Scaling-up and promoting PLHIV support groups was another key component of EGPAF’s work in adult care in 2013. LENASO worked with over 60 PLHIV PSS groups, including groups specifically for pregnant women, mothers-in-law, men, and fathers-in-law.

Another key element of EGPAF’s adult care program is integrating HIV prevention services into routine care for PLHIV. These prevention services (including both behavioral and biomedical activities), combined with other health services, make up the PHDP service package. EGPAF focused efforts on partner and couples HIV testing and counseling to identify sero-discordant couples and train health workers on a variety of strategies to prevent sero-conversion of uninfected partners. EGPAF continued to use male partner invitation letters in the PMTCT program, which has shown promise in increased rates of male partner HIV testing and counseling and linkage to care and treatment.

3.3 ADULT TREATMENT

Although ART was available in private sector sites in Lesotho as early as 2001, the government of Lesotho launched a more ambitious response to HIV in 2004 by providing free ART nationwide. However, a major challenge to providing universal access to ART is the human resource constraint - Lesotho has very few physicians to initiate treatment. To address this, Lesotho is implementing task shifting and decentralization of service provision.

In 2007, EGPAF-Lesotho was working in 17 health facilities; by 2009, EGPAF had expanded to 103 health facilities. Prior to implementing partner rationalization on December 1, 2013, EGPAF was supporting 200 (93%) health facilities for adult ART, surpassing the SCS project objective of 90% coverage for adult treatment nationwide. A total of 81,607 new adults were initiated on ART under SCS, and the total number of adults on ART at EGPAF-supported health facilities was 86,708 by the end of September, 2013. After implementing partner district rationalization, EGPAF has continued to support adult ART at over 140 facilities in six districts, with a total of 59,681 adults on ART by the end of December 2013.

EGPAF has supported the MOH to scale up comprehensive care and treatment services through the development of strategic plans, guidelines, training materials, and job aids. In 2013, EGPAF also provided TA to the MOH to finalize national documents and supported the printing and distribution of tools for quality HIV care, including appointment books and a defaulter tracking tool to address challenges of loss to follow-up (LTFU). To address LTFU of those enrolled in treatment programs due to a weak national referral system and community-clinic linkages, EGPAF implemented intensified case finding by community focal persons and VHWs, appointment books, and SMS reminders to strengthen the referral systems and follow-up. EGPAF initiated a patient clinical chart audit in 2013 to identify outcomes of patients ever initiated on ART in Lesotho (see Research and Evaluation on page 32).

EGPAF supported facilities and health workers in provision of adult ART through TA, mentorship, and supportive supervision, and provided high-level of TA to the MOH and DHMTs. EGPAF’s technical advisors also provided advice to facility staff on complicated treatment cases, including review for treatment failure and requests to the second line ART committee.
3.4 TB AND TB/HIV CO-INFECTION

TB is the most common OI and the leading cause of death among PLHIV. Since EGPAF has supported the full integration of PMTCT into MNCH services, EGPAF has also been integrating TB services for pregnant women into MNCH. Integration increases health system cost efficiency and access to services while improving outcomes by reducing deaths among HIV patients and increasing cure rates among TB patients. ANC and post-natal care are suitable platforms for TB screening, and make these services and referrals for case detection and treatment readily available to women and children in MNCH. EGPAF has also ensured that women accessing ANC and post-natal care are being screened for TB, and that TB testing and treatment information is documented in registers. HIV-positive mothers and children with no active TB were given Isoniazid Preventive Therapy (IPT) at MNCH. Those suspected of being TB-active were referred to TB clinics for further investigation and treatment.

Since the district rationalization process, TB and TB/ HIV is now an even larger part of EGPAF’s program portfolio. EGPAF placed an intensified focus on scaling up intensive case finding and a back-cascade system for pediatric TB and rapid scale up of IPT at the health centers in EGPAF-supported districts. In addition, EGPAF has supported all EGPAF-supported hospitals to implement Model Three of TB-HIV integration, in which patient-centered care is provided by the same trained health care provider at the same visit (a “one-stop service”). In this model, all TB/HIV co-infected people are initiated on ART and TB treatment at TB clinics and remain there until treatment is complete. This approach, along with increased prevention and testing strategies, has shown significant increase in the number of co-infected patients initiated on ART.
4. Health Systems Strengthening
Effective and locally-owned leadership at the national, sub-national, and community levels is critical to ensuring a viable and efficient health system that delivers quality services and improves the health of women, children, and their families. EGPAF programs support all six WHO HSS building blocks, while also supporting governments to increase coordination amongst the six areas. While each of the building blocks has an essential role, a health system will only be strong when the six blocks work in concert. EGPAF works to strengthen local health systems through in-country capacity building, which supports the MOH and other local organizations to deliver services and help develop evidence-based policy. EGPAF is committed to working within the systems of government programs, in close cooperation with the MOH and other local service providers.

4.1 HEALTH SERVICE DELIVERY

Good health service delivery systems provide effective, safe, quality health interventions to those who need them. EGPAF has worked with the MOH to strengthen MNCH, ANC, TB, and primary care platforms, and to integrate HIV services into these platforms. EGPAF supported the MOH to successfully integrate HIV and TB services within broader MNCH services at every health facility across the country. EGPAF also supported and scaled up integration of HIV services in TB services at the facility level.

EGPAF strives to improve clinical care by integrating quality improvement (QI) processes into all facets of programming. QI is facilitated through supportive supervision and mentoring, frequent site visits, regularly scheduled staff meetings to share successful activities, and utilization of standardized tools to improve performance. EGPAF has established QI committees in each district, trained health workers on the Plan-Do-Study-Act cycle, and implemented QI projects at 18 facilities. Key indicators have shown improvement due to QI: proportion of HIV-positive pregnant women assessed for ART eligibility increased significantly from 60% to 88%, uptake of DNA/PCR testing at two months of age increased from 62% to 85%, and follow-up of HIV-exposed infants and HIV rapid test at nine months increased from 15% to 65% over a period of 6 months.

EGPAF also works directly with district and site staff to review practices, identify bottlenecks, and implement changes related to planning, management, and implementation of health services in an effort to improve the efficiency of health services. EGPAF supported the MOH to establish systems and services that immediately enroll HIV-positive clients in care and treatment in MNCH, ANC, and TB services, thereby reducing delay in referrals and the number of patients who are LTFU. Because adequate space and equipment are essential to improving service quality, EGPAF has also provided crucial equipment (including CD4, biochemistry, and hematology machines) and supplies (delivery beds, blood pressure machines, and weighing scales) to several of EGPAF supported sites. EGPAF procured two mobile clinics in 2013 to bring services to hard-to-reach populations less likely to access static health facilities in Thaba-Tseka and Mohale's Hoek districts.

4.2 HEALTH WORKFORCE

A well-performing health workforce has sufficient numbers, distribution, and a mix of competent, responsive, and productive frontline health workers with managerial and regulatory support to achieve the best health outcomes possible given available resources. EGPAF supports the training of graduating health professionals on the integrated management of adolescent and adult illnesses and in-service training and develops job aids to ensure all health care providers
have the most up-to-date technical knowledge and skills for providing quality services. EGPAF provides innovative strategies to support the MOH to attract and retain health workers, such as ongoing supportive supervision, mentoring, and training.

From EGPAF’s central office in Maseru, senior staff members in 2013 continued to provide national-level TA and supportive supervision and oversight to districts. EGPAF’s DCCs provided direct TA, supportive supervision, and mentorship to district hospital staff. EGPAF’s ART/MCH integration nurses at 17 hospitals provided direct MCH/ART integration services and served as mentors for other hospital staff, and EGPAF’s nutrition officers worked in four districts to offer nutrition counseling. EGPAF also continued to support logistics and transportation gaps through provision of a driver and a vehicle in each supported district.

4.3 HEALTH INFORMATION SYSTEMS

A well-functioning health information system ensures production, analysis, dissemination, and use of needed information to maximize health system performance and population health. In Lesotho, there remain significant gaps in the effective collection, analysis, and use of data to manage the country’s HIV program. Key barriers include: insufficient M&E expertise, low numbers of trained staff at national, district, and facility levels, and lack of formal data feedback systems to link national-level analysis back to districts or health facilities. Reliance on a paper-based data recording and reporting system also continues to affect accuracy and timeliness of reporting, as well as the depth of information.

In 2013, EGPAF continued to support health information systems at the national, district, and health facility-level and worked to ensure that district-and health facility-level reporting activities were locally owned, and that all data was of high quality. EGPAF provided TA to improve clinical patient records, registers, and electronic clinical information systems. EGPAF trained M&E staff engaged in supportive supervision, and supported local stakeholders to use data for evidence-based decision-making and care provision. EGPAF’s support for M&E included a strong focus on capacity building and increased ownership of M&E activities for the MOH through training and mentorship. QI activities promote the use of data for decision-making.

EGPAF’s M&E team is based in Maseru, but spent substantial time in the field in 2013, collaborating closely with the central MOH, district health information officers (DHIO), AIDS officers, and DHMTs. EGPAF’s M&E activities at the district and facility level in 2013 included:

- Health worker mentorship and onsite training on data recording and reporting;
- Revision of ANC and maternity databases to accommodate guideline changes;
- Support for data collection and report submission logistics;
- Provision of DHIOs with 3G modems and internet to facilitate electronic data submission; and
- Data verification and patient file audits of 2011 and 2012 ANC data and 2013 ART data.

EGPAF’s M&E activities at the national level in 2013 included:

- Development and revision of national M&E tools (ANC, maternity, under 5, integrated TB/HIV, patient tracking tool, etc.);
- Printing and distribution of national M&E tools;
- Data entry and management of HIV care and treatment data for Disease Control Directorate;
- Strengthened systems and improved data quality by placing an EGPAF M&E officer at the national Health Planning and Statistics Unit;
- Support for revision of the National Health Management Information System Strategic Plan;18
- TA to MOH QI program, including joint supportive supervision and facility accreditation;
- Rapid assessment of use of the national M&E tools;
- Establishment of an electronic medical records system for Senkatana;
- Tracking of data submission and reporting completeness; and
- Training on data recording and reporting.

4.4 ACCESS TO ESSENTIAL MEDICINES

A well-functioning health system ensures population access to essential medical products, vaccines, and technologies. In 2013, EGPAF provided national, district, and site level TA to strengthen the supply chain to ensure a consistent supply of drugs and other commodities to health facilities. EGPAF has played a key role in costing medicine needs for all national strategic plans and guidelines.
4.5 HEALTH SYSTEM FINANCING

A good health financing system raises adequate funds for health and uses them most cost effectively to ensure people can use needed services. EGPAF’s main contribution to this building block has been its health economics work, including:

• A financial gap analysis of the resources necessary to eliminate pediatric HIV;
• Costing of PMTCT Option B+;
• Economic evaluation of PHFS initiative;
• Costing of FHD program; and
• Costing of Senkatana Centre of Excellence.

4.6 LEADERSHIP AND GOVERNANCE

Good leadership and governance assures that strategic policy frameworks exist, effective oversight, coalition-building, and citizen input, as well as appropriate regulations, standards, and incentives assure the population’s health and access to quality health services. EGPAF serves on national technical working groups that provide technical guidance and policy recommendations.

Through its national program support, EGPAF led the revision of the following national documents from 2010-2014:

• 2010 and 2014 ART guidelines;
• 2010 and 2013 PMTCT guidelines;
• 2010 and 2013 TB guidelines;
• 2010 and 2013 HIV testing and counseling guidelines;
• 2013 cervical cancer screening guidelines;
• Integrated management of acute malnutrition guide;
• National strategic plan for elimination of pediatric HIV;
• National strategic plan for TB; and
• National strategic plan for HIV.

EGPAF supports the development of national training curricula and builds local capacity for HIV service delivery with the ultimate goal of transition of program implementation responsibility to national governments and local NGOs. EGPAF has supported the revitalization and capacity building of LENASO as a national CBO network through a comprehensive organizational development approach.

One of EGPAF’s key HSS initiatives has been the Partnership for Management Development (PMD)/District Multidisciplinary Team (DMT) program. From 2012-2013, EGPAF implemented PMD, a program designed by the University of Cape Town Business School for Lesotho’s MOH, to address health service gaps by developing the management capacity of health care leaders. A gap analysis identified four topics for needed improvement: team-based leadership; facility-based deliveries; supply/drug stock-outs; and data use to support managerial approaches. PMD teams actively embraced the multi-disciplinary approach to health care management rooted in data use. Accomplishments of the PMD program include:

• Initial one-week training on PMD curriculum for 79 health care leaders;
• Formation of one national and 10 district PMD teams;
• Orientation and co-opting into PMD team of each district’s district administrator, district council secretary, DHMTs, and hospital management, plus senior MOH management;
• Supportive supervision questionnaire administered and regularly occurring joint supportive supervision visits initiated in 2012 and continued throughout 2013 in order to support health facilities in implementing quality services;
• Development of MOH referral form, district-specific baseline and target data, and integrated supportive supervision tools;
• Development of district and national PMD health implementation plans and activities;
• Development of a pharmaceutical management information system reporting template and meetings;
• Quarterly and mid-year review PMD meetings to chart progress; and
• Training of more than 700 health workers on several aspects of health delivery.

From 2012 to 2013, the percentage of HIV-positive infants aged two months or younger decreased from four to three percent, and average attendance of first and fourth ANC visits increased by seven percent. Facility-based deliveries increased from 41% to 64%, and timeliness of report submission from health facilities to district level also improved. Ninety-eight percent of respondents in the final survey of health managers trained under the PMD program reported a large change in their personal approach to service delivery.5
5. Community Initiatives
Eliminating pediatric HIV and providing quality HIV care and treatment for children and adults will remain out of reach if efforts are focused solely at clinical and facility levels. EGPAF supports innovative models of community involvement and employs a multifaceted approach to: improve health-seeking behaviors, increase uptake of HIV and MCH services, retain women, children, and families in services, and enhance the psychosocial well-being of PLHIV.

In Lesotho, tracking patients is challenging given that many clients move from one facility to another (transfer in/transfer out) without proper documentation, and, due partly to stigma and migration patterns, some patients may provide false identities or addresses, which can add to tracing challenges. EGPAF’s community activities in 2013 focused on supporting the MOH community initiative, training VHW, providing support to facilities and communities on linkages to ensure the continuum of care, capacity building of local NGOs and support groups, and encouraging service uptake at the community level.

EGPAF engaged in activities to promote health-seeking behavior, improve awareness about available health and social services, provide education about HIV and other health issues, encourage uptake of ANC and post-natal care, and address stigma and discrimination. EGPAF led the implementation of multiple rounds of FHD in each district to bring services to those who are the hardest to reach. Mobilization for both HIV services (including HIV testing and counseling) and non-communicable diseases (such as blood pressure checks) was integral to FHD success.

EGPAF also strengthened two-way referral systems and provided systems strengthening for local organizations and community service providers through training, mentorship, and supportive supervision. EGPAF continued to support LENASO to scale-up and lead community engagement activities. EGPAF and LENASO trained community focal persons on integrated HIV care and community linkages to strengthen community support for PMTCT and promote access to and uptake of MCH and PMTCT services.

In 2013, EGPAF trained over 2,500 VHW on PMTCT Option B+ and tracking and referral of expectant mothers to health facilities. EGPAF staff also participated in the review and dissemination of the VHW policy and supportive supervision guidelines, and the revitalization of the national primary health care strategic plan. EGPAF’s role in revitalizing the national VHW program and providing TA on PMTCT and data quality will support increased service utilization and quality towards elimination of pediatric HIV in Lesotho.
6. Research and Evaluation

(Photo: Heather Mason)
In 2013, EGPAF-Lesotho continued to lead studies in clinical, laboratory, and implementation science research with a focus on optimizing health service delivery, building an evidence base for new and innovative interventions, and effectively scaling up promising HIV and maternal, newborn, and child health interventions. Progress on several ongoing EGPAF studies in Lesotho are highlighted below.

- In 2013, EGPAF Lesotho began two program evaluations in Lesotho to evaluate the effectiveness of the MOH PMTCT program in selected EGPAF-supported health facilities. A two-year prospective cohort study of ANC attendees and their infants will aim to assess program effectiveness following implementation of Option B+, by determining HIV transmission rates among HIV-exposed infants, measuring 18-24 month HIV-free survival among HIV-exposed infants, and identifying factors associated with transmission and survival. In addition, HIV infection rates and HIV-free survival (and associated factors) among 18-30 month old HIV-exposed infants who were born during implementation of the previous PMTCT guidelines (Option A) will be measured through cross-sectional community-based household surveys. Taken together, these evaluations will assess the effectiveness of current PMTCT service delivery to establish a baseline assessment of the benefits garnered with the implementation of the PMTCT program under Option A, as well as to monitor progress towards the virtual elimination of new pediatric HIV infections under Option B+.

- EGPAF received a sub-award from Population Services International (PSI) through which EGPAF conducted a baseline assessment of post-exposure prophylaxis (PEP) services from September-October 2012 in collaboration with the MOH in each district of Lesotho. The assessment report and findings were presented and disseminated to stakeholders in March 2013, and have formed the basis for reviewing and updating the PEP national registers and reporting of HIV-exposed individuals in the occupational and non-occupational settings.

- In 2010, prior to implementation of activities under the SCS project, a baseline assessment of facilities in 10 supported districts was conducted in order to inventory the needs of each site and community to fully implement comprehensive HIV/AIDS services and programs. Using the findings of this baseline assessment, project activities under SCS were planned. In the baseline assessment, all existing health facilities were evaluated to determine the steps that needed to be taken to help each site move toward provision of more comprehensive HIV/AIDS services. Each site was supported by EGPAF and by DHMTs to develop a facility strategy and work plan to scale up services. A mid-term evaluation was planned as part of the original project proposal and conducted in 2013. The findings of the mid-term assessment will be compared against the benchmark information obtained from the baseline assessment, and will provide critical information to Lesotho and the MOH for continued response to the HIV epidemic. Results of this mid-term assessment will be presented in our 2014 annual report.

- In 2013, EGPAF initiated a patient file audit with the aim of determining outcomes of PLHIV who had been initiated on ART. The exercise was extensive, with over 100,000 files reviewed in 2013 alone. In 2014, EGPAF will conclude the data collection in Maseru District. The data will be analyzed and results of the patient file audit will be presented in our 2014 annual report.

- EGPAF finalized the evaluation of the Mother-Baby Pack in 2013 and is documenting the distribution and implementation of the packs and their feasibility and acceptability. Results from the evaluation (which will be available in 2014) will have significant implications for the PMTCT program in Lesotho as well as globally, as other countries consider implementation of similar PMTCT drug distribution models.

- In 2013, EGPAF also finalized a study focused on HIV and TB during pregnancy to identify best practices in programming, clinical mentoring, and implementation science, and to support national implementation of relevant programs.
7. Looking Forward
The U.S. government implementing partner district rationalization was established in late 2013. EGPAF-Lesotho drafted a new strategic plan for the time period covering 2014-2018. The goal of the plan is to expand comprehensive HIV services to reach the tipping point for reversing Lesotho’s HIV epidemic in order to reduce morbidity, mortality, and new infections, in line with OGAC’s district rationalization strategy. The strategic plan objectives are as follows:

- EGPAF-Lesotho will build on country-level, regional, and global research and evidence to implement quality HIV prevention, care, and treatment services in Lesotho;
- EGPAF-Lesotho will expand and integrate comprehensive HIV prevention, care, and treatment services that are high quality, family-centered, and sustainable;
- EGPAF-Lesotho will advocate for an optimal environment to sustain the gains made against the Lesotho HIV epidemic; and
- EGPAF-Lesotho will ensure an organizational culture of efficiency, accountability, and effectiveness to support the pursuit of our goals and objectives.

In 2014, EGPAF also plans to achieve the following:

- Work with MOH to set specific targets for facilities, districts, and village health workers in terms of number of services provided to try to increase accountability and service delivery;
- Scale up program reach based on various national strategic plans;
- Successfully implement the increased scope of the SCS Project in six districts using the district approach;
- Monitor the implementation of PMTCT Option B+, especially in relation to population-based scale-up, retention in care, and outcome of infants;
- Scale up the cervical cancer program to other districts of the country;
- Begin implementation of the program evaluations of the effectiveness of the MOH PMTCT program in selected EGPAF-supported health facilities;
- Develop and publish manuscripts from current operation research studies; and
- Support the revision of the national HIV care and treatment guidelines for adults and children.
EGPAF-Lesotho’s annual operating budget has gradually increased from US$2 million in 2009 to over US$5.8 million in 2013, with PEPFAR as the main funding source via a cooperative agreement from the USAID for the SCS Project. Other funding sources in 2013 included: the Global Fund to Fight AIDS, Tuberculosis, and Malaria; ViiV Healthcare; JHU; PSI; UNICEF-Lesotho; and UNICEF. The breakdown of the 2013 country budget, which totaled over $5.8 million, is shown below by project:

![Figure 9. EGPAF Lesotho 2013 annual budget](image)

With the diversification and expansion of the funding portfolio, the EGPAF-Lesotho team grew from 36 staff persons in March 2009 to 87 by December 31, 2013. From EGPAF’s central office in Maseru, senior staff members provide national-level TA and supportive supervision and oversight to the district level.

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References
