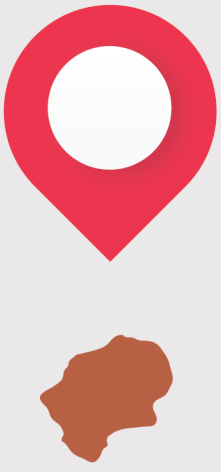
Lesotho

Key Populations' Strategic Priorities



Introduction

By the end of 2024, Lesotho had made significant strides in advancing HIV prevention, care, and treatment services for key populations (KPs, largely driven by PEPFAR support. Comprehensive, holistic service delivery for gay and bisexual men (GBMSM), transgender people (TG), sex workers (SW), and people who use drugs (PWUD) was established through well-coordinated one-stop-shop services, outreach initiatives, and drop in centres (DICs) .

In December 2024, four (4) fully functional DICs were operational in Maseru and Leribe under the PEPFAR-funded project and served as vital safe spaces where KPs could access a range of biomedical, psychosocial, and structural services in a nonjudgmental environment. Beyond health services, these centres provided mental health support, legal referrals, and empowerment programmes. These centres also conducted extensive community outreach and peer-led linkage and retention support. PEPFAR-supported programmes in Lesotho were delivering differentiated and stigma-free ART and PrEP services to an estimated 42,050 newly enrolled (KPs and general population) on oral antiretroviral pre-exposure prophylaxis (PrEP) across priority districts, especially in Maseru and Leribe. These services were provided through tailored approaches that emphasised confidentiality, peer navigation, and KP-friendly clinical staff.

However, PEPFAR's announcement of grant cancellations led to the abrupt termination of comprehensive KP programmes in Maseru and Leribe. Over the first half of 2025, the KP community has experienced severe setbacks due to complete withdrawal of PEPFAR funding and termination of holistic HIV programmes.

As of mid-2025, the current state of access to HIV and related health services for KPs in Lesotho ostensibly became precarious, marked by significant service disruptions, shrinking safe spaces, and reduced community participation in health planning processes. Presently the 4 KP-led DICs providing PrEP, ART, STI services have been terminated. Peer outreach activities and education, peer navigators, and KP-friendly service providers previously trained and deployed under these programmes were disengaged, resulting in a 100% reduction in the KP-led service delivery infrastructure.

Only an estimated 30–40% sites remain functional and accessible to KPs, with all KP-specific standalone sites closed and only a portion of public facilities continuing to provide services.

The discontinuation of safe spaces and services addressing psychosocial needs, GBV response, shelter, and food insecurity for vulnerable KPs has created critical gaps in holistic care and protection. Most impacted populations such as TGs, SWs and young GBMSM especially those living in informal settlements or with limited mobility are experiencing increased stigma in public facilities and lack of tailored services. With no dedicated services, many KP individuals are missing ART refills, discontinuing PrEP, or avoiding testing altogether, raising the risk of new infections and loss to follow-up.

The KP-led organisations in Lesotho have identified essential elements for restoring critical services and rebuilding the foundation for sustainable KP programming, acknowledging that complete reinstatement of previous service levels is vital to the sustainability of the KP programme.

What does the data say about HIV prevalence among KPs in Lesotho[1]?

- Female sex workers (FSWs): 71.9%
- Men who have sex with men (MSM): 32.9%
- Transgender individuals (TG): n/a
- People who use drugs (PWUD): n/a

[1] https://www.unaids.org/en/regionscountries/countries/lesotho

KP Size Estimates[2]

- Female sex workers (FSWs): 7500
- Men who have sex with men (MSM): 6100
- Transgender individuals (TG): n/a
- People who use drugs (PWUD): n/a

Programmatic Disruptions

- **Termination of community-level service delivery**: The only four KP-led DICs in Maseru and Leribe were permanently shut down. These centres had been the only safe, stigma-free spaces offering comprehensive HIV services tailored to the unique needs of KP groups. Their closure resulted in a 100% disruption of access to KP-led HIV testing, ART and PrEP initiation, STI screening, mental health support, and legal referrals.
- **Cessation of outreach and peer navigation:** Community-based outreach activities and peer-led linkage support were discontinued. This has left thousands of KPs—especially those disconnected from formal health systems—without the trusted community liaisons that helped them access and stay on treatment or prevention services.
- **ART service losses:** Closure of all four DICs in Maseru and Leribe eliminated access to KP-friendly HIV testing, ART and PrEP initiation, STI management, mental health support, and legal referrals.
- **Interruption in access to PrEP services:** Informal reports have surfaced stock-outs or delayed access to PrEP in some public clinics, especially for KP clients. With the absence of DICs to manage and monitor continuity, ART adherence has likely been compromised for many.
- **Increased stigma and discrimination in mainstream health facilities:** With the termination of KP-friendly sites, KPs are forced to access services at general health facilities, where many report experiencing increased stigma, discrimination, and breach of confidentiality. These negative experiences discourage health-seeking behaviour and contribute to service disengagement.
- **Decline in KP community engagement and influence:** The KP community's ability to participate meaningfully in HIV planning has weakened. With the dissolution of PEPFAR-supported platforms for community programme monitoring and coordination structures, KP-led organisations are now sidelined from national strategic conversations, despite ongoing rhetoric about inclusion.
- **Sustainability and long-term planning stalled:** Progress on sustainability planning into national systems, securing domestic funding, and building long-term programme resilience has stalled. No transitional funding or support plan was put in place following the withdrawal of PEPFAR support, creating a dangerous programme vacuum.
- **Data gaps and fragmentation:** The dismantling of PEPFAR-supported monitoring systems has left a vacuum in KP-specific data collection and reporting. This undermines evidence-based advocacy and prevents accurate assessment of HIV outcomes within KP communities.
- **Deterioration of GBV and mental health services:** Access to GBV services and psychosocial support are not conditional to life saving services.

[2] https://www.unaids.org/en/regionscountries/countries/lesotho

KP Community Core Priorities

1. Antiretroviral Therapy (ART) and Service Continuity

Before January 2025, PEPFAR supported four KP-led service delivery sites in two districts namely Maseru and Leribe. These DICs had been the only safe, stigma-free spaces offering comprehensive HIV services tailored to the unique needs of KP groups including HIV testing, ART and PrEP initiation, STI screening, mental health support, and legal referrals. These facilities also managed community-based outreach activities for the provision of peer-led linkage and support services.

The PEPFAR supported programme delivered differentiated and stigma-free ART and PrEP services to an estimated 4,500–5,000 KP individuals across priority districts, especially in Maseru and Leribe by December 2024. These services were provided through tailored approaches that emphasised confidentiality, peer navigation, and KP-friendly clinical staff. As of June, there are no operational KP-led facilities or DICs funded by PEPFAR. All have ceased operations resulting in a 100% reduction in ART service delivery capacity at the community-level.

Among general health facilities that are accessed by KPs, only an estimated 20% to 30% remain functional in providing relevant services.TG, GBMSM, and SW in urban informal settlements have been disproportionately affected due to stigma, lack of alternative KP-specific services, and limited access to public health facilities.

The Global Fund (GF) had been supporting KP programming across eight districts, but implementation was also suspended following significant funding cuts. It is expected that implementation under the GF will resume, guided by the outcomes of the reprioritisation meeting scheduled for the end of June. However, it is already evident that KP-specific funding has been significantly reduced, which will impact the scale and scope of future interventions.

Since the termination of peer support services and cadres, there have been no peer-led follow-up systems or community-based adherence support models in place for KPs, which had previously played a crucial role in reducing loss to follow-up. As a result, retention rates have likely declined, particularly among mobile and hard-to-reach KPs.

Non-negotiable Priorities:

- **Restore and fund KP-led service delivery:** Prioritise funding and operational support for the terminated KP-led DICs to restore trusted access points and client-centred service models.
- Scale up access to ART commodities for KPs living with HIV in the DICs. Ensure uninterrupted access to ART commodities for KPLHIV in DICs to mitigate risks of loss to follow-up and treatment interruption.
- Restore peer cadres to address gaps in ART access at community-level. Ensure uninterrupted deployment of peer educators and lay cadres to address service continuity gaps and re-engage clients lost during the disruption.
- Train health service providers in KP serving general population ART sites on KP service delivery. Implement targeted training for healthcare workers in public ART sites to enhance delivery of KP-competent services and reduce stigma-related barriers.
- Scale up KP centres and ensure they have the capacity to be one-stop centres of excellence offering opportunistic infection diagnosis and treatment and TB diagnosis, prevention and treatment. Equip KP centres to function as one-stop hubs delivering comprehensive care listed in the KP core package of **care.**
- **Scale up and maintain viral load access by ensuring commodities are available and wait times are shorter.** Ensure sustained availability of viral load testing commodities and reduce result turnaround times to support clinical decision-making and treatment monitoring.

Strategic Element	Current Status (June 2025)	Annual Funding Required	Key Notes
KP-specific ART sites	100% termination of 4 KP-led DICs	$300,000 per centre annually	Limited access to safe and friendly access to ART service.
KP-friendly public sites, including community HIV based testing	Estimated 20-30% functional	$40,000 (setup)	Restore facilities that provided access to ART and other key services for KPs in Lesotho.
Peer cadres and outreach workers	100% termination of peer cadres at KP sites.	$551,508	Peer support is vital to the service delivery at the community level. A support of $50 for peers and $130 for outreach Workers monthly.
ART commodities	No longer accessible at KP-led sites.	$50,000	Access to ART at KP DICs must be restored.
Viral load (VL) monitoring	Not available at community level	$20,000	Currently community-level mobile clinic facilities are terminated and KP cannot access VL services closer to them.
TB diagnosis and prevention	100% terminated in the KP-led service delivery sites.	$20,000	Services are not available at KP-led sites since the stop work orders began.
Opportunistic infections (OI) diagnosis and treatment	100% terminated in the KP-led service delivery sites.	$20,000	Access to opportunistic infections (OI) services only available in public health facilities

ART Funding Gap: Approximately **$1,001,508** annually to restore comprehensive, peer-supported ART services for KPs.

What is the cost of inaction? Since January 2025, access to KP-ART services has declined as a result of the termination of the 4 KP-led service delivery DICs. Access to PrEP, STI, mental health support and GBV services has been severely disrupted. Inaction will create a loss of confidence in service delivery and a loss of KPs in need of life saving medication leading to increased mortality.

2. Primary Prevention

Lesotho has made incredible gains over the years in prevention interventions. The Government of Lesotho introduced PrEP in 2016, and the number of people who have been newly enrolled on PrEP by Q4 was 42,050 people (KPs and general population)[3]. By December 2024, PrEP services were available in the 4 PEPFAR-funded KP-led DICs in Maseru and Leribe and peer outreach and support was available at the community level to facilitate linkage and referral for PrEP.

As of June 2025, the 4 KP-service delivery sites are no longer operational, representing a 100% dismantling of the service delivery infrastructure for the uptake of PrEP services among KPs. All peer navigator programmes that supported PrEP education, initiation, and continuation among KPs under PEPFAR, are also currently not operational. As a result, KP PrEP initiation and retention reduced by the end of June 2025.

Despite the challenges, PrEP remains available in government operated facilities within the 10 districts of Lesotho, but at a reduced capacity of 60-70% according to estimations[4] by KPs. These are not KP-specific or tailored services, and stigma remains a barrier to access. GF-supported PrEP activities are currently on hold, pending outcomes from a national reprioritisation meeting expected to clarify future geographic focus and scale.

An estimated 60–70% of condoms and lubricants[5] remain available in the 10 districts. Distribution is currently managed through the Ministry of Health's (MOH) national supply chain, with commodities available primarily at public health facilities and some community-level (non KP-led) distribution points supported by the Global Fund. However, accessibility varies by location, with more consistent supply and uptake in urban and peri-urban clinics (e.g., Maseru, Leribe, Berea), while rural and hard-to-reach areas often face stock delays or limited distribution.

Whilst there is some availability, the termination of all peer navigator programmes has resulted in significant deterioration of condom and lubricant access and distribution among KPs. Without peer outreach programmes, DICs and targeted distribution events at the community level services are limited significantly. The closure of all DICs eliminated safe, confidential spaces where KPs could access services without fear of stigma or violence. Public facilities often lack KP-friendly protocols, and KPs now face increased safety risks and exposure to discrimination.

Given the breakdown in infrastructure, it is worth considering differentiated service delivery (DSD) options that can support KPs outside of the traditional facility settings such as telehealth and pharmacy delivery. Innovation in financing, delivery, and partnerships is needed now to reach KPs where they are with effective services.

Current Planning for Long-Acting PrEP Rollout

In July 2025, the GF named Lesotho as one of nine priority countries to roll out Lenacapavir (LEN)[6], a groundbreaking long-acting injectable PrEP. LEN PrEP is expected to boost PrEP access in the country and address the pill burden challenge linked to oral PrEP. The first shipments will be dispatched by end 2025 and a national roll-out is expected in early 2026 pending regulatory approval. This announcement recognises the over 3,200 new infections reported in the country in 2024.

In anticipation of the national roll-out, the KP community encourages stakeholder involvement with the inclusion of KPs to ensure no one is left behind in the planning processes, as well as to ensure successful implementation.

[3] https://mer.amfar.org/location/Lesotho/PrEP_NEW [4, 5] Community Estimates [6] https://www.lena.gov.ls/lesotho-among-first-nations-to-access-hiv-prevention/

Non-negotiable Priorities:

- **Reinstate PrEP access:** Ensure uninterrupted access to oral and injectable PrEP commodities in KP-led DICs and community levels.
- **Roll out and scale up LEN PrEP:** Lesotho is one of 9 countries selected to pilot the rollout of LEN PrEP in sub-saharan Africa. PEPFAR should invest in LEN PrEP including for KPs.
- **Reinstate KP-led prevention sites:** Prioritise operational support for the 4 KP-led prevention service delivery sites to increase PrEP initiation and retention.
- **Train health providers on KP-competent prevention:** Strengthen capacity of public and private sector providers to deliver non-judgmental, evidence-based prevention services tailored to KP needs.
- **Expand condom and lubricant distribution:** Condom and lubricant access has not been available since the stop-work orders began as a result of the termination of peer-led outreaches. Scale up peer-led outreach programmes to ensure consistent availability of condoms and lubricants.
- **Fund harm reduction programmes:** Harm reduction interventions are crucial for PWID communities, however these services were previously provided without robust PWID involvement or engagement resulting in poor performance and defunding. Harm reduction programmes must be restored with a clear engagement plan with the leadership of PWID in Lesotho.
- **Scale up opioid substitution therapy (OST):** Roll out and expand access to buprenorphine and methadone at community sites, including provision of take-home dosing, to improve adherence and retention in care.
- **Prepare for LEN rollout:** Restore foundational systems to ensure Lesotho is ready to fully implement the GF-supported roll-out of injectable Lenacapavir for PrEP among KPs.

Service Area	Current Status	Annual Funding Required	Notes
PrEP access	30-40% of PrEP Access for KPs available	$361,066	This is a result of termination of KP-led PrEP sites and the deprioritisation of PEPFAR supported PrEP access for KPs.
PrEP sites	100% termination of KP PrEP sites.	$253,208	All 4 DICs closed, need restoration
Demand creation and awareness building	Continued investment needed to ensure use of prevention and PrEP products in particular.	$34,600	
Fund harm reduction programmes	Not provided/funded	$50,000	NSP services are not available in the country
Condom and lube distribution	60-70% general population coverage	$20,000	No KP-specific distribution currently
Prepare for LEN rollout start up	KP must be involved in LEN PrEP rollout planning	$184,841	Critical for Len start up

Primary Prevention Funding Gap: Approximately **$903,715** annually to restore comprehensive prevention services with peer support networks.

What is the cost of inaction? Although some prevention interventions such as PrEP, condoms remain available in principle, the dismantling of KP-focused infrastructure, lack of peer support, and limited safe access points have severely compromised the effectiveness, continuity, and acceptability of prevention for KPs in Lesotho. A lack of urgent reinvestment to rebuild supportive systems that maintain communities on prevention risks loss to follow-up, low uptake of LEN and oral PrEP, reduced access to condoms and lubricants and other prevention options. A lack of action will lead to increased HIV and STI infection among KPs.

3. Sexually Transmitted Infections

According to the LePHIA 2020, Lesotho has a STI prevalence rate of 22.7% which is one of the highest in the world. Whereas the MoH has made some progress in scaling up access to STI services, uptake in STI treatment remains low. Limited access to services in rural areas, poor condom use, limited community education on STI, are among those closely attributed to this challenge.

Access to STI screening and treatment services was available in most public health facilities before January 2025. However, since the stop-work orders were announced, access to STI services for KPs have been impacted. 4 KP-led STI treatment centres lost their funding making access to KP-friendly STI screening and treatment services unavailable. The termination of peer support has made a bad situation worse, with limited access to STI information and services at the community level. KPs are only able to access STI services at public facilities where STI-free services are not prioritised.

Non-Negotiable Priorities

- **Restore STI service access at community level:** Screening and treatment of STI for KPs have been significantly degraded since the termination of peer education and outreaches and support. These services must be fully restored.
- **Restore STI treatment sites for KPs**: Since the funding cuts began, PEPFAR discontinued support to 4 KP-Led services delivery DICs catering to KPs.
- **Ensure STI commodities availability:** The disruption in the HIV funding landscape has cast doubt in the future of STI programmes for KPs. Investment in STI treatment, diagnostic and other laboratory necessities must be restored and scaled up.

The non-negotiables and costs are shown in the table below:

Strategic Element	Funding Required (USD)	Implementation Notes
Service delivery	$17,914	Include management and follow-up
STI treatment	$87,600	Including commodities
STI lab monitoring	$29,200	Including lab commodities

Sexual Transmitted Infections Gap: Approximately **$134,714** annually to restore comprehensive STI screening, prevention and treatment.

4. Community Infrastructure

The Lesotho KP network has been a significant force in advancing KP representation and meaningful engagement in GF, PEPFAR, and in the MoH. Since the disruptions occasioned by the stop-work orders in January 2025, 4 KP-led organisations have ceased operations/ have been unable to sustain their advocacy and accountability work.

Community-Based Services and Safe Spaces

By December 2024, the four fully functional PEPFAR-funded DICs in Maseru and Leribe served as vital safe spaces where KPs could access biomedical, psychosocial, and structural services in a non-judgmental environment. Beyond health services, the centres provided mental health support, legal referrals, and empowerment programmes. Community outreach activities included mobile services and peer-led engagements, enabling access to hard-to-reach populations.

- **Site closures and service reductions:** All four KP DICs were permanently closed, eliminating safe and trusted spaces for KP service access. These centres had been the only safe, stigma-free spaces offering comprehensive HIV services tailored to KP needs. Their closure abruptly ended access to HIV testing, ART and PrEP initiation, STI screening, mental health support, and legal referrals.

- **Loss of outreach and peer navigation:** Community-based outreach activities and peer-led linkage support were discontinued. This left thousands of KP individuals—especially those disconnected from formal health systems—without trusted community liaisons who helped them access and stay on treatment or prevention services. All peer educators, navigators, and KP-friendly clinicians previously trained and deployed were disengaged.

- **Rising stigma and reduced access to friendly services:** With no alternative KP-friendly sites, KPs are forced to access general health facilities, where many experience increased stigma, discrimination, and breach of confidentiality. These negative experiences discourage health-seeking behaviour and contribute to service disengagement. ART and PrEP continuity for many KP clients became uncertain, with some individuals falling out of care due to lack of targeted support and safe service entry points.

Engagement in National HIV Planning

Prior to the funding cuts, engagement between KP-led organisations and the MoH was moderate and advocacy efforts were ongoing to institutionalise KP voices in national strategic plans. While KP representatives were invited to some national consultations, meaningful participation in decision-making and budgetary processes remained limited.

- **Decline in KP community engagement and influence:** The KP community's ability to participate meaningfully in HIV planning has weakened. With the dissolution of PEPFAR-supported platforms and coordination structures, KP-led organisations are now sidelined from national strategic conversations. Progress on sustainability planning—including integrating KP services into national systems, securing domestic funding, and building long-term programme resilience—has stalled. No transitional funding or support plan was implemented following PEPFAR withdrawal.

Sustainability Roadmaps and Action Plans

KP programming was partially aligned with UNAIDS-supported sustainability roadmaps. While there was intention to institutionalise and integrate KP services within national HIV programming, actual implementation remained fragmented. PEPFAR had supported development of a KP Action Plan in collaboration with civil society, but execution depended heavily on continued donor funding.

Guiding Principles for Sustaining Effective KP Programming

- **Community-led decision making:** KP communities must determine priorities when resources are constrained and decide what matters most and which services can be set aside.
- **Essential element prioritisation:** Focus on identifying which elements must be maintained and scaled up, what can be expanded or changed, and what might need to be temporarily set aside.
- **Collaborative planning:** Programming requires collaboration among coalition members, organisations, key stakeholders including KP focal people, government representatives, funders and advocacy allies.
- **Comprehensive rights-based approach:** Maintain focus on comprehensive, rights-based responses without scaling back visions for full KP service packages.
- **Strategic integration:** Address increasing emphasis on HIV integration into government systems while maintaining KP-specific protections and services.
- **Coalition formalisation:** Formalise networks to coordinate activities and resource mobilisation efforts.

Key Estimates of Losses (December 2024 - June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
KP led Drop-In Centres	100% reduction in KP-led service delivery capacity	At least 4 DICs (In Maseru and Leribe) need reopening to provide KP-friendly ART, PrEP, HIV/STI testing, and psychosocial support.
Community outreach and peer navigation	100% reduction in KP-led capacity	Immediate funding required to support peer educators, community navigators, and mobile outreach teams to link and retain KP clients in care.
Provide psychosocial and emergency support:	100% reduction in KP-led service delivery capacity	Safe spaces and emergency support (shelter, food, GBV response) must be reinstated for vulnerable KPs, particularly TGs and SWs.
Train KP-friendly public health staff	100% termination of stigma reduction programmes	Sensitisation and capacity-building for at least 50% of public health workers to reduce stigma and improve service quality for KPs.

Support KP-led organisations	100% termination of funding to 4 KP organisations.	Core operational and programmatic support for 4 KP CSOs to engage in advocacy and accountability efforts with the MoH and other partners and stakeholders needs to be restored.
Community-led monitoring (CLM)	100% KP capacity reduction	One KP-led CLM programme has lost its PEPFAR funding for CLM.
Lesotho KP network	No funding	The network exists but requires funding for formalisation to coordinate activities and resource mobilisation.

Non-negotiable Priorities:

- **Fund and support the national KP network:** Resources terminated in January need to be restored to support the network coordination, convening, advocacy and resource mobilisation efforts.
- **Restore and scale up KP advocacy and accountability funding:** Approximately 4 KP organisations lost funding that supported advocacy and accountability efforts targeting the government and relevant stakeholders. This support should be restored and scaled up.
- **Restore and fund KP-led CLM activities:** We recommend the restoration of funding for CLM, including KP CLM.
- **Restore and fund KP-led DICs:** Prioritise funding and operational support for 4 KP-led DICs to restore trusted access points and client-centred service models.
- **Provide psychosocial and emergency support:** KPs are often targeted by violence and abuse. Psychosocial and emergency support programmes provided at safe spaces at DICs and community levels must be restored. Criminalisation and stigma predisposes KPs to violence and funding and support needs to be restored to respond to violence against KPs and facilitate increased access to services.

Area of Impact	Estimated Reduction	Annual Funding Required	Narrative Explanation
KP led Drop-In Centres	100% reduction in KP-led service delivery capacity	$120,000	At least 4 DICs (In Maseru and Leribe) need reopening to provide KP-friendly ART, PrEP, HIV/STI testing, and psychosocial support.
Provide Psychosocial and Emergency Support:	100% reduction in KP-led service delivery capacity	$37,494	Safe spaces and emergency support (shelter, food, GBV response) must be reinstated for vulnerable KPs, particularly TGs and SWs.
Train KP-Friendly Public Health Staff:	100% termination of stigma reduction programmes	$47,494	Sensitisation and capacity-building for at least 50 public health workers to reduce stigma and improve service quality for KPs.
Support KP-Led Organisations:	100% termination to KP organisations.	$106,379	Core operational and programmatic support for KP CSOs to engage in advocacy and accountability efforts with the MoH and other partners and stakeholders.
Community-led Monitoring:	100% KP capacity reduction	$146,000	One KP-led community-led monitoring programme lost its CLM Funding.
Lesotho KP Network	No funding	$39,440	The network exists but requires funding for formalisation to coordinate activities and resource mobilisation.

Community Infrastructure Funding Gap: $496,807 to rebuild essential community systems and protective mechanisms.

What is the cost of inaction? The destruction of the community infrastructure that had made it simpler for the KP programme in Lesotho to maintain consistent and uninterrupted access to quality services. The shutdown of KP-led DICs will create more barriers to safe spaces for community members, the ability to organise, plan and coordinate advocacy, plan accountability campaigns or provide psychosocial and emergency support. These interventions must be restored

5. Data and Monitoring System

Access to KP-specific data became severely compromised as public facilities do not collect KP-disaggregated information. The loss of community-level service delivery eliminated the primary source of KP-specific data along the HIV cascade, from testing through treatment and viral load monitoring.The termination of peer cadres has undermined data collection and reporting obligations in the KP programme. Programme staff with limited data expertise are now expected to perform this role. Further, support supervision which is a key component of data verification, validation, and mentorship opportunity for KP has not resumed since the termination orders.

Access to KP data from the government operated DHIS2 has also been a challenge despite multiple requests by KPs making it difficult to demonstrate the scale of the reductions as a result of the stop-work orders.

Key Estimates of Losses (December 2024- June 2025):

Area of Impact	Estimated Reduction	Narrative Explanation
Data Disaggregation	100% reduction. No longer available.	Public facilities providing KP services do not collect disaggregated KP data.
Data collection and entry	Significant loss	Data disaggregation was only collected at KP-led DICs which are now not operating.
Support supervision	100% reduction	Support supervision is a key element of quality control assurance and mentorship and learning for KPs.

Non-negotiable Priorities:

- **Restore high-quality, disaggregated KP data** for an effective prevention and treatment programme for KPs.
- **Restore data staff who supported data collection.** This includes data clerks, health records and information officers and M&E officers including peer educators and field officers/outreach workers.
- **Restore the support supervision:** Support supervision is a key element of quality control assurance and mentorship and learning for KPs.

Strategic Element	Current Status	Annual Funding Required	Key notes
Disaggregated data	Data disaggregation stopped from January 2025 and KP services are no longer provided.	$25,000	Restore high-quality, disaggregated data
Data collection and entry	Terminated	$25,000	Salary support for programme staff to collect and disaggregate data and report to MoH and other relevant stakeholders for tailored academic control.
Support supervision	100% reduction	$10,000	Support supervision is a key element of quality control assurance and mentorship and learning for KPs.

Data and Monitoring Systems Gap: $60,000 annually to rebuild data and monitoring

What is the cost of inaction? Data monitoring and planning is an essential component of programme tracking. Without access to data, the programme is unable to assess its performance, identify or respond strategically to programme gaps or concerning trends.

Lesotho Key Populations Costed Strategy Summary

Targeting and Costing Methodology

In Lesotho, the methodology used the national population size estimates from PEPFAR and UNAIDS KP Atlas. Where lacking an estimate for TG, a standard percentage from the region is used. We considered the percentage of KPs that need prevention services (set initially at 90%). We further estimated KP living with HIV using HIV prevalence from PEPFAR or the KP Atlas. Where lacking prevalence data, a standard percentage from the region is used. We had considered % of KPLHIV in need of treatment services (set initially at 100%). To meet the Lesotho budget, the country will focus on 100% of treatment and 100% as indicated below. Prisoners and clients of FSW are not included in the costing exercise.

The itemised costing of each intervention is found on this link: [Lesotho Targeting and Costing]

Lesotho Priorites	Costs	Total	Cost per target	General costs	GBV	Testing	TX	Biomedical Prev	STI	MAT
Priorites	Costs	**$2,694,198**	$185	$197,648	$8,733	$109,191	$954,107	$1,222,449	$202,071	$0
	Percent of total			7.34%	0.32%	4.05%	35.41%	45.37%	7.50%	0.00%
		National Targets								
Targets	KP Treatment	**6,400**								
	KP Primary Prevention	**8,200**								
	Total	**14,600**								

Methodology

This rapid strategy and costing exercise was designed as a structured assessment process to capture country-level impacts of foreign aid transitions and identify essential services requiring continued investment for KPs. The methodology began with orientation to a standardised Excel worksheet framework designed to systematically capture country coalitions' assessments across three critical domains: ART service delivery, HIV prevention programming, and community infrastructure (including civil society engagement, community-led monitoring, community mobilisation, and advocacy capacity).

The assessment process examined three distinct time periods: baseline status at the end of 2024, immediate impacts following foreign aid transitions that began in January/February 2025, and current conditions as of June 2025. The country coalition made of representatives from KP-led ad LGBTQI organisations collected quantitative and qualitative data from surveys, reports, and coalitions and community organisations consultations to document service disruptions, funding gaps, and programmatic changes across these timeframes.

Following data collection, the coalition engaged in facilitated consensus-building processes to analyze findings, identify priority concerns, and develop collective views on current programming status. Through these discussions, the coalition articulated their "essentials"—critical activities, services, and investments necessary to maintain effective HIV responses for KPs in their contexts. This worksheet was used as the basis for a strategy narrative, developed by the GBGMC support team, that included a summary table of priority interventions requiring funding and attention.

This narrative report with draft/indicative cost components was shared with subject matter experts who provided technical input on unit costs, coverage targets, implementation approaches, and country-specific considerations. Finally, the updated comprehensive narrative documents were shared back for validation processes with the originating in-country coalitions to ensure accuracy and authentic representation of community perspectives and needs.

The Team

We thank the many advocates, organisations, and government partners who participated in national consultations and supported the drafting of each plan. Your leadership and lived expertise are at the heart of this work.

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