ESTABLISHING HIV-1 RECENT INFECTION SURVEILLANCE USING A POINT-OF-CARE TEST FOR RECENT INFECTION AMONG PERSONS NEWLY DIAGNOSED WITH HIV INFECTION IN LESOTHO: FINAL REPORT

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
AGYW	Adolescent girls and young women
ART	Antiretroviral Therapy
CDC	US Centres for Disease Control and Prevention
COVID-19	Coronavirus Disease 2019
CAPA	Corrective and Preventive Action
CQI	Continuous Quality Improvement
DHMT	District Health Management Team
EAC	Enhanced Adherence Counselling
EGPAF	Elizabeth Glaser Paediatric AIDS Foundation
GoL	Government of Lesotho
HC	Health Center
HIV	Human Immunodeficiency Virus
HIVST	Human Immunodeficiency Virus Self-Test
HTS	HIV Testing Services
IP	Implementing Partner/In-Patient
L&D	Labour and Delivery
LT	Long Term
MOH	Ministry of Health
MSM	Men having sex with men
OPD	Outpatient Department
PEPFAR	President's Emergency Plan for AIDS Relief
PDSA	Plan-Do-Study-Act
PHR	Public Health Response
POC	Point-of-care
PT	Proficiency Testing
PPT	Proficiency Panel Testing
PLHIV	People Living With HIV
PNC	Postnatal care
PNS	Partner Notification Services
PrEP	Pre-exposure Prophylaxis
QC	Quality Control
RIS	Recent Infection Surveillance
RITA	Recent Infection Testing Algorithm
RTRI	Rapid Test for Recent Infection
SD	Standard Deviation
SOP	Standard Operating Procedure
TB	Tuberculosis
TOT	Training of Trainers
VL	Viral Load

Executive Summary

Lesotho launched HIV-1 recent infection surveillance (RIS) in July 2019 through a collaborative effort between the Ministry of Health (MOH), ICAP at Columbia University, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), and the U.S. Centers for Disease Control and Prevention (CDC). This program was introduced to generate timely epidemiologic data on new HIV diagnoses to guide targeted prevention and treatment strategies to accelerate progress toward epidemic control.

Following an initial pilot in Leribe district, RIS was scaled nationally across all 10 districts, 220 health facilities, and 10 community sites. To support this expansion, 201 master trainers and 1,242 trainees and community testers have been certified, and three national data use workshops have been held, ensuring standardized implementation and capacity to sustain recency testing and reporting at scale. Recency testing is integrated within routine HIV testing services through a point-of-care model: newly diagnosed individuals who screen HIV-positive using the Alere Determine™ test undergo parallel confirmatory testing (e.g., Uni-Gold™) and recency testing using the Asante™ HIV-1 Rapid Recency Assay (Sedia Biosciences). Beginning in April 2022, baseline viral load (VL) testing for all RTRI-recent cases was incorporated as part of a Recent Infection Testing Algorithm (RITA) to strengthen case classification.

By December 2024, there were a total of 28,099 newly diagnosed people living with HIV (PLHIV) from 211 of the 214 sites reporting RIS data across all 10 districts in Lesotho. Of those, 22,556 (80%) received an RTRI test. Following implementation of VL testing as part of RITA, from April 2022 to December 2024, 25,236 clients were newly diagnosed with HIV at the 211 sites in 10 districts reporting RIS data; 20,719 (82%) of these clients received a RTRI test. During this period (April 2022–December 2024) the program maintained 82% RTRI uptake, rising to over 85% by mid-2023. Uptake was consistently higher among women compared to men, with the lowest uptake observed among young men (18–24 years).

Number of Clients Tested by RTRI Over Time and By Sex, September 2019–December 2024
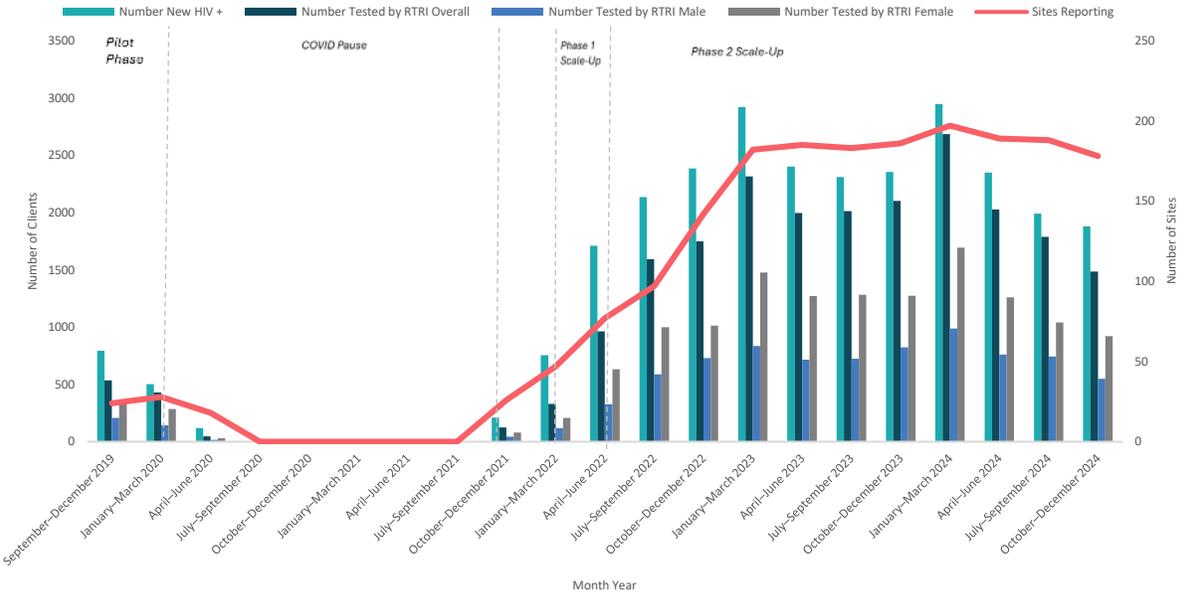
Among the 20,719 RTRI-tested clients during April 2022–December 2024, 5% (1,007/20,669) were RTRI recent, 95% (19,662/20,669) were RTRI long-term. 88 percent (887/1,007) of the RTRI recent clients had a VL sample collected of which 885 (99%) had VL results available for interpretation. Of those with available VL, 597 (67%) were classified as recent as part of the RITA, bringing the overall proportion of RITA recent infections to 3% (597/20,548) and RITA long-term infections to 97% (19,951/20,548).

Number of Clients with a New HIV+ Diagnosis, Number and Percent Tested by RTRI and RITA, and RTRI and RITA Recent, April 2022–December 2024 (Post-RITA Implementation)
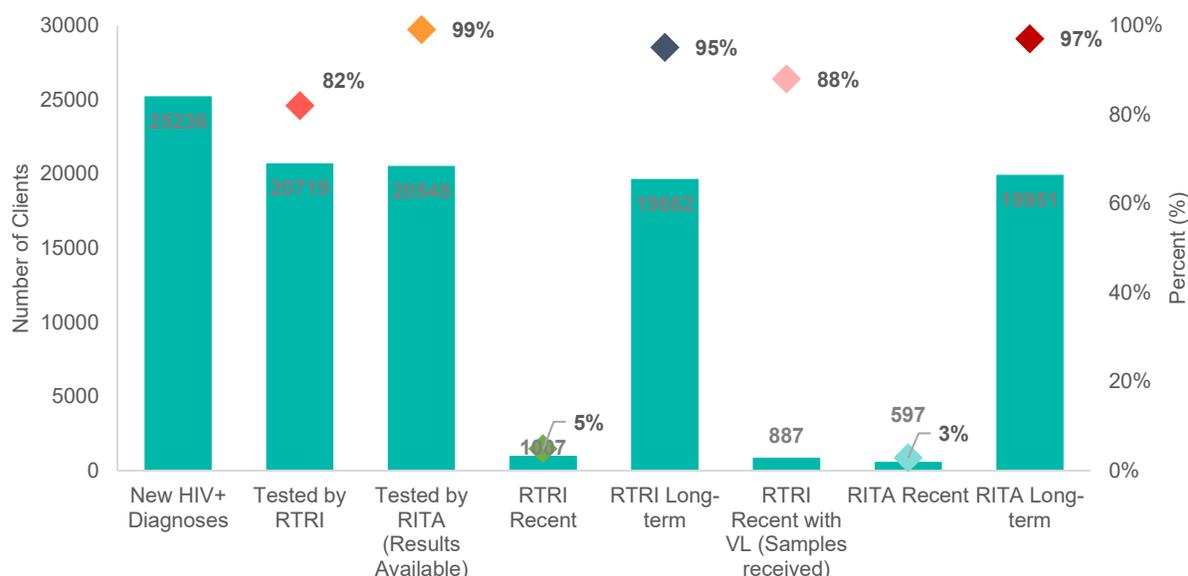
The majority of RITA recent infections occurred among women under 25 years. Outpatient departments (OPDs) accounted for the largest number of RITA-confirmed recent cases, while antenatal care (ANC) settings had the highest proportion—consistent with women's healthcare-seeking behaviors. Geographically, Maseru district reported the largest number of recent cases, while Thaba-Tseka district had the highest proportion (7%), prompting targeted investigations. Monitoring trends in the proportion recent among those at risk of HIV (defined as the number of clients testing HIV negative plus clients testing recent) revealed a decline from 0.23% in January 2022 to 0.13% in December 2024 (RR: 0.90, 95% CI: 0.86–0.94), with similar reductions across age, sex, and regional subgroups.

Program quality has been ensured through 7,450 QC panels, with >99% pass rates, and six proficiency panel testing rounds since 2022, with corrective action ensuring >98% overall performance. Fewer than 0.4% invalid or inconclusive tests were recorded across the entire implementation period (2019–2024).

To guide implementation, Lesotho developed a Public Health Response (PHR) strategy in 2020, refined in 2023. The strategy uses RIS data to identify and respond to potential signals of HIV acquisition. As a result, 30 HIV transmission signals have been identified and investigated. From July 2022–December 2024, 30 hotspots were identified across 9 districts, with 289 RITA recent cases investigated. Action plans addressed gaps such as low PrEP uptake, weak partner notification, and delayed management of high viral load clients. Eleven hotspots have since been closed following successful interventions.

A PHR in Thaba-Tseka district illustrated the value of this approach. Despite accounting for only 5% of new diagnoses nationally, the district recorded 7% RITA recent cases, prompting the DHMT to initiate a targeted PHR in three health facilities with 29 recent cases. Findings highlighted gaps in prevention, testing, and management that were addressed through targeted, data-driven interventions (Jan 2022–Mar 2025), leading to marked improvements. HIV testing among men increased, PrEP coverage rose, and ART interruption declined, based on PHR-specific data triangulated with routine program data. These results demonstrate the effectiveness of Lesotho's RIS and PHR framework in strengthening HIV prevention and treatment outcomes.

Lesotho's experience demonstrates that national RIS, when integrated with routine data systems and supported by quality assurance and structured PHR processes, provides powerful tools for identifying

service delivery gaps, responding to transmission hotspots, and guiding HIV prevention and treatment strategies. Continued investment in RIS and data use will be essential to sustaining epidemic control.

1.0 Introduction

In 2018, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) introduced HIV recent infection surveillance as a strategic tool to monitor and sustain epidemic control. This approach uses a rapid test for recent infection (RTRI) assay to classify newly diagnosed HIV patients as having acquired an HIV infection within the past 12 months vs. more than a year ago. The RTRI assay was introduced as a supplementary test within HIV testing services at the point of diagnosis, or in a laboratory, in many PEPFAR-supported countries to inform HIV prevention and treatment programming and to avert new infections.

HIV recent infection surveillance (RIS) in Lesotho began in July 2019 and is implemented in partnership with the Government of Lesotho (GoL) Ministry of Health (MOH) and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF). This report summarizes Lesotho's experience implementing RIS to date, highlighting key results and achievements, and summarizes lessons learned and recommendations to inform future efforts and sustain progress toward HIV epidemic control.

1.1 Overview

The overall program goal is to establish a HIV-1 RIS system among persons newly diagnosed with HIV infection by integrating point-of-care (POC) testing for recent HIV infection into routine HIV testing services (HTS). The system aims to provide continuous epidemiological data (person, place, and time) on newly diagnosed individuals to inform HIV prevention and treatment strategies.

1.2 Specific Objectives

Primary Objectives:

- To determine the proportion of individuals with recent HIV infection, as evaluated by Asante HIV-1 Rapid Test for Recency Assay among patients newly diagnosed as HIV-infected in participating health facilities and communities in Lesotho.
- To determine the proportion of individuals with recent HIV infection, as evaluated by the Recent Infection Testing Algorithm (RITA), among clients newly diagnosed as HIV-infected in participating health facilities and communities in Lesotho.
- To determine trends in the proportion of individuals with RTRI/RITA recent HIV infection among newly diagnosed PLHIV in participating health facilities and communities in Lesotho.

Secondary Objectives:

- To determine demographic characteristics and factors associated with RTRI/RITA recent HIV-infection among individuals seen in participating health facilities and associated communities in Lesotho.
- To identify hot-spot locations in Lesotho associated with testing /RITA recent using the Asante HIV-1 Rapid Recency Assay results to inform geographic prioritization of interventions.
- Monitor trends in RTRI/RITA recent HIV-infection cases as a proportion of the proxy population at risk of HIV infection, calculated as the number of clients testing recent divided by the number of clients testing HIV negative plus clients testing recent.
- To determine the number and proportion of misclassified recent cases (tested recent with VL< 1000 cp/ml) by select demographic characteristics.

2.0 Design and methods

Recent infection surveillance in Lesotho was implemented nationally in a phased approach across both facility-based and community-based HTS. Lesotho has 10 districts and 289 health facilities providing HIV services. As of the latest phase of implementation, recency testing is conducted in 220 activated health facilities and 10 community-based testing sites in 10 districts, representing 76% coverage of sites offering HIV testing services (220/278).

Recency testing is integrated into routine HTS using a point-of-care approach. At participating sites, newly diagnosed individuals who screen HIV-positive using the Alere Determine™ test undergo parallel confirmatory testing (e.g., Uni-Gold™) and recency testing using the Asante™ HIV-1 Rapid Recency Assay (Sedia Biosciences). Testing is performed by trained HTS providers. Individuals who self-test HIV-positive in the community and are not immediately linked to conventional testing are referred to facilities offering recency testing for confirmatory diagnosis and eligibility assessment.

Eligibility criteria for participation in RIS in Lesotho include: (1) being newly diagnosed HIV-positive during an HTS visit at a participating site, (2) being aged 15 years or older (revised from 18+ in September 2023), and (3) providing verbal, voluntary informed consent for supplementary recency testing. For eligible and consenting individuals, a finger-prick blood sample is collected in parallel to the confirmatory HIV test sample (Uni-Gold or similar). Individuals who decline participation in recency testing still receive HIV testing and results per the national algorithm but are excluded from participating in RIS. Beginning in April 2022, clients with a recent result on the RTRI assay also undergo viral load (VL) testing as part of a RITA. Clients with VL ≥1,000 copies/mL are classified as RITA recent infections. Recency test results are not returned to participants and are used solely for public health surveillance and programmatic planning.

The recency testing procedure is depicted in Figure 1.

Figure 1. Recency testing timeline indicating integration of recency testing within HIV testing services
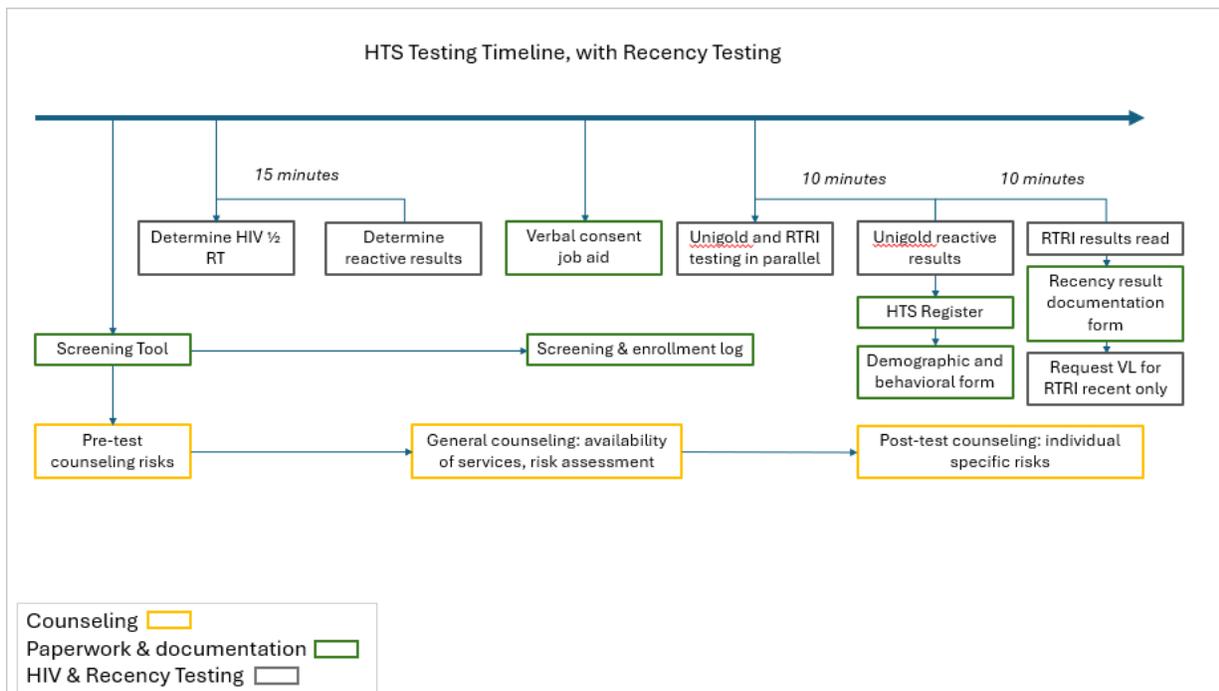
Recency surveillance data in Lesotho are collected using standardized paper-based forms at participating health facilities. Three primary forms are used: (1) the POC Test for Recent Infection Results

Documentation Form, which captures eligibility information, enrollment status, test details (including lot number, expiry date, date of testing), and recency test results; (2) a Demographic and Behavioral Questionnaire, which gathers key information on client characteristics to support epidemiological analysis; and (3) a Verbal Informed Consent Form, documenting participant agreement to undergo supplementary recency testing. On a designated day each week, completed forms are collected from each surveillance site by Riders for Health or implementing partners (EGPAF, ICAP, Baylor) and transported in sealed, clearly labeled envelopes to designated laboratories. At the laboratory, forms are stored in lockable cabinets until the Senior Counsellor and Data Entrant reviews and enters the data into the national TRACE DHIS2 database at the District Health Management Team (DHMT) level, ensuring timely and secure data transmission to support ongoing surveillance and program monitoring.

Figure 2 illustrates the data flow pathway for recency testing, showing how information moves from health facilities to the DHMT for data management.

Figure 2. Overview of Recency data flow from health facilities to the District Health Management Team
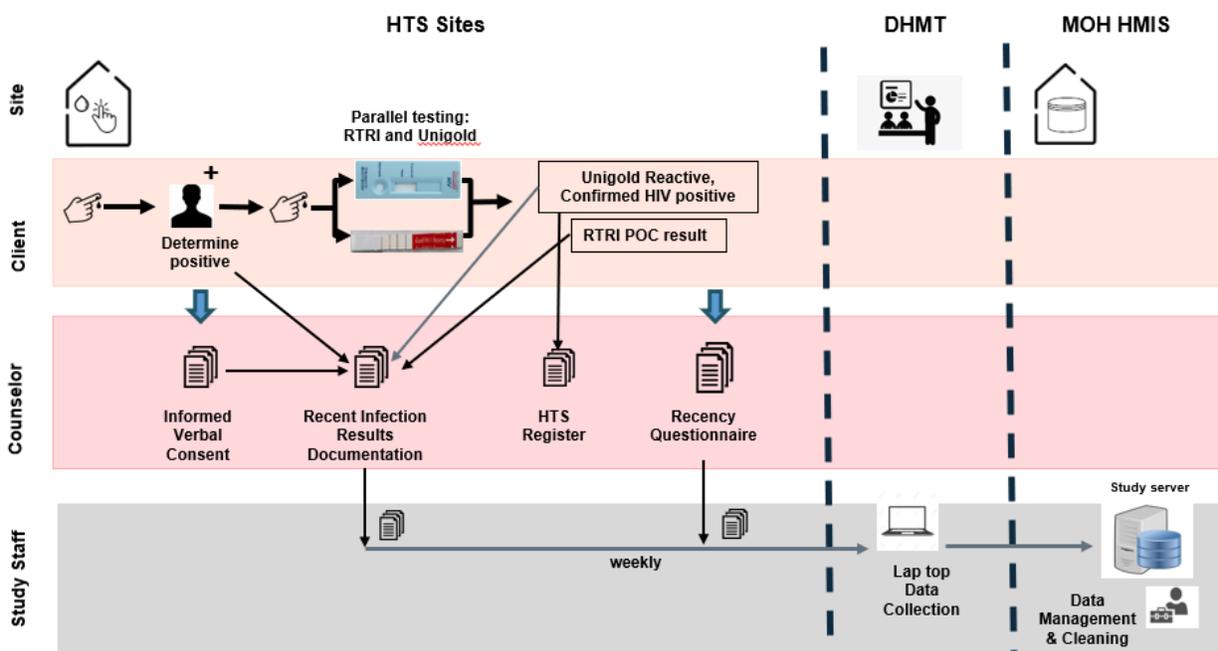
3.0 Implementation Summary

The implementation of HIV-1 RIS in Lesotho followed a phased approach across the country's 10 districts, covering 220 health facilities providing HIV services, and community-testing sites in 5 districts (Figure 4). The initial pilot phase began in 2019 at 24 health facilities in Leribe district, after the surveillance protocol and tools were developed and approved, and a training curriculum was created. Fifteen master trainers and 126 HIV testers were trained, and 12 DHMT were sensitized to prepare for implementation. Pilot implementation at the 24 sites later expanded to cover the remaining 7 sites, plus one community testing site for key and priority populations in Leribe district, through March 2020. During this period, quarterly checklist-guided mentorship and supportive supervision of testers at the 32 pilot health facilities were completed. As a result of the COVID-19 pandemic, at the end of March 2020, the GoL implemented a mandatory lockdown that included restricting nonessential travel between and within districts in Lesotho and limiting gatherings of individuals, among other restrictions. To ensure the protection of healthcare workers implementing HIV recent infection testing during the COVID-19 pandemic, the recency surveillance

investigators decided to pause RTRI testing in April 2020, illustrated by the notable downward trend in Figure 4. Inter-agency calls and review of surveillance data continued during this period.

Recent infection surveillance activities were halted from April 2020 until October 2021 due to pandemic-related restrictions and donor guidance. Activities resumed in Leribe district in October 2021 at all 31 health facilities and one community testing site. The first phase of national scale-up post COVID-19 started in February 2021 with the expansion of activities to a total of 101 testing sites in all 10 districts. Additionally, recency testing was conducted in the community councils associated with the selected health facilities. Eligible individuals newly identified as HIV-positive in the community were offered recency testing upon consent. In addition, VL testing as part of the RITA was incorporated in April 2022 to further strengthen recent infection classification. The MoH implemented a second national scale-up phase with the roll-out of RIS to a total of 220 health facilities and 10 community testing sites. An implementation status snapshot for Oct 2021–Dec 2024 is presented in Figure 3.

Figure 3. Implementation status snapshot, October 2021-December 2024

10 of 10 (100%) Districts	220 Facilities + 10 Community-based Testing Sites	6 Training of Trainers Conducted	201 Certified Master Trainers	1 Recency Dashboard	3 Data Use Workshops
220 of 289 (76%) facilities Offering HTS	211 of 220 (96%) Activated Facilities Reported Data	32 Step-Down Trainings Conducted	1242 Certified Trainees including Community Testers	3410 QCs with 100% Pass Rate	1 Public Health Response Strategy
		10 Refresher Trainings Conducted		6 PT Rounds (97% Pass Rate; 100% after repeat PT)	Public Health Response Plans Developed in 10 Districts
				10 Research Assistants	
				1 VL Coordinator	

Figure 4. Number of Clients Tested by RTRI Over Time and By Sex, September 2019-December 2024
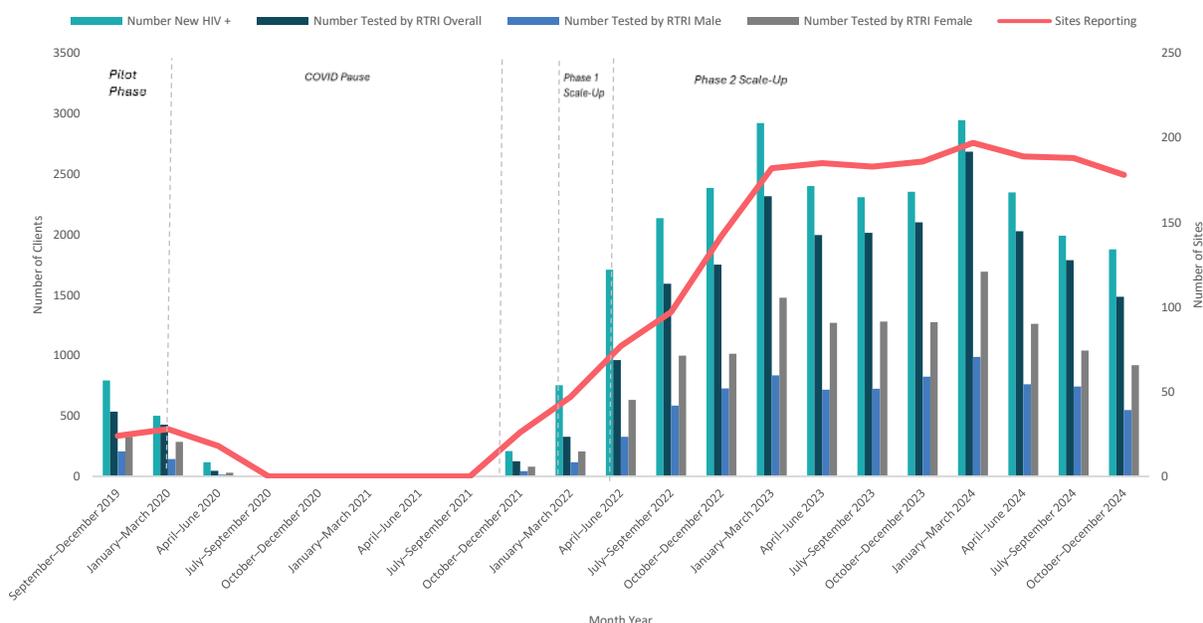
From September 2019 to December 2024, there were a total of 28,099 newly diagnosed people living with HIV (PLHIV) from 211 of the 214 sites reporting RIS data across all 10 districts in Lesotho. Of the 28,099 newly diagnosed PLHIV, 22,556 (80%) received an RTRI test, and the remaining 5,543 (20%) were either not offered the test, ineligible, or did not consent to the test.

4.0 Surveillance Results

The following section presents key surveillance results, with a focus on the period from April 2022 to December 2024. This timeframe reflects the national scale-up of RIS following the integration of VL testing as part of the RITA. The inclusion of VL testing allowed for improved accuracy of classification of recent infections, classifying participants with a RTRI recent result and a VL ≥1000 copies/mL as RITA recent cases.

Following implementation of VL testing as part of RITA, from April 2022 to December 2024, 25,236 clients were newly diagnosed with HIV at the 211 sites in 10 districts reporting RIS data; 20,719 (82%) of these clients received a RTRI test. The remaining 4,517 (18%) were either not offered the test, ineligible or did not consent to the test. Overall, 5% (1,007/20,669) were RTRI recent, 95% (19,662/20,669) were RTRI long-term; the denominator includes only clients with valid RTRI results (excluding 46 negative and 4 invalid tests). 88 percent (887/1,007) of the RTRI recent clients had a VL sample collected of which 885 (99%) had VL results available for interpretation. Of those with available VL, 597 (67%) were classified as recent as part of the RITA, bringing the overall proportion of RITA recent infections to 3% (597/20,548) and RITA long-term infections to 97% (19,951/20,548) (Figure 5).

Figure 5. Number of Clients with a New HIV+ Diagnosis, Number and Percent Tested by RTRI and RITA, and RTRI and RITA Recent, April 2022-December 2024 (Post-RITA Implementation)
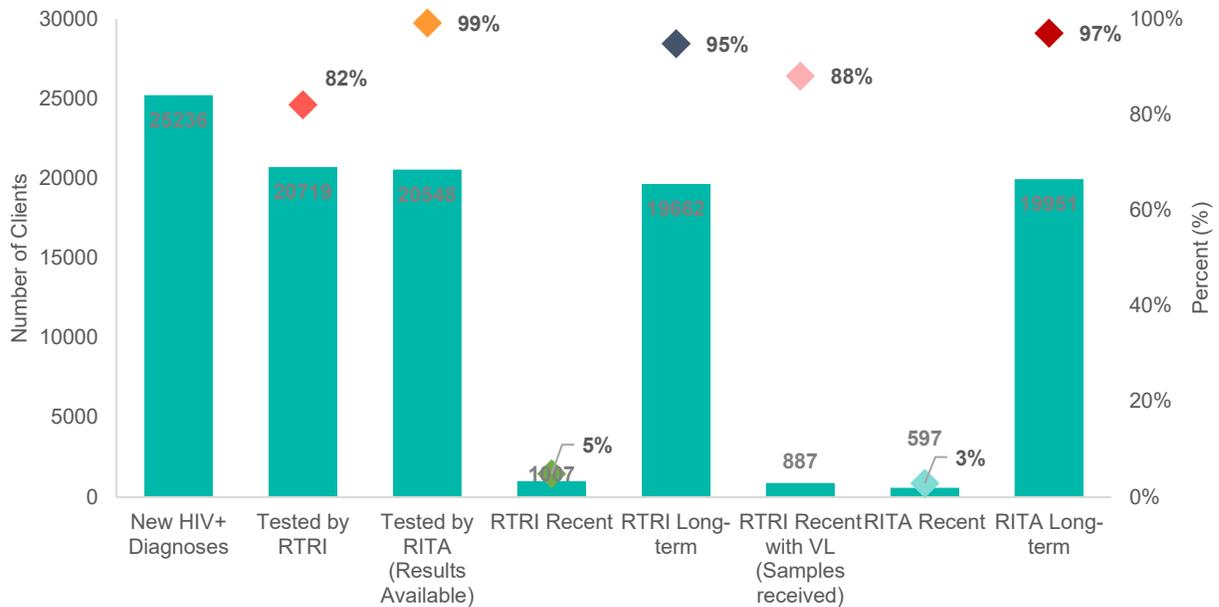
During this reporting period, overall RTRI testing uptake among newly diagnosed PLHIV at the 211 reporting sites was 82% (Figure 6). Uptake steadily increased from April 2022, reaching stable levels above 85% by mid-2023 and maintaining that level throughout 2024, with only brief fluctuations. A temporary decline across all groups was observed around October–November 2024, coinciding with a period of transition marked by the conclusion of several contracts and staffing adjustments, followed by a recovery in December 2024 (Figure 7).While RTRI testing uptake among females remained relatively high and stable (around 80–85%) across age groups, male testing rates showed more variability with uptake lowest among young males (18-24 years) compared to other age, sex groups (Figure 8).

Figure 6. Number of Clients with a New HIV+ Diagnosis, Tested by RTRI and RITA, by Sex[1], April 2022-December 2024 (Post-RITA Implementation)
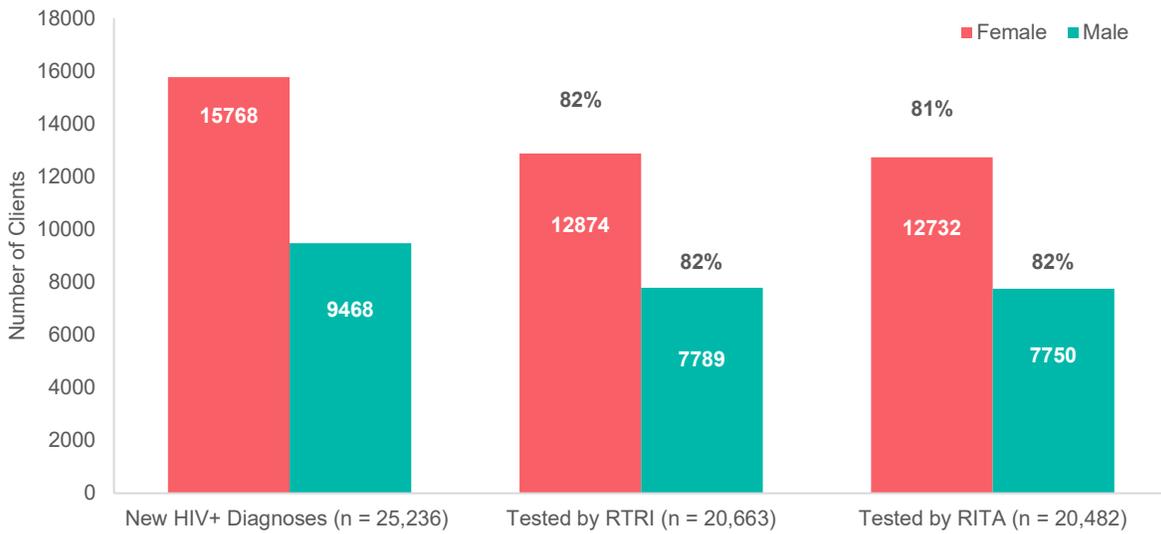
Figure 7. Percent of Clients Tested by RTRI, by Month and Sex[1], April 2022-December 2024 (Post-RITA Implementation)

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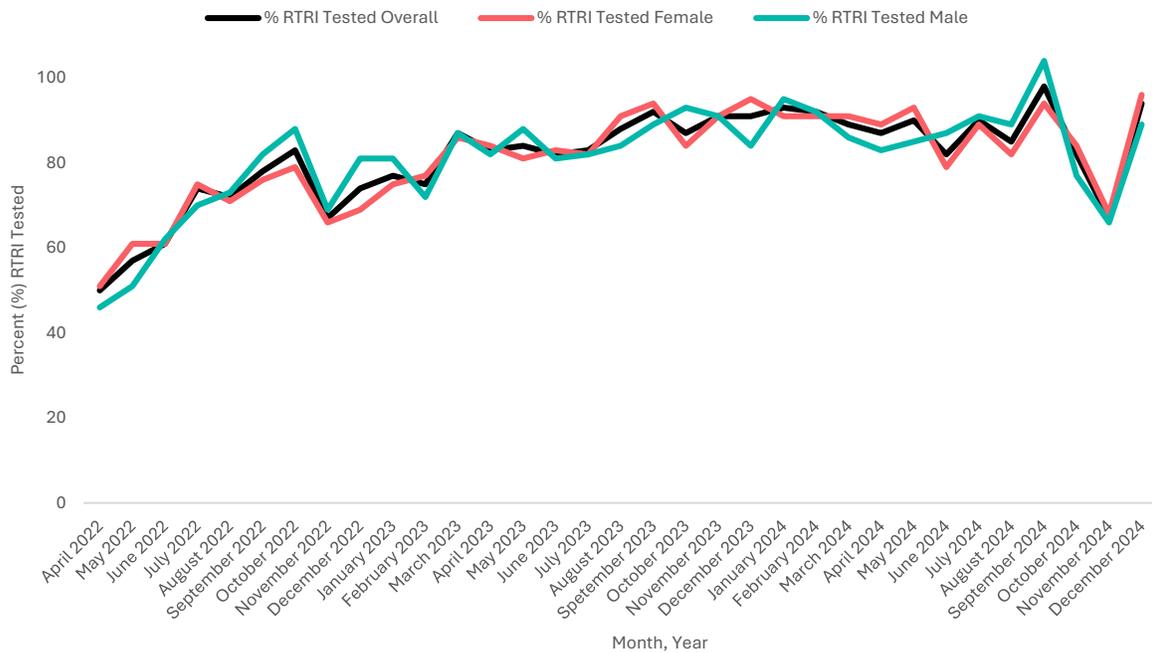
[1] Displays counts or percentages for clients recorded as female or male sex only. Records coded as, refused to answer, or other are excluded from the sex-disaggregated bars and are not shown; totals may therefore not sum exactly to the overall n.

Figure 8. Percent of Eligible Clients Tested by RTRI, by Age and Sex[1], April 2022-December 2024 (Post-RITA Implementation)
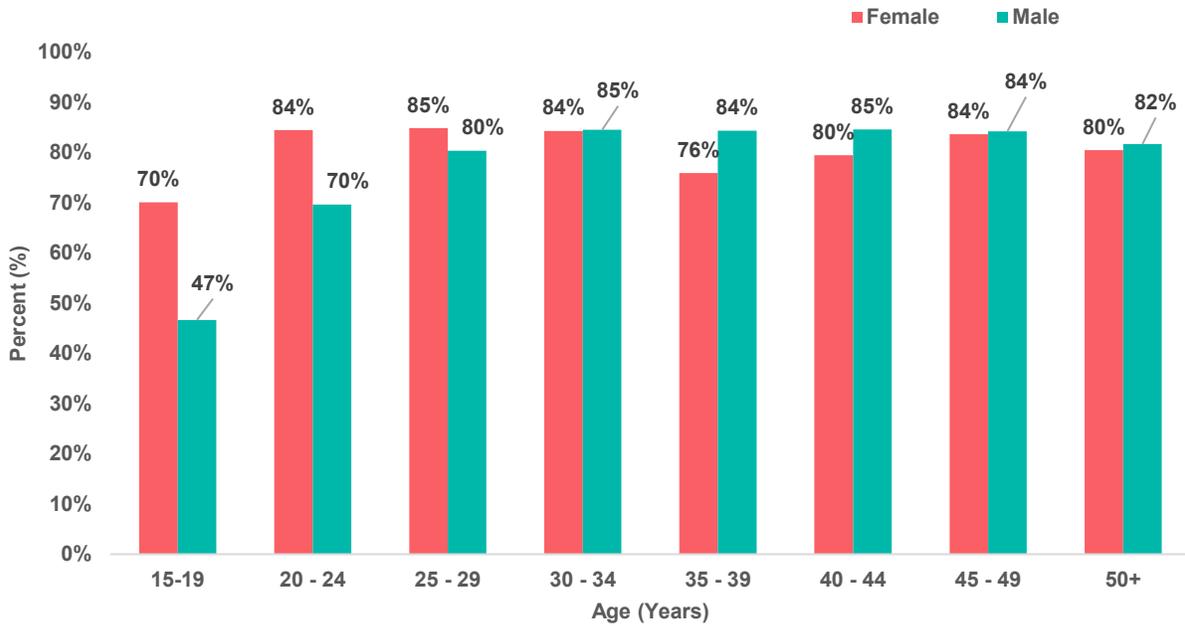
The proportion of RITA recent infections is highest among women less than 25 years and declines in older age groups; similarly, among males, the highest proportion of RITA recent cases occurs in those aged 20-24 years, with no cases classified as RITA recent among males 15-19 years during this post-RITA implementation period (Figure 9).

Figure 9. Percent of Clients RTRI and RITA Recent, by Age and Sex[1], April 2022-December 2024 (Post-RITA Implementation)
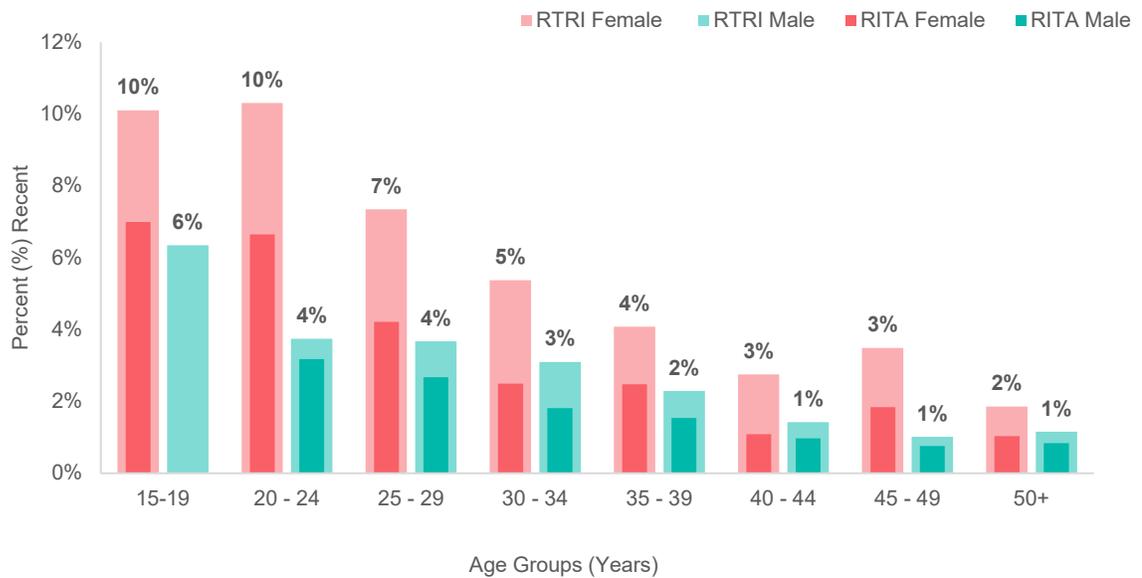
Across modalities, the outpatient department (OPD) accounted for the largest number of RITA recent infections of total RITA recent cases identified, followed by antenatal care (ANC) clinics and community-based testing entry points, yet the proportion of RITA recent infections is highest at ANC and adolescent clinics, as well as ART clinics and community-based testing entry points where index testing and services to people at higher risk for HIV are offered, respectively (Figures 10-11). This also reflect settings where females of child-bearing age are presenting (i.e., ANC and adolescent clinic) as opposed to men, indicating health seeking patterns. Most persons who present to the adolescent clinic are female as opposed to boys who typically present at the men's clinic.

Figure 10. Percent of Clients RTRI and RITA Recent, by Testing Point[2], April 2022-December 2024 (Post-RITA Implementation)
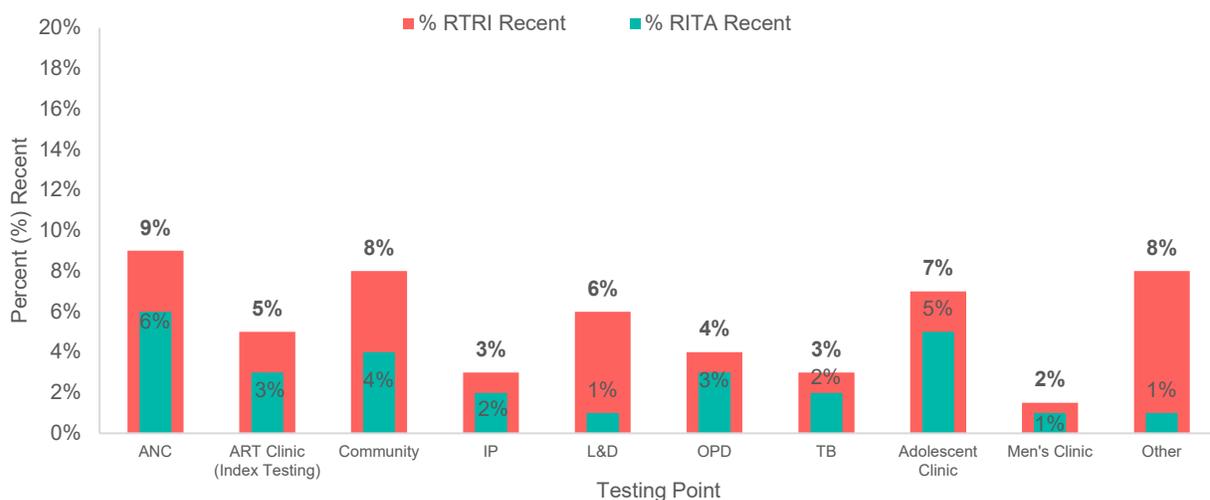
Figure 11. Number and Percent of Clients RITA Recent, by Testing Point[2], April 2022-December 2024 (Post-RITA Implementation)
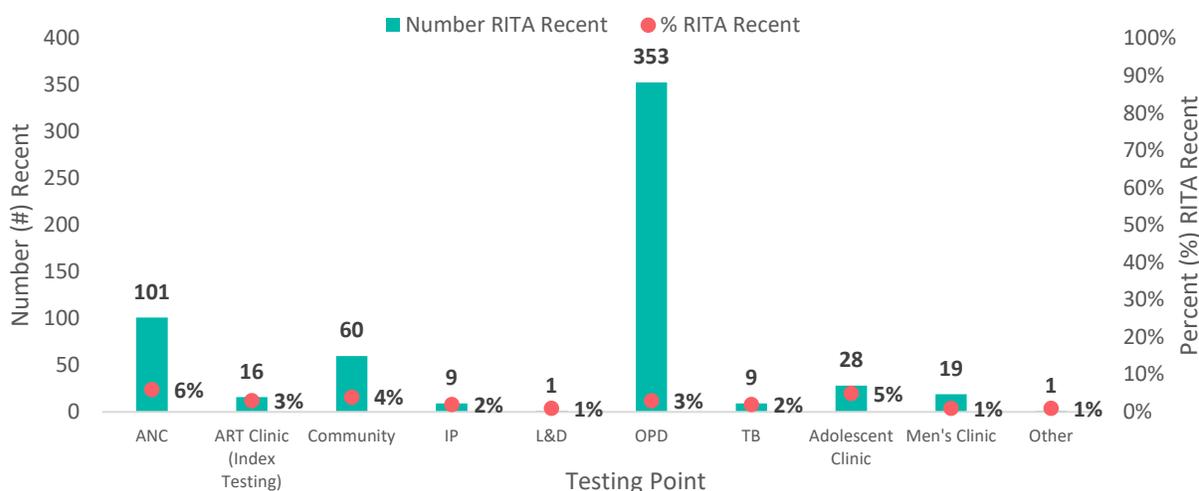
During this reporting period, of the 885 RTRI recent cases with VL results available, 33% (290/885) had VL less than 1,000 copies/mL and were reclassified as long-term. Most reclassified clients were identified at facility-based testing points, including OPD which accounted for the largest share (171/290, 59%). Antenatal care (ANC) and community testing contributed 18% (52/290) and 10% (28/290) of reclassified cases, respectively. Other facility points, such as the ART clinic, TB clinic, and inpatient wards, contributed smaller proportions. Labor & Delivery (L&D) testing points had the highest proportion of reclassification among those with VL available (75%), though absolute numbers were small (3 cases). Across other testing points, current RIS data indicate that 21-36% of clients were reclassified as long-term infections (Figure 12). The proportion of RTRI recent cases reclassified as long-term after RITA varied across districts, ranging from 19% in Qacha's Nek to 39% in Leribe (Figure 13). Leribe (39%) and Maseru (38%) had the

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[2]Ten testing point categories are represented. Antenatal Clinic (ANC); Index testing through ART Clinic; Community; Inpatient (IP); Labor and Delivery (L&D); Outpatient Department (OPD); Tuberculosis Clinic (TB); Adolescent Clinic; Men's Clinic; and Other.

highest reclassification rates, followed by Berea and Mohale's Hoek (36% each). Districts with the lowest reclassification rates included Qacha's Nek (19%), Thaba-Tseka (20%), and Mokhotlong (21%).

Figure 12. Number and Percent of Clients RTRI Recent Reclassified Long-Term (LT) by Testing Point[2], April 2022-December 2024 (Post-RITA Implementation)

Figure 13. Percent of RTRI Recent Clients Reclassified Long-Term (LT) by District, April 2022-December 2024 (Post-RITA Implementation)
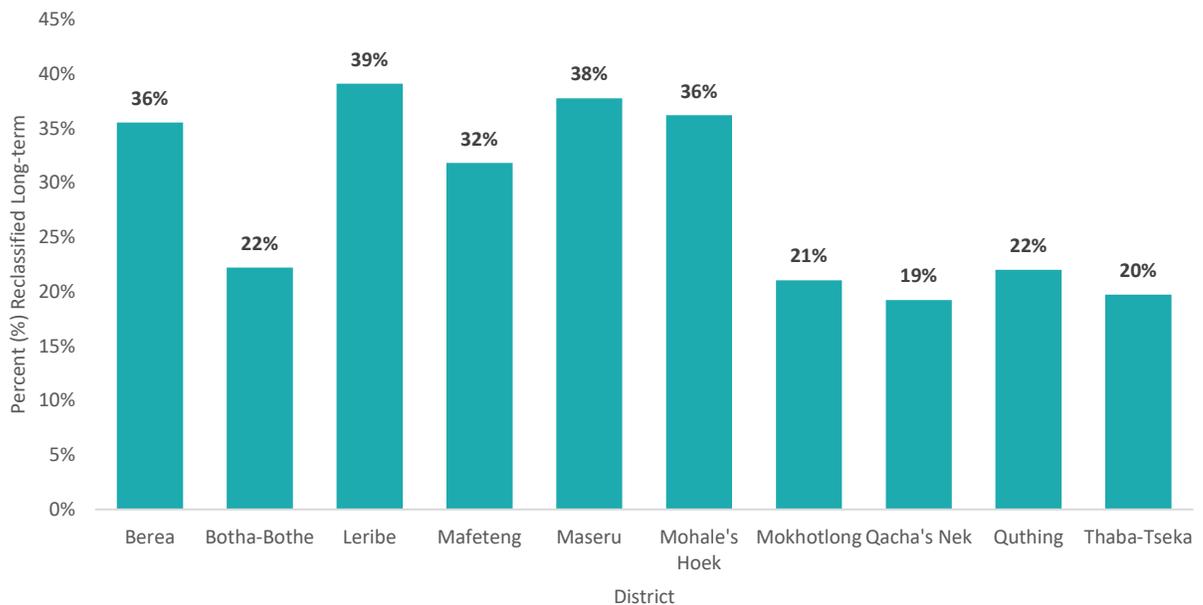
Figure 14. Percent of RTRI Recent Clients Reclassified Long-Term (LT) by Age and Sex[3], April 2022-December 2024 (Post-RITA Implementation)
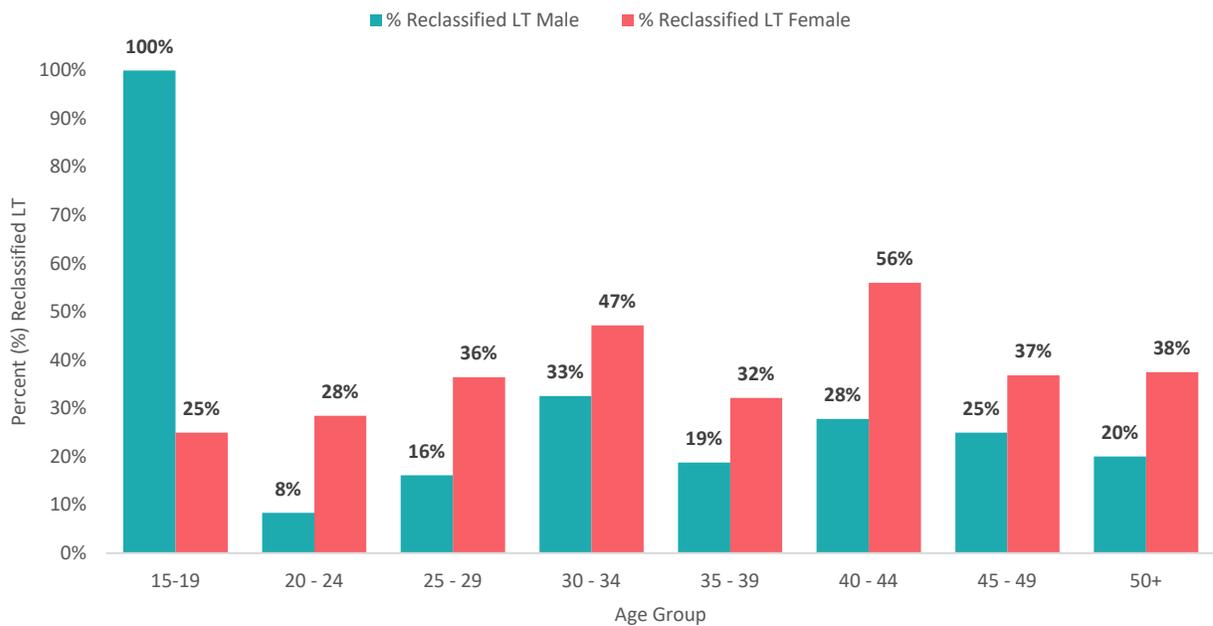
Among populations at higher risk of HIV acquisition tested by RITA, 4% (64/1668) of RITA recent infections were among women who engage in commercial sex, 4% (20/475) were among men who have sex with men (MSM), and 3% (1/ 37) were among those classified in other high-risk groups (Figure 15).

Figure 15. Number and Percent of Clients RITA Recent by Population Group at Higher Risk for HIV, April 2022-December 2024 (Post-RITA Implementation)

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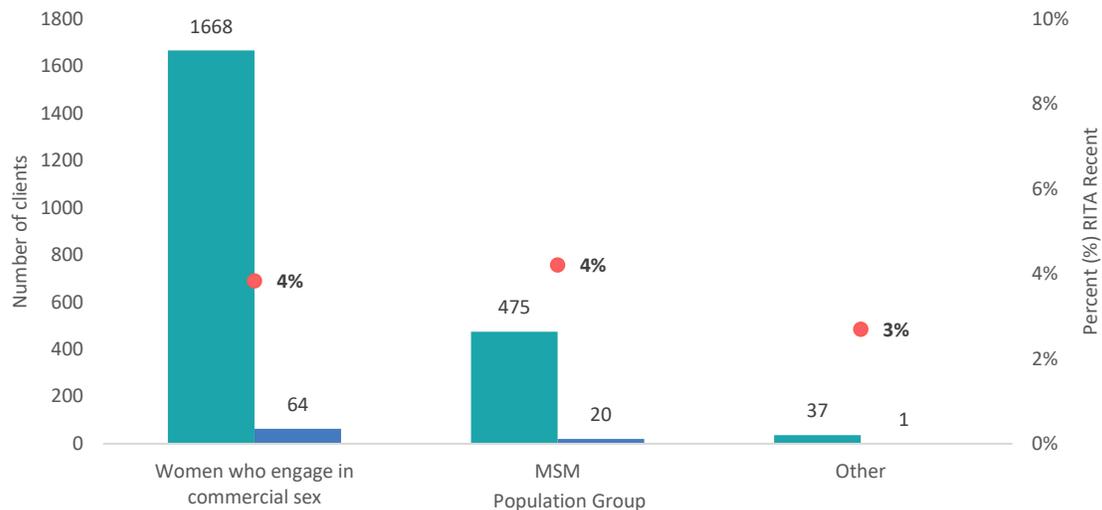
[3]Percentages are for RTRI-recent clients recorded as female or male only; two records coded as are excluded from the sex-disaggregated bars and are not shown; totals may therefore not sum to the overall n (RTRI-recent clients with VL results available for interpretation).

During the reporting period, RTRI testing volumes varied significantly across districts, with Maseru accounting for the highest number of clients tested (6,549), followed by Leribe (3,211) and Berea (2,630). In contrast, districts such as Mokhotlong (905), Qacha's Nek (607), and Thaba-Tseka (1,105) reported lower overall testing volumes (Figure 16). Notably, Thaba-Tseka recorded the highest percentage of RITA recent infections at 5%, followed by Quthing (4%), while Berea had the lowest at 2%. Thaba Tseka Health Division is a referral center for people at higher risk for HIV (Figure 17).

Figure 16. Number of Clients Tested by RTRI by District and Percent RITA Recent, April 2022-December 2024 (Post-RITA Implementation)
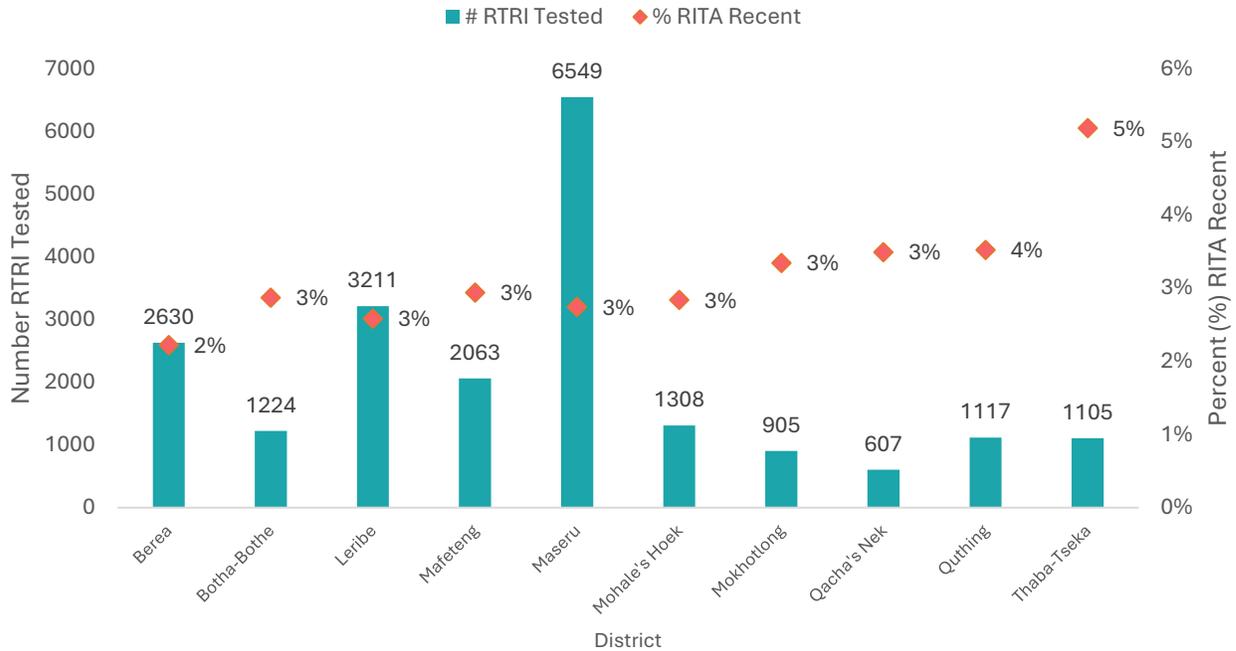
Figure 17. Map of Percent of Clients RTRI and RITA Recent in Implementing Districts, April 2022-December 2024 (Post-RITA Implementation)
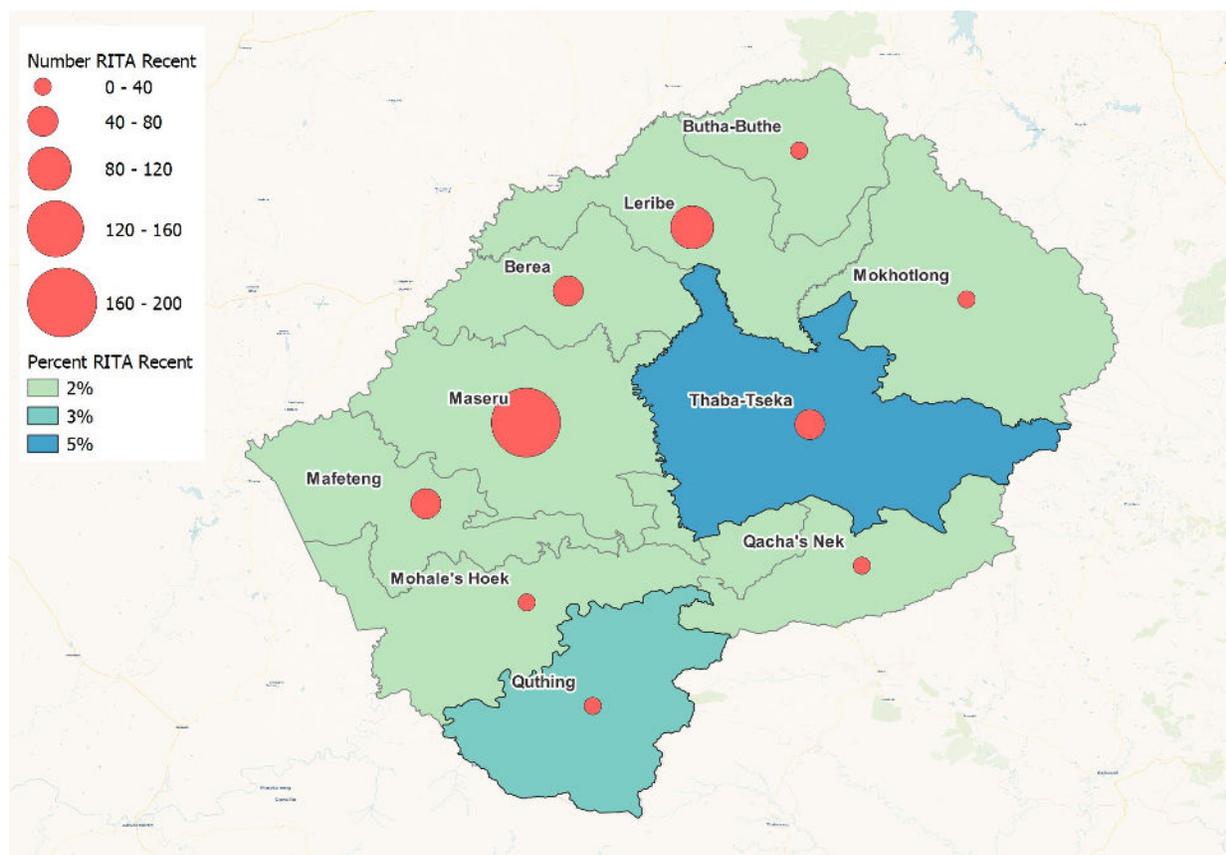
Among all eligible participants tested on RITA (Table 1), females comprised 62% of all participants and accounted for a disproportionately higher proportion of recent infections (80%) compared to long-term infections (61%). Recent infections were concentrated among younger age groups, with 30% of recent infections occurring among individuals aged 20–24 years, compared to 14% among long-term infections. Geographically, the distribution of recent infections was broadly like that of long-term infections, with the largest proportion observed in Maseru district (30%). However, recent infections were relatively more common in Thaba-Tseka (10% vs. 5%). Most individuals had lived in their current residence for more than 12 months (73%). Educational attainment tended to be lower among recent infections, with the majority reporting primary (34%) or secondary (46%) schooling as their highest level. A greater proportion of participants with recent infections were unemployed (44%) or students (5%) compared to their counterparts with long-term infections (38% and 2%, respectively). Being single (never married) was also more common among recent infections (34%) relative to those with long-term infection (27%), though nearly half of recent infections occurred among married individuals. Time since last HIV test also differed, with 18% of recent infections testing <3 months prior to diagnosis and 30% testing 3–6 months prior, compared to 6% and 12% among long-term infections, respectively. Partner HIV status knowledge was limited, with 62% of recent infections reporting they did not know their partner's status. Behavioral risk factors were largely similar between the two groups; 11% of RITA recent cases reported having exchanged sex for money and 1% were currently incarcerated. The median age at sexual debut was slightly younger among recent infections (17 years) compared to long-term infections (18 years), and only small proportions reported ever having anal intercourse (3%) or anal intercourse with a man (1%).

Table 1. Sociodemographic and clinical characteristics by recent infection status (column %), April 2022-December 2024 (Post-RITA Implementation)[4]

Characteristic	Total	RITA Recent	RITA Long-term
N	20548	597 (100%)	19951 (100%)
Sex			
Female	12732	477 (80%)	12255 (61%)
Male	7750	119 (20%)	7631 (38%)
Other	47	1 (0%)	46 (0%)
Refused to Answer	9	0 (0%)	9 (0%)
Missing	10	0 (0%)	10 (0%)
Age Group			
15-19	832	54 (9%)	778 (4%)
20-24	2919	182 (30%)	2737 (14%)
25-29	3943	151 (25%)	3792 (19%)
30-34	3852	85 (14%)	3767 (19%)
35-39	3232	64 (11%)	3168 (16%)
40-44	2349	24 (4%)	2325 (12%)
45-49	1442	18 (3%)	1424 (7%)
50+	1913	18 (3%)	1895 (9%)
Missing	66	1 (0%)	65 (0%)
Facility District			
Berea	2611	58 (10%)	2553 (13%)
Botha-Bothe	1219	35 (6%)	1184 (6%)
Leribe	3175	82 (14%)	3093 (16%)
Mafeteng	2039	60 (10%)	1979 (10%)
Maseru	6488	178 (30%)	6310 (32%)
Mohale's Hoek	1303	37 (6%)	1266 (6%)
Mokhotlong	897	30 (5%)	867 (4%)
Qacha's Nek	601	21 (4%)	580 (3%)
Quthing	1107	39 (7%)	1068 (5%)
Thaba-Tseka	1098	57 (10%)	1041 (5%)
Missing	10	0 (0%)	10 (0%)
Current residence status			
< 6 months	2671	91 (15%)	2580 (13%)
6-12 months	1412	70 (12%)	1342 (7%)
>12 months	16405	436 (73%)	15969 (80%)
Refused to answer	49	0 (0%)	49 (0%)
Missing	11	0 (0%)	11 (%)
Education			

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[4]Counts (n) and percentages (%) are reported unless otherwise specified.

None	1057	18 (3%)	1039 (5%)
Primary	7909	204 (34%)	7705 (39%)
Secondary	8334	272 (46%)	8062 (40%)
Higher (university/other post-secondary school)	3218	102 (17%)	3116 (16%)
Refused to answer	19	1 (0%)	18 (0%)
Missing	11	0 (0%)	11 (0%)
Occupation			
Not currently working	7766	264 (44%)	7502 (38%)
Student	448	29 (5%)	419 (2%)
Farmer	1999	44 (7%)	1955 (10%)
Vendor	673	16 (3%)	657 (3%)
Domestic worker	3171	91 (15%)	3080 (15%)
Migrant worker	716	11 (2%)	705 (4%)
Other	5728	142 (24%)	5586 (28%)
Refused to answer	37	0 (0%)	37 (0%)
Missing	10	0 (0%)	10 (0%)
Marital status			
Single, never married	5578	201 (34%)	5377 (27%)
Married	9818	294 (49%)	9524 (48%)
Cohabiting	380	6 (1%)	374 (2%)
Widowed	1547	20 (3%)	1527 (8%)
Divorced/separated	3205	76 (13%)	3129 (16%)
Refused to answer	10	0 (0%)	10 (0%)
Missing	10	0 (0%)	10 (0%)
Age of first marriage/live with partner (union)			
Median age (interquartile range)	21 (19-25)	20 (18-23)	21 (19-25)
Missing	6828	227 (38%)	6601 (33%)
Most recent HIV test			
Never tested	2615	28 (5%)	2587 (13%)
<3 months ago	1252	109 (18%)	1143 (6%)
3-6 months ago	2485	178 (30%)	2307 (12%)
7-12 months ago	2907	94 (16%)	2813 (14%)
>12 months ago	9417	160 (27%)	9257 (46%)
Don't know	1818	28 (5%)	1790 (9%)
Refused to answer	44	0 (0%)	44 (0%)
Missing	10	0 (0%)	10 (0%)
HIV status of main spouse/partner			
HIV positive	5729	127 (21%)	5602 (28%)
HIV negative	2322	78 (13%)	2244 (11%)
N/A	1001	19 (3%)	982 (5%)
Don't know	11410	371 (62%)	11039 (55%)

Refused to answer	76	2 (0%)	74 (0%)
Missing	10	0 (0%)	10 (0%)
Age of first sex			
Median age (interquartile range)	18 (16-19)	17 (16-19)	18 (16-19)
Missing	3577	88 (15%)	3489 (17%)
Number of sexual partners in lifetime			
0	12	0 (0%)	12 (0%)
1	1193	37 (6%)	1156 (6%)
2+	13404	413 (69%)	12991 (65%)
Missing	5939	147 (25%)	5792 (29%)
Number of sexual partners in the past 12 months			
0	705	6 (1%)	699 (4%)
1	9709	264 (44%)	9445 (47%)
2+	8501	285 (48%)	8216 (41%)
Missing	1633	42 (7%)	1591 (8%)
Exchanged money/material for sex			
Yes	1668	64 (11%)	1604 (8%)
No	18769	531 (89%)	18238 (91%)
Refused to answer	55	2 (0%)	53 (0%)
Missing	56	0 (0%)	56 (0%)
Ever had anal intercourse			
Yes	475	20 (3%)	455 (2%)
No	19979	577 (97%)	19402 (97%)
Refused to answer	43	0 (0%)	43 (0%)
Missing	51	0 (0%)	51 (0%)
Ever had anal intercourse with a man			
Yes	151	5 (1%)	146 (1%)
No	138	0 (0%)	138 (1%)
N/A	69	0 (0%)	69 (0%)
Refused to answer	605	592 (99%)	13 (0%)
Missing	19585	0 (0%)	19585 (98%)
Currently incarcerated (in prison)			
Yes	200	5 (1%)	195 (1%)
No	20338	592 (99%)	19746 (99%)
Missing	10	0 (0%)	10 (0%)
Currently pregnant			
Yes	2149	116 (19%)	2033 (10%)
No	11211	366 (61%)	10845 (54%)
Don't Know	341	10 (2%)	331 (2%)
N/A	6785	105 (18%)	6680 (33%)
Refused to answer	12	0 (0%)	12 (0%)

Missing	50	0 (0%)	50 (0%)

When examining row percentages (Table 2), 4% of all females tested on RITA were classified as RITA recent compared to 2% of males. The proportion of recent infection was higher among adolescents aged 15–19 years (6%) and young adults aged 20–24 years (6%), compared to ≤2% among individuals aged 30 years and older. By geography, 5% of individuals residing in Thaba-Tseka district were classified as recent compared to ≤3% in most other districts. A higher proportion of recent infection was also observed among those who had lived in their current residence for 6–12 months (5%). By occupation, 6% of students and 4% of those not currently working were recent cases, compared to 2% among farmers, vendors, and migrant workers. Four percent of participants who were single/never married were recent, compared to 1% among widowed individuals. HIV testing history also showed strong differences: 9% of those who had tested within the past 3 months and 7% of those tested 3–6 months prior were recent, compared to only 1% of those who had never been tested. Behavioral and clinical factors followed similar patterns, with 4% of participants who had exchanged sex for money and 4% of those reporting anal intercourse classified as recent. Finally, 5% of women who were currently pregnant were recent compared to 3% of those not pregnant, whereas almost no participants reporting no sexual partners in the past year were recent (<1%).

Table 2. Sociodemographic and clinical characteristics by recent infection status (row %), April 2022-December 2024 (Post-RITA Implementation)[5]

Characteristic	Total	RITA Recent	RITA Long-term
N	20548	597 (3%)	19951 (97%)
Sex			
Female	12732	477 (4%)	12255 (96%)
Male	7750	119 (2%)	7631 (98%)
Other	47	1 (2%)	46 (98%)
Refused to Answer	9	0 (0%)	9 (100%)
Missing	10	0 (0%)	10 (100%)
Age Group			
15-19	832	54 (6%)	778 (94%)
20-24	2919	182 (6%)	2737 (94%)
25-29	3943	151 (4%)	3792 (96%)
30-34	3852	85 (2%)	3767 (98%)
35-39	3232	64 (2%)	3168 (98%)
40-44	2349	24 (1%)	2325 (99%)
45-49	1442	18 (1%)	1424 (99%)
50+	1913	18 (1%)	1895 (99%)
Missing	66	1 (2%)	65 (98%)
Facility District			
Berea	2611	58 (2%)	2553 (98%)
Botha-Bothe	1219	35 (3%)	1184 (97%)
Leribe	3175	82 (3%)	3093 (97%)
Mafeteng	2039	60 (3%)	1979 (97%)

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[5]Counts (n) and percentages (%) are reported unless otherwise specified.

Maseru	6488	178 (3%)	6310 (97%)
Mohale's Hoek	1303	37 (3%)	1266 (97%)
Mokhotlong	897	30 (3%)	867 (97%)
Qacha's Nek	601	21 (3%)	580 (97%)
Quthing	1107	39 (4%)	1068 (96%)
Thaba-Tseka	1098	57 (5%)	1041 (95%)
Missing	10	0 (0%)	10 (100%)
Current residence status			
< 6 months	2671	91 (3%)	2580 (97%)
6-12 months	1412	70 (5%)	1342 (95%)
>12 months	16405	436 (3%)	15969 (97%)
Refused to answer	49	0 (0%)	49 (100%)
Missing	11	0 (0%)	11 (%)
Education			
None	1057	18 (2%)	1039 (98%)
Primary	7909	204 (3%)	7705 (97%)
Secondary	8334	272 (3%)	8062 (97%)
Higher (university/other post-secondary school)	3218	102 (3%)	3116 (97%)
Refused to answer	19	1 (5%)	18 (95%)
Missing	11	0 (0%)	11 (100%)
Occupation			
Not currently working	7766	264 (3%)	7502 (97%)
Student	448	29 (6%)	419 (94%)
Farmer	1999	44 (2%)	1955 (98%)
Vendor	673	16 (2%)	657 (98%)
Domestic worker	3171	91 (3%)	3080 (97%)
Migrant worker	716	11 (2%)	705 (98%)
Other	5728	142 (2%)	5586 (98%)
Refused to answer	37	0 (0%)	37 (100%)
Missing	10	0 (0%)	10 (100%)
Marital status			
Single, never married	5578	201 (4%)	5377 (96%)
Married	9818	294 (3%)	9524 (97%)
Cohabiting	380	6 (2%)	374 (98%)
Widowed	1547	20 (1%)	1527 (99%)
Divorced/separated	3205	76 (2%)	3129 (98%)
Refused to answer	10	0 (0%)	10 (100%)
Missing	10	0 (0%)	10 (100%)
Age of first marriage/live with partner (union)			
Median age (interquartile range)	21 (19-25)	20 (18-23)	21 (19-25)
Missing	6828	227 (3%)	6601 (97%)

Most recent HIV test

Never tested	2615	28 (1%)	2587 (99%)
<3 months ago	1252	109 (9%)	1143 (91%)
3-6 months ago	2485	178 (7%)	2307 (93%)
7-12 months ago	2907	94 (3%)	2813 (97%)
>12 months ago	9417	160 (2%)	9257 (98%)
Don't know	1818	28 (2%)	1790 (98%)
Refused to answer	44	0 (0%)	44 (100%)
Missing	10	0 (0%)	10 (100%)

HIV status of main spouse/partner

HIV positive	5729	127 (2%)	5602 (98%)
HIV negative	2322	78 (3%)	2244 (97%)
N/A	1001	19 (2%)	982 (98%)
Don't know	11410	371 (3%)	11039 (97%)
Refused to answer	76	2 (3%)	74 (97%)
Missing	10	0 (0%)	10 (100%)

Age of first sex

Median age (interquartile range)	18 (16-19)	17 (16-19)	18 (16-19)
Missing	3577	88 (2%)	3489 (98%)

Number of sexual partners in lifetime

0	12	0 (0%)	12 (100%)
1	1193	37 (3%)	1156 (97%)
2+	13404	413 (3%)	12991 (97%)
Missing	5939	147 (2%)	5792 (98%)

Number of sexual partners in the past 12 months

0	705	6 (1%)	699 (99%)
1	9709	264 (3%)	9445 (97%)
2+	8501	285 (3%)	8216 (97%)
Missing	1633	42 (3%)	1591 (97%)

Exchanged money/material for sex

Yes	1668	64 (4%)	1604 (96%)
No	18769	531 (3%)	18238 (97%)
Refused to answer	55	2 (4%)	53 (96%)
Missing	56	0 (0%)	56 (100%)

Ever had anal intercourse

Yes	475	20 (4%)	455 (96%)
No	19979	577 (3%)	19402 (97%)
Refused to answer	43	0 (0%)	43 (100%)
Missing	51	0 (0%)	51 (100%)

Ever had anal intercourse with a man

Yes	151	5 (3%)	146 (97%)

No	138	0 (0%)	138 (100%)
N/A	69	0 (0%)	69 (100%)
Refused to answer	605	592 (98%)	13 (2%)
Missing	19585	0 (0%)	19585 (100%)
Currently incarcerated (in prison)			
Yes	200	5 (3%)	195 (98%)
No	20338	592 (3%)	19746 (97%)
Missing	10	0 (0%)	10 (0%)
Currently pregnant			
Yes	2149	116 (5%)	2033 (95%)
No	11211	366 (3%)	10845 (97%)
Don't know	341	10 (3%)	331 (97%)
N/A	6785	105 (2%)	6680 (98%)
Refused to answer	12	0 (0%)	12 (100%)
Missing	50	0 (0%)	50 (100%)

4.1 Monitoring trends in proportion recent among the at-risk population testing at HIV clinics

Beginning in January 2022, Lesotho began to routinely monitor trends in the proportion of presumably HIV-negative individuals testing for HIV at HIV testing clinics that are classified as likely to be new (incident) infections by taking the ratio of RITA recent HIV infections over the total number of HIV-negative plus HIV RITA recent results.

Box 1. Proportion recent among at-risk population calculation

$$Proportion\ recent\ among\ at-risk\ population = \frac{RITA\ Recents * \frac{1}{RTRI\ Coverage}}{HTS\ Negative + (RITA\ Recents * \frac{1}{RTRI\ Coverage})}$$

$$= \frac{RITA\ Recents}{RITA\ Recents + (HTS\ Negative)(RTRI\ Coverage)}$$

This trend provides an estimate of changes in six-month HIV incidence among populations seeking HIV tests at these clinics. To assess trends in the expected number of recent infections over time, negative binomial regression models were used. Relative rates (RR) for linear changes were estimated by exponentiating the time term in the regression model, where an RR of 1.0 indicates no linear trend over time. Models included robust standard errors to account for clustering at the facility level and to address correlation inherent in rolling average methods. Analyses were stratified by sex, age group, and region (North vs. South) to evaluate differences in incidence trends across key subpopulations.

Overall, the proportion of RITA recent cases among those at risk for HIV and testing at HIV clinics has declined, decreasing from 0.23% in January 2022 to 0.13% in December 2024 (Figure 18) (RR: 0.90, 95% CI: 0.86–0.94) with similar magnitude reductions across males and females, both under and over 30 years of age (Figure 19). In addition, the Southern districts, which experienced a peak in October–December

2022, have since returned proportions of RITA recent among those at risk comparable to those in the Northern districts (Figure 20).

Figure 18. Proportion RITA Recent Among Those Testing at HIV Clinics, January 2022-December 2024

	2022			2023				2024			
	Apr-Jun (76 clinics)	Jul-Sep (77 clinics)	Oct-Dec (140 clinics)	Jan-Mar (180 clinics)	Apr-Jun (185 clinics)	Jul-Sep (180 clinics)	Oct-Dec (184 clinics)	Jan-Mar (191 clinics)	Apr-Jun (185 clinics)	Jul-Sep (187 clinics)	Oct-Dec (178 clinics)
HTS+	1869	1380	2665	3023	2302	2259	2282	2844	2078	2014	1816
HTS-	18228	11586	23521	22415	20574	20727	20839	20580	21895	25596	21657
% positive	9.30%	10.64%	10.18%	11.88%	10.06%	9.83%	9.87%	12.14%	8.67%	7.29%	7.74%
RITA tested	924	983	1737	2284	1971	1960	2052	2606	1909	1751	1448
RITA recent	29	38	67	77	91	57	49	65	30	33	19
% RITA recent	3.14%	3.87%	3.86%	3.37%	4.62%	2.91%	2.39%	2.49%	1.57%	1.88%	1.31%
RITA coverage	49.4%	71.2%	65.2%	75.6%	85.6%	86.8%	89.9%	91.6%	91.9%	86.9%	79.7%

Figure 19. Proportion RITA Recent Among Those Testing at HIV Clinics, by Age/Sex Groups, January 2022-December 2024

	2022			2023				2024			
	Apr-Jun (76 clinics)	Jul-Sep (77 clinics)	Oct-Dec (140 clinics)	Jan-Mar (180 clinics)	Apr-Jun (185 clinics)	Jul-Sep (180 clinics)	Oct-Dec (184 clinics)	Jan-Mar (191 clinics)	Apr-Jun (185 clinics)	Jul-Sep (187 clinics)	Oct-Dec (178 clinics)
HTS+	1869	1380	2665	3023	2302	2259	2282	2844	2078	2014	1816
HTS-	18228	11586	23521	22415	20574	20727	20839	20580	21895	25596	21657
% positive	9.30%	10.64%	10.18%	11.88%	10.06%	9.83%	9.87%	12.14%	8.67%	7.29%	7.74%
RITA tested	924	983	1737	2284	1971	1960	2052	2606	1909	1751	1448
RITA recent	29	38	67	77	91	57	49	65	30	33	19
% RITA recent	3.14%	3.87%	3.86%	3.37%	4.62%	2.91%	2.39%	2.49%	1.57%	1.88%	1.31%
RITA coverage	49.4%	71.2%	65.2%	75.6%	85.6%	86.8%	89.9%	91.6%	91.9%	86.9%	79.7%

Figure 20. Proportion RITA Recent Among Those Testing at HIV Clinics, by Region, January 2022 - December 2024
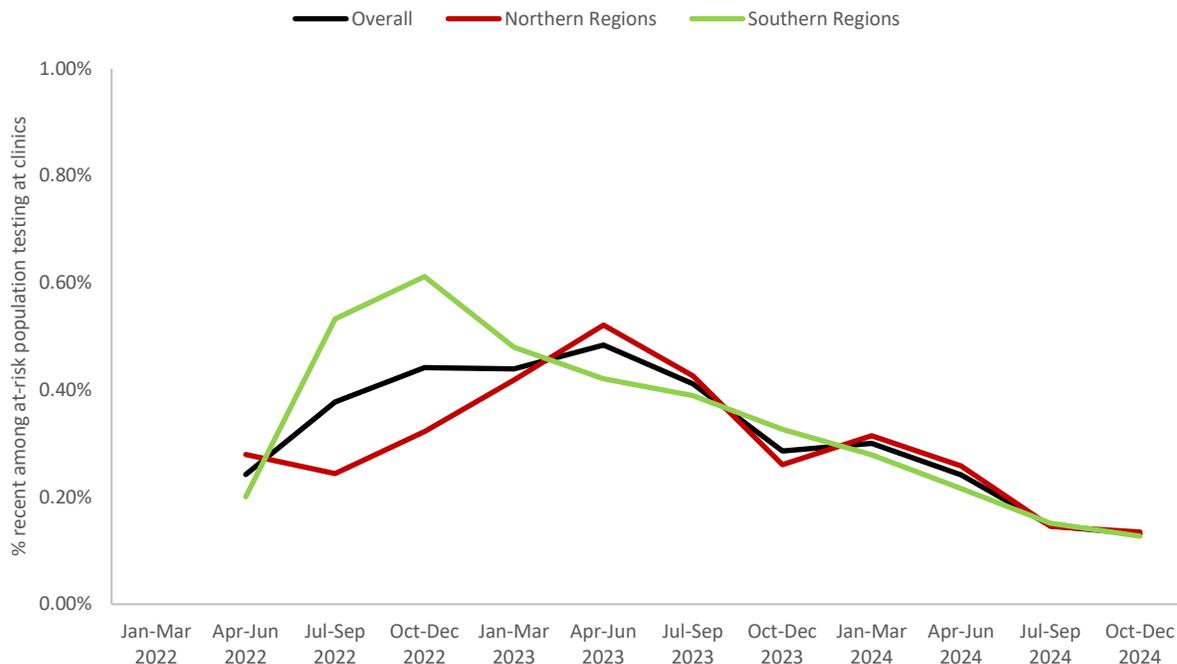
		2022			2023				2024			
		Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec
Overall	HTS+	1869	1380	2665	3023	2302	2259	2282	2844	2078	2014	1816
	HTS-	18228	11586	23521	22415	20574	20727	20839	20580	21895	25596	21657
	% positive	9.30%	10.64%	10.18%	11.88%	10.06%	9.83%	9.87%	12.14%	8.67%	7.29%	7.74%
	RITA tested	924	983	1737	2284	1971	1960	2052	2606	1909	1751	1448
	RITA recent	29	38	67	77	91	57	49	65	30	33	19
	% RITA recent	3.14%	3.87%	3.86%	3.37%	4.62%	2.91%	2.39%	2.49%	1.57%	1.88%	1.31%
North	HTS+	1051	514	1757	1758	1392	1382	1386	1759	1235	1236	1107
	HTS-	11259	4974	16800	13457	12830	12942	13025	12956	13179	14604	12757
	% positive	8.54%	9.37%	9.47%	11.55%	9.79%	9.65%	9.62%	11.95%	8.57%	7.80%	7.98%
	RITA tested	562	329	1051	1396	1176	1178	1214	1572	1110	1018	814
	RITA recent	18	5	38	51	62	32	27	46	15	20	9
	% RITA recent	3.20%	1.52%	3.62%	3.65%	5.27%	2.72%	2.22%	2.93%	1.35%	1.96%	1.11%
South	HTS+	818	866	908	1265	910	877	896	1085	843	764	709
	HTS-	6969	6612	6721	8958	7744	7785	7814	7624	8716	10552	8900
	% positive	10.50%	11.58%	11.90%	12.37%	10.52%	10.12%	10.29%	12.46%	8.82%	6.75%	7.38%
	RITA tested	362	654	686	888	795	782	838	1034	799	722	634
	RITA recent	11	33	29	26	29	25	22	19	15	13	10
	% RITA recent	3.04%	5.05%	4.23%	2.93%	3.65%	3.20%	2.63%	1.84%	1.88%	1.80%	1.58%

5.0 Testing quality and continuous quality control

5.1 Quality Control testing

Overall RTRI testing quality for the entire implementation period (2019–2024) is summarized below. A total of 7,450 quality control (QC) panels were distributed to all implementing facilities across 10 districts. 100% QC pass rate for all samples except for February and May 2023 where the long-term pass rate was 99.3% and 99.9% respectively. Failed QCs are reported to district labs and new samples provided with direct observation and mentorship during repeat testing.

Of 20,697 RTRI tests run, <0.4% or 51 RTRI tests yielding inconclusive recent infection status were recorded, giving an assay sensitivity of 99.8% (Figure 21). Only 4 invalid test results were identified.

Figure 21. Sensitivity of the Positive Verification Line of RTRI

20,697	51	99.8%
Tested by RTRI	**Recent Infection Status Inconclusive**	**RTRI Sensitivity**

5.2 Proficiency Panel Testing

Proficiency panel testing (PPT) for recency is integrated within the routine HIV rapid testing proficiency testing (PT) program. PPT for recency is conducted biannually, each June and November, for all eligible and enrolled testers. A total of six PPT rounds have been completed since the start of implementation, covering a total of 207 sites and 784 testers. The first PT round was conducted in June 2022 with a total of 102 testers from 32 participating sites. Across PPT rounds, pass rates have ranged between 91% and 98% on the first attempt. Overall, 90% of testers who initially failed on their first attempt were reached with a corrective action and preventive action (CAPA) intervention. All participating testers that failed on their first attempt achieved a 100% score on their second attempt following implementation of a CAPA (Figure 22).

Figure 22. Proficiency Panel Testing (PPT) Results and Percent Passed by PPT Round, October 2021-November 2024
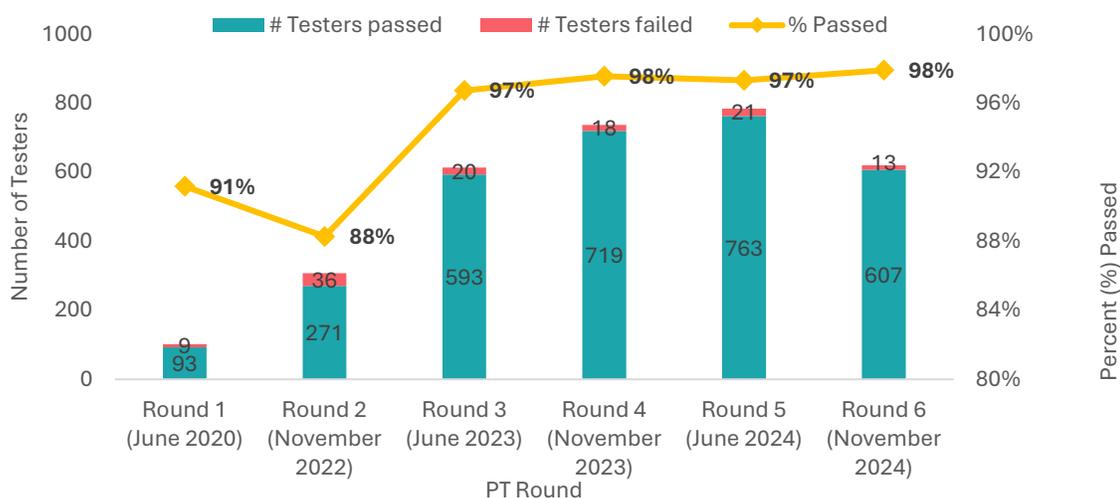
5.3 Continuous quality control (CQI)

Point-of-care recency testing must be conducted in compliance with standard procedures and supported by robust quality assurance and quality improvement mechanisms at all levels. Continuous quality improvement (CQI) is a structured, ongoing process for assessing performance and enhancing the quality of services to address clients' needs effectively, responsively, and respectfully. Continuous quality improvement aids in identifying service delivery issues, implementing targeted actions to address them, and following up through regular monitoring (e.g., the Plan–Do–Study–Act (PDSA) cycle). Site-level staff lead these efforts, working to pinpoint problems, take remedial actions, and track progress over time. The CQI toolkit for recency includes a checklist and scorecard for assessing site performance and an action plan matrix for improvement.

As recency was scaled up and implementation began in Botha Bothe and Mokhotlong districts, a trained focal person was designated to coordinate activities in collaboration with the DHMTs and was responsible for conducting monthly monitoring visits. In total, 18 DHMT staff and 8 implementing partner staff were trained to utilize a tablet-based CQI checklist. Four tablets (two per district) were provided to enable electronic capture of CQI data into the DHIS2 system. During each supervisory visit, the DHMT monitoring team completes a brief electronic supervision checklist, which assesses each facility against defined criteria across six key categories. The team works closely with site-level staff to identify gaps, develop remedial actions, and monitor their impact.

To further support these efforts, a CQI dashboard (integrated within the DHIS2 recency dashboard) was developed to visualize key metrics, enabling routine access and review of data. The CQI dashboard strengthens district-level monitoring, site support, and supervision by tracking progress using data captured by the CQI checklist. Figure 23 shows overall performance of all 32 sites in Botha-Bothe and Mokhotlong across the six assessment categories. Notably, performance improved in four out of six categories following the implementation of remedial actions. However, study staff and data management areas continue to score below 80%, indicating the need for focused improvement plans in these domains.

Figure 23. Average CQI Score by Domain in Botha-Bothe and Mokhotlong Districts, June 2023-December 2024
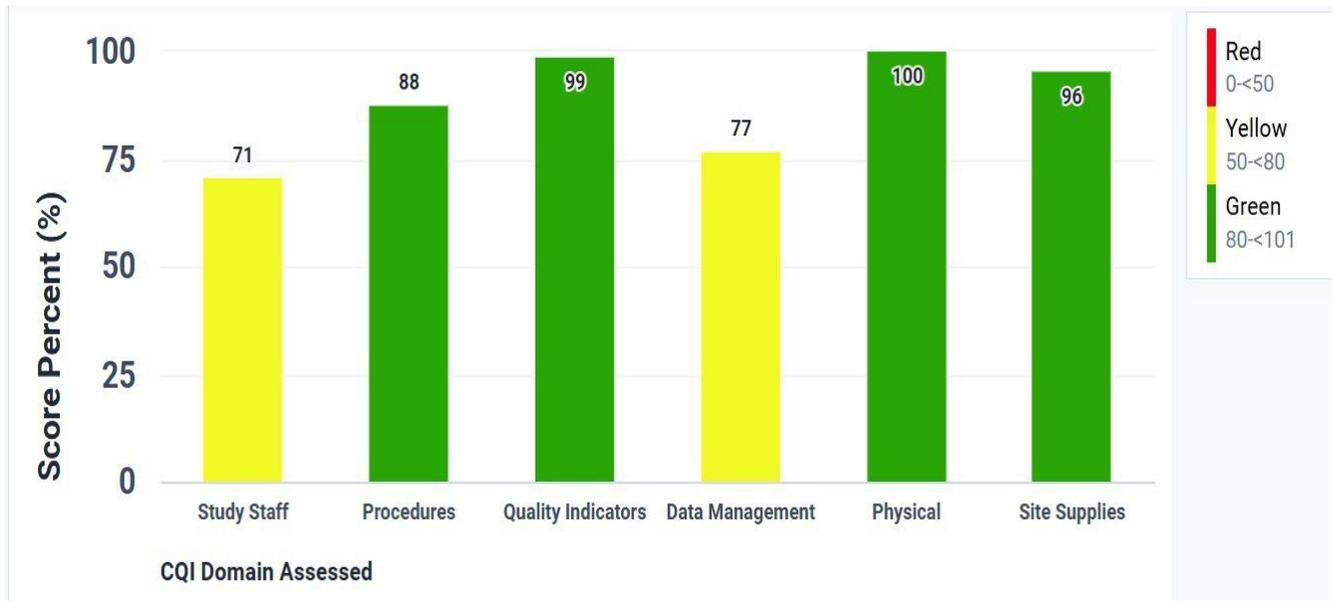
6.0 Public Health Response and Data Use

The MoH, in partnership with implementing partners, developed a Public Health Response (PHR) Strategy in August 2020 to guide the use of RIS data for PHR. As part of this effort, a total of 42 participants from MOH, EGPAF, PSI, CDC, and ICAP took part in a three-week virtual data use and PHR workshop. The workshop focused on developing a strategy for responding to signals of HIV acquisition based on trends in available RIS data and resulted in consensus on a preliminary threshold for PHR: the occurrence of 3 or more RTRI recent cases in at least two of the past three months, initially applied to Leribe District as part of an above-site response.

Building on this foundation, a second data use and PHR workshop was held in-person in September 2022, bringing together 55 participants from the MoH, CDC, ICAP, EGPAF, and other implementing partners. The workshop resulted in an updated PHR strategy and standard operating procedure (SOP), including revised thresholds for initiating investigations based on the number of RTRI and/or RITA recent cases reported per month. As part of this workshop, three participating districts–Berea, Maseru and Leribe–developed action plans to further investigate 5 potential signals of HIV acquisition, and designed program improvement plans with the involved health facilities.

A third data use workshop was conducted in May 2023 with participation from 78 representatives from DHMTs and implementing partners across seven districts. During the workshop, the threshold definition for triggering a PHR was further refined as two standard deviations above the national mean, enabling a more data-driven and adaptive approach to hotspot detection.

The workshops laid the foundation for a structured PHR approach that integrates RIS data into actionable decision-making. In Lesotho, this approach leverages data on recent HIV infections—supplemented by routine HIV program data and other surveillance sources—to identify geographic areas, demographic groups, or subpopulations at heightened risk of HIV acquisition. Figure 24 outlines the strategic framework for using RIS data for PHR that is used in Lesotho to inform timely, targeted interventions at the local, sub-national, and national levels. Figure 25 illustrates how RIS data is used to identify potential signals of transmission by mapping the distribution of recent and long-term infections according to place of testing and place of residence. These geospatial insights help pinpoint areas that may require targeted prevention and intervention efforts.

Figure 24. Overview of the Public Health Response Strategy Using Recent Infection Surveillance
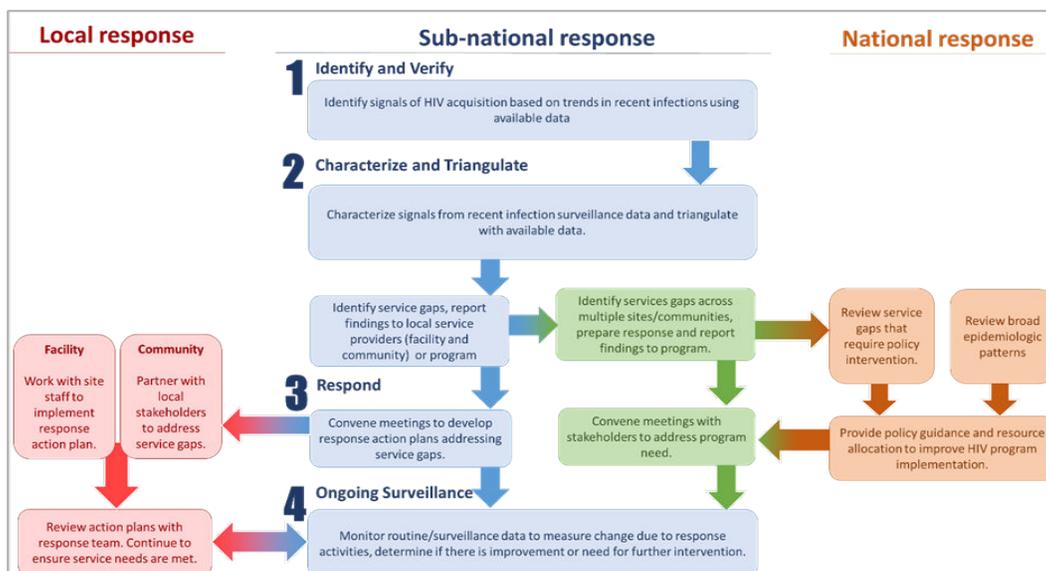
Figure 25. Geospatial Maps of Potential Signals of Transmission Hotspots, by Place of Testing and Place of Residence, January 1, 2024-December 31, 2024
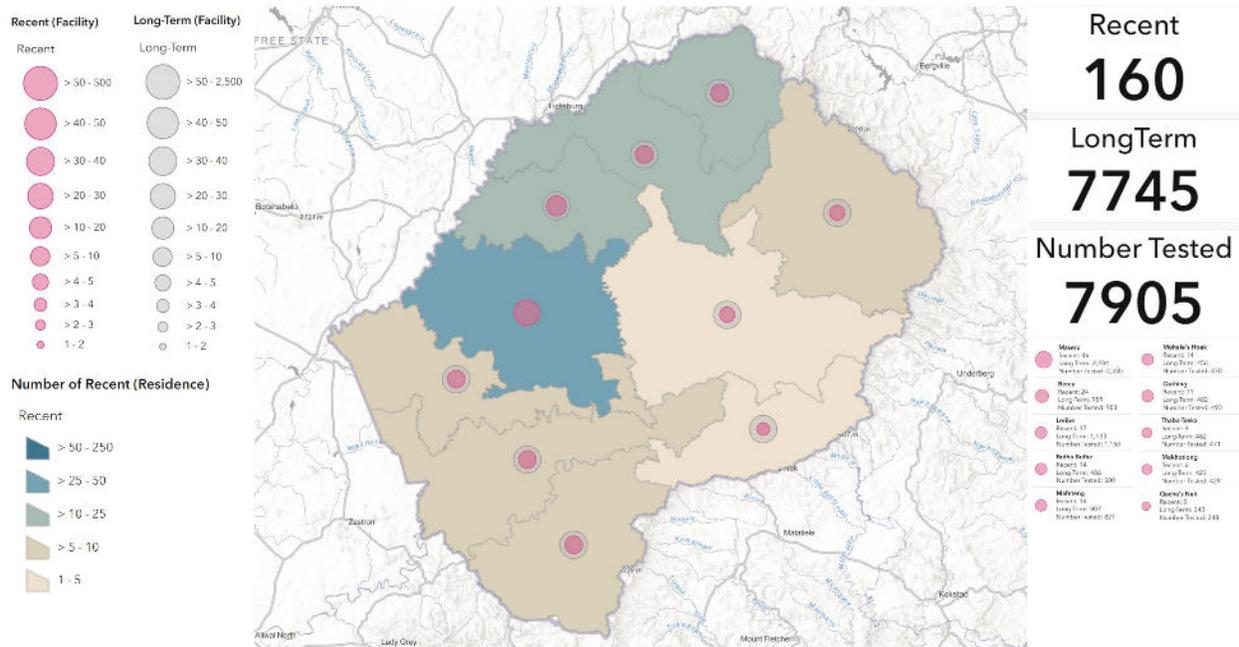
To initiate a PHR in Lesotho following the identification of a potential signal of HIV acquisition, a structured sequence of activities is conducted to verify, characterize, respond to, and monitor signals of potential ongoing HIV transmission:

Step 1: Identify and verify

- Review of the DHIS2 recency dashboard to verify recent infection surveillance data and assess data quality.

Step 2: Characterize and triangulate

- Recent infection surveillance data is extracted and triangulated with other available routine data using MOH DHIS2 or partner databases (e.g., DATIM, EADEL & Baylor's Basidac) and registers
- Local consultations with key stakeholders to understand contextual factors
- Identification of service delivery gaps from collected data

Step 3: Respond

- Development of response action plans with facility teams to address service gaps identified in Step 2.

To support each step of the PHR process, a set of standardized tools is used to guide data collection, contextualize analysis, and facilitate action planning at the facility level. These tools are summarized in Table 3.

Table 3. Tools Used in Cluster Investigations for Public Health Response in Lesotho

Tool	Purpose/Use
Indicator table	Review and document site performance on key HIV indicators from existing national and IP platforms.
Index testing cascade	Abstract available site-level data on elicitation, testing services offered, and follow-up of elicited sexual partners.
Local Consultation Interview-Guide	Gathers contextual information that may be contributing to HIV transmission (e.g., service availability, access, and acceptability of services for target populations; service gaps) from stakeholders (health facility management staff, frontline healthcare workers, community members and village health workers or coordinators).
Action Plan Matrix	Documents identified service delivery gaps against standard of care for HIV-infected clients and outlines plans for performance improvement with timelines and responsible actors.

Following the development and implementation of action plans, a structured follow-up procedure is conducted to monitor progress, assess impact, and determine whether targeted interventions have successfully addressed service delivery gaps. Under the supervision of DHMTs, health facilities implement action plans for improving HIV prevention, testing, and treatment services in identified hotspots. These plans are reviewed quarterly, and key indicators are tracked over time to assess whether meaningful progress is being made. If, after at least two follow-up site visits, there is no significant improvement despite consistent implementation of planned interventions, the root cause analysis is revisited to determine whether other underlying factors are contributing to the identified gaps. Conversely, if a facility demonstrates sustained improvements across key program areas over at least two follow-up site visits, it may be considered for hotspot closure. However, these facilities remain under close monitoring and support by the district team to prevent regression. Final closure is contingent upon meeting predefined national criteria (Box 2) and agreement by district and national stakeholders.

Box 2. Criteria for closure of public health response hotspots

- Hotspot is implementing its action plan for at least 1 year
- 2–4 follow ups done on action plan
- 80% of action plan implemented, and service gaps addressed
- Improvement in program performance defined as a constant upward trend over 6 months during follow-up visits

Following the PHR pilot in 2020, a total of 30 hotspots were identified at the central level from July 2022 to December 2024, using defined threshold definitions. These hotspots have been identified across nine out of the ten districts of Lesotho, at 30 out of 230 recency testing sites. During this period (July 2022–Dec 2024), 289 RITA recent cases were identified at these sites. The majority of the facilities exceeding thresholds are medium-to-high volume facilities, hospitals, filter clinics and Roman Catholic health facilities in high economic activity areas. Other facilities are located along busy roads, serve people at higher risk for HIV, or are near construction sites, as shown in Table 3. Among 30 hotspots, 11 were closed following

the successful implementation and closure of identified service gaps, as well as a reduction in recent RITA cases. The 19 remaining hotspots remain active and continue to implement their action plans. Table 4 presents common gaps identified, and interventions implemented during PHR investigations, which were used to inform action plans.

Table 4. Summary of hotspots by district and year, 2022-2024

District	Summary	2022 (PHR threshold: ≥2 RTRI recent or ≥ 1 RITA recent per facility in 2 out of the last 3 consecutive months.	2023 (PHR threshold: 2 SD above the national mean)	2024 (PHR threshold: 2 SD above the national mean)
Maseru	No. recency sites	60	60	N/A
	No. hotspots	8 (13% of sites)	2 (3% of sites)	
	Facilities meeting threshold criteria	Loretto HC, LPPA, Maseru SDA HC, Nazareth HC, Senkatana, St Joseph Hospital, St Leo HC, and Thamae HC.	Likotsi Filter Clinic and Qoaling Filter Clinic.	
	Characteristics of facilities	• Mostly high-volume facilities. • Along main roads. • Serve factory workers • One serves population groups at higher risk for HIV • Roman Catholic Health Facilities – do not provide complete HIV prevention services package.	• High-volume facilities • Mostly serving factory workers	
Berea	No. recency sites	25	25	N/A
	No. hotspots	1 (4% of sites)	2 (8% of sites)	
	Facilities meeting threshold criteria	Khubetsoana HC	Mabote Filter Clinic and St. Theresa HC.	

	Characteristics of facilities	• High-volume facility. • Along the main road. • Has many pubs around the vicinity	• High-volume facilities • Located along the main road • Catholic health facility - does not provide a complete HIV prevention services package.	
Leribe	**No. recency sites**	32	32	N/A
	No. hotspots	2 (6% of sites)	3 (9% of sites)	
	Facilities meeting threshold criteria	Maputsoe Filter Clinic and Seshote HC	Motebang Hospital, St. Margaret HC, and St. Monica's HC	
	Characteristics of facilities	• High-volume facility. • Near the border. • Serves factory workers and populations at higher risk for HIV • Another facility is near the construction site and in the highlands	• One is a high-volume, district hospital and a regional referral hospital. • Located along the main road • The other two facilities are Roman Catholic facilities – they do not provide a comprehensive HIV prevention services package	
Botha-Bothe	**No. recency sites**	N/A	16	N/A
	No. hotspots		2 (13% of sites)	
	Facilities meeting threshold criteria		Butha-Buthe Hospital and Makhunoane HC.	
	Characteristics of facilities		• High-volume and medium-volume facilities • Government facilities • Located along the main roads • One was along the	

			construction site	
Mokhotlong	**No. recency sites**	N/A	16	N/A
	No. hotspots		1 (6% of sites)	
	Facilities meeting threshold criteria		Mokhotlong Hospital	
	Characteristics of facilities		• Rural district hospital • Government-owned • Near construction • The district is now a tourist attraction	
Thaba-Tseka	**No. recency sites**	N/A	20	N/A
	No. hotspots		3 (15% of sites)	
	Facilities meeting threshold criteria		Paray Hospital, St. James Hospital, and Thaba-Tseka Health Division HC.	
	Characteristics of facilities		• All high-volume facilities and rural • All are near high economic activity, especially bars and hotels	
Mafeteng	**No. recency sites**	N/A	19	N/A
	No. hotspots		3 (16% of sites)	
	Facilities meeting threshold criteria		LeCoop HC, Mafeteng Hospital, and Samaria HC.	
	Characteristics of facilities		• All high-volume facilities, along the main roads • Two are government-owned, and the other is a Roman Catholic facility. • Located around the	

			• high economic activities. • Two are in the city center, and another one is out of town, but many people from surrounding villages gather around due to recreational activities	
Mohale's Hoek	**No. recency sites**	N/A	N/A	18
	No. hotspots			2 (11% of sites)
	Facilities meeting threshold criteria			Holy Cross HC and Nts'ekhe Hospital
	Characteristics of facilities			• One is a government-owned district hospital, and the other is a medium-volume facility owned by the Roman Catholic Church • Both located along the main roads • Both are near economic activities • Clinic is near two high schools
Quthing	**No. recency sites**	N/A	N/A	11
	No. hotspots			1 (9% of sites)
	Facilities meeting threshold criteria			Quthing Hospital
	Characteristics of facilities			• Rural district hospital • Government-owned

| | Around high economic activity |
| | Serves all population groups, including population groups at higher risk for HIV |

Table 5. Summary of common gaps identified and interventions implemented during PHR investigations

Gaps Identified	Interventions
Challenges with the implementation of index testing: ▪ Not all newly diagnosed HIV-positive patients were offered index testing services ▪ Partner elicitation was limited to main sexual partners ▪ Index testing/partner notification services (PNS) were conducted only by counsellors ▪ Index testing/PNS primarily offered only at the time of diagnosis ▪ Elicited partners, particularly men, were not consistently followed up ▪ Facilities were not tracking site-level indicators to allow them to better understand reasons for gaps in contacts not tested ▪ Missed opportunities for partner testing or offering HIV self-testing (HIVST)	▪ Initiated index testing campaigns during weekends and major public holidays to reach underserved sub-populations such as partners who are migrants or farmers ▪ Strengthened the multidisciplinary approach to index testing services through: - Re-defining and revising the patient flow to enable patient contact with counsellors at every visit - Mentoring and supervising testers to use calling scripts for index testing - Liaising with community stakeholders for follow up of elicited partners - Providing HIVST kits to all index clients who refuse PNS and those whose partners are not tested - Encouraging partner accompaniment during ANC/PNC visits
Low PrEP uptake	Strengthened integrated, community-based outreach to promote HIV prevention through: ▪ Health education sessions ▪ Distribution of condoms and IEC materials ▪ Demand creation for PrEP initiation and continuation
Poor management of patients with high viral loads (HVL): ▪ Poor documentation and delayed updating of HVL clients in facility HVL registers ▪ Delayed initiation of enhanced adherence counseling (EAC) due to tracking gaps	▪ Strengthen multi-disciplinary collaboration between nurses and counsellors to ensure timely follow-up ▪ Ensured fast-track updating of HVL patients in registers upon receipt of results ▪ Initiated timely patient tracking–by phone or in-person– to start EAC sessions

6.1 Case Study: Recency Surveillance Signals Lead to Improved District-Level HIV Prevention and Testing Strategies in Thaba-Tseka

Routine analysis and triangulation of RIS data with HIV program data enhance the early detection of potential signals of HIV acquisition. The Thaba-Tseka district began implementing RIS in September 2022. By May 2023, the DHMT had established a PHR threshold, defined as two standard deviations (SD) above the district and national mean for RITA recent infections.

From September 2022 to March 2024, Lesotho recorded 15,980 newly diagnosed HIV-positive cases across its 10 districts, with the highest numbers reported in the populous northwestern districts of Berea (13%, n = 2,033) and Leribe (14%, n = 2,246). Among these, 2% of cases in Berea and 3% in Leribe were classified as RITA recent. In comparison, Thaba-Tseka accounted for only 5% (n = 878) of new diagnoses but reported a disproportionately high 7% as RITA recent, prompting the DHMT to initiate a targeted PHR in three locations with potential signals of recent transmission.

Between January and June 2023, RIS data revealed 29 RITA recent cases across the three health facilities, detected at multiple entry points, including OPD (n = 15), maternal and child health (n = 6), adolescent services (n = 4), community outreach (n = 2), and men's clinic (n = 2). Follow-up investigations were conducted at the three facilities that surpassed the PHR threshold: Health Division (14 RITA recent cases), St James Hospital (7 RITA recent cases), and Paray Hospital (8 RITA recent cases). Facility-level assessments included a review of key HIV testing indicators and stakeholder interviews with ART nurses, site directors, and Village Health Workers. This process identified service delivery gaps and informed the development of targeted action plans.

Key Findings

The investigations highlighted several contributing factors to the elevated number of RITA recent infections:

- The catchment areas serve villages with large populations of illegal miners and migrant workers, often located near taxi and bus depots.
- A popular annual football tournament draws large cross-border crowds, potentially increasing HIV transmission risk.
- There is low HIV testing uptake among males, alongside high rates of intergenerational sex and child marriage.
- Among 29 RITA recent cases at these facilities, 9 adolescent girls and young women (AGYW, aged 15-24) and 13 women aged 25 and older tested RITA recent.

Facility staff also noted:

- Limited HIV prevention efforts targeting AGYW and adult women,
- Low uptake of PrEP,
- Gaps in index testing and partner elicitation, and
- Inadequate management of clients with high VL.

In response, the Thaba-Tseka DHMT is implementing targeted health campaigns focused on AGYW and men. Interventions include:

- Health education sessions,

- Condom distribution, and
- Demand generation for PrEP

Efforts are being aligned with local holidays and public events to increase male engagement, with the support of village chiefs to enhance community mobilization. As of the latest review, the identified hotspots remain active and have not yet met the criteria for closure (refer to Box 2 for criteria).

Figure 26 below summarizes findings from baseline to date. HIV testing among men declined initially from 30% at baseline to 25% in April–June 2024 but then steadily increased, reaching 39% by January–March 2025. PrEP coverage rose sharply to 56% in April –June 2025 from a baseline of 29%, before decreasing somewhat yet remaining above baseline at 44% in January–March 2025. ART interruption increased modestly at the start of implementation (11% in April–June 2024 vs. 9% at baseline) but then decreased to just 1% by January–March 2025, reflecting significant gains in treatment continuity. Overall, these trends suggest improvements in HIV testing uptake and treatment continuity, with PrEP coverage stabilizing above baseline levels following data-driven PHR programmatic interventions.

Figure 26. Quarterly Trends in HIV Testing, PrEP Coverage, and ART Interruption at Baseline (October 2023) vs. Post-PHR Intervention (April 2024-March 2025)
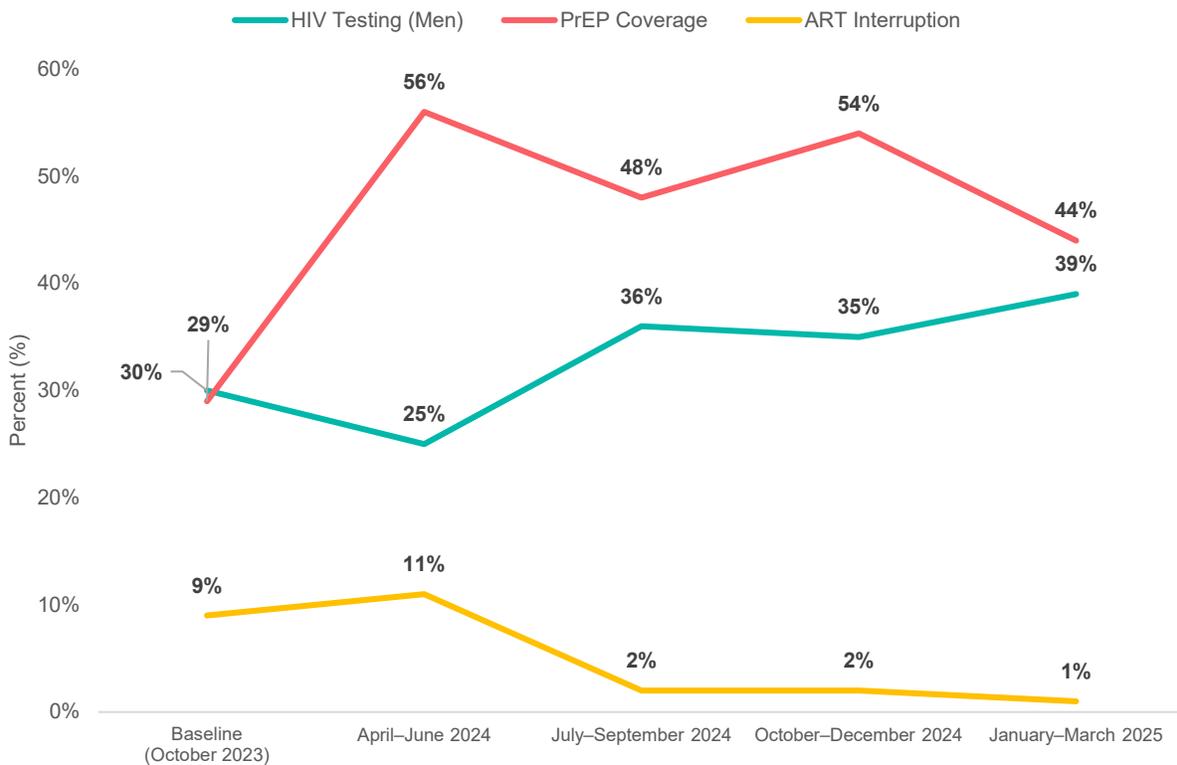
7.0 Discussion

Despite operational challenges, including an 18-month pause in implementation due to the COVID-19 pandemic, Lesotho successfully scaled-up HIV-1 RIS to all 10 districts in its first five years, integrating recency testing into routine HTS (Figure 1). Implementation of RIS required strong collaboration across laboratory, clinical and strategic information sectors, facilitated by effective partnerships between the GoL, MoH, EGPAF, and CDC.

Importantly, recency surveillance contributes to significant capacity building across the healthcare workforce. A total of 201 master trainers and 1,242 testers were trained, and three data use workshops were conducted to enhance analytic capacity at both national and subnational levels, strengthening the ability to use data for programmatic action. Quality assurance efforts led to 3,410 QCs achieving a 100% pass rate and 6 rounds of PT showing a 97% pass rate (100% after repeat testing). Critical components to successful surveillance included the data dashboard, 10 research assistants covering all districts, a viral load coordinator and 3 data use workshops producing public health response strategies to guide action. Integration of recency and CQI data into the DHIS2 dashboard enabled near real-time monitoring of recent infection trends. This system supported the identification and investigation of 30 transmission signals, using standard tools outlined in Lesotho's public health response strategy.

Notably, Lesotho maintained high data quality and reliability throughout the implementation period. Only four invalid RTRI test results were recorded over five years, and recency uptake among newly diagnosed clients remained strong – reaching 85% in recent years. The introduction of viral load testing for RTRI-recent cases in April 2022 further strengthened the classification process with the recent infection testing algorithm. Viral load testing coverage reached 88%, reflecting high service delivery performance. The appointment of a VL coordinator played a key role in tracking specimens and ensuring timely results delivery.

Between September 2019 and December 2024, a total of 28,099 newly diagnosed people living with HIV (PLHIV) were reported from 211 of the 214 sites submitting RIS data across all 10 districts in Lesotho; 22,556 (80%) received a RTRI test. After viral load (VL) testing was incorporated based part of the RITA in April 2022, 25,236 new HIV diagnoses were recorded through December 2024, of whom 20,719 (82%) received an RTRI test. Of those tested with valid RTRI results, 5% (1,007/20,669) were classified as RTRI recent, while 95% (19,662/20,669) were RTRI long-term. Of the RTRI-recent cases, 887 (88%) had a VL sample collected, and 885 (99%) had VL results available for interpretation. Using RITA, 597 individuals were confirmed as RITA-recent infections. Overall, this corresponds to 3% RITA-recent (597/20,548) and 97% RITA long-term (19,951/20,548).

Recency data provided critical insights by distinguishing between recent and long-term infections among newly diagnosed individuals, allowing us to characterize the testing population and identify not only where new diagnoses are occurring, but also where and among whom new infections are emerging, information not available from routine program data alone. Women under 25 years of age, accounted for a disproportionate share of recent infections, with the highest proportions identified through outpatient (OPD) and antenatal care (ANC) entry points. In contrast, young men aged 18-24 years were less likely to receive RTRI testing, suggesting gaps in health-seeking behavior and underscoring the need for targeted outreach to under-resourced populations. While trends in the proportion RITA recent among those testing at HIV clinics showed a decline in recent infections, subnational analysis further revealed important gaps: : while Maseru reported the largest absolute number of recent infections, Thaba-Tseka had the highest proportion of recent cases, highlighting geographic heterogeneity in transmission dynamics. These insights prompted further investigations that helped identify geographic hotspots and inform more targeted, effective interventions.

RIS applies a data-driven approach that enables responsive, evidence-based programming. In Thaba-Tseka, for example, the district health team implemented targeted campaigns for AGYW and men, including health education sessions, condom distribution, and demand generation for PrEP. These activities were aligned with local holidays and supported by village chiefs to boost male engagement and community mobilization. As a result, key outcomes such as HIV testing among men and PrEP coverage improved, while ART interruptions declined—demonstrating how insights from RIS can be translated into timely, measurable impact on the ground.

8.0 Lessons Learned

Insights from Lesotho's phased implementation to national scale-up of offer valuable guidance for both sustaining national efforts and informing implementation in other contexts. Success was underpinned by strong coordination and partnerships – particularly between the MoH, EGPAF, ICAP and CDC – which ensured smooth implementation and laid the foundation for long-term sustainability. This leadership ensured ownership of the program and strict adherence to protocol requirements. Continuous monitoring, training, and retraining of surveillance teams were critical to reinforcing good documentation practices, informed consent procedures, accurate reporting, and secure storage of surveillance documents.

Integrating recency testing into routine HTS proved critical to maximizing uptake and enhancing cost-efficiency. All HTS staff newly recruited or trained to provide HTS were also trained in recency testing; this integration helped reduce missed opportunities for patient enrollment. Harmonizing supervision tools for both HTS and recency strengthened quality assurance mechanisms across programs. Where recency surveillance was viewed as a standalone activity, its programmatic value to the larger HIV program was often underappreciated.

Despite these successes, reliance on a paper-based data system remains a significant limitation. Transitioning to electronic data collection at the POC could substantially improve operational efficiency, timeliness, and the ability to analyze and act on data in real time. Routine targeted mentorship and CQI processes have also been key in maintaining high-quality implementation and data integrity at the site level.

Finally, RIS provided actionable insights for guiding tailored prevention and treatment efforts. Data highlighted AGYW as a priority population due to their high burden of recent infection and underscored the need for improved outreach and awareness for young men, who remain underrepresented in HIV testing and surveillance efforts.

9.0 Recommendations

Looking ahead, guidance for improving and sustaining RIS in Lesotho is grounded in the lessons learned during implementation and scale up, offering actionable insights for stakeholders. Building on these lessons, the following strategies are recommended to strengthen and sustain RIS in Lesotho:

- Incorporate HIV-1 RIS into national HIV guidelines, transitioning from protocol-based to routine HIV/TB surveillance aligned with the One Health framework for long-term sustainability.
- Integrate recency testing into routine program activities by incorporating recency indicators into MOH-approved data collection tools, electronic medical records (EMR), and DHIS2 for seamless reporting and monitoring.
- Transition to electronic data capture at POC to improve reporting efficiency, enable near real-time analysis, and reduce data entry errors.
- Maintain routine CQI processes and mentorship to ensure quality implementation at the site level. Enhance district-level engagement in supervision by involving district teams in central-level supervisory visits and embedding recency within routine supportive supervision activities.
- Invest in regular refresher trainings to mitigate the impact of staff turnover, sustain skill competence, and uphold high standards for implementation and QC/PT.
- Strengthen district-level data use capacity to support subnational decision-making and a timely public health response. Encourage DHMTs to use recency data for geospatial and epidemiological analysis, enabling identification of emerging trends and guiding program design and resource allocation.
- Strengthen collaboration between district laboratories and HTS teams to ensure effective monthly QC and PT for both HTS and recency, alongside timely reporting.

- Integrate RTRI proficiency testing into the national HIV rapid testing QC/PT system to ensure quality and consistency in recency testing across all sites.
- Engage the national supply chain management team to transition RTRI commodities into the Informed Push distribution system for long-term sustainability and reduced stockouts.
- Scale successful targeted interventions in high-risk populations and geographic areas with elevated numbers and proportions of recent infections.
- Formalize and integrate public health response processes requiring multistakeholder engagement including prevention and treatment partners, civil society and community leadership under MOH leadership to ensure sustainability and country ownership.
- Facilitate regular recency data reviews and triangulation with programmatic, VL, and prevention indicators to drive data-informed response strategies

  By leveraging these lessons and recommendations, Lesotho can strengthen the role of RIS as a critical component of its national HIV response, ultimately contributing to epidemic control.

10.0   Conclusion

Lesotho's successful national scale-up of HIV-1 RIS demonstrates that when effectively integrated into routine HIV programming, recency testing serves as a powerful tool for epidemic control. Despite periods of implementation disruption, the program achieved and maintained high quality, strong uptake, and measurable impact. Leveraging recency data for real-time public health action has enabled the identification of service delivery gaps and informed targeted prevention and treatment interventions. As Lesotho advances toward HIV epidemic control, sustaining this surveillance system will be critical. In an increasingly resource-constrained environment, sustaining RIS hinges on leveraging efficiencies, strengthening integration, and maintaining a commitment to data-driven decision-making to safeguard the gains made toward epidemic control.

11.0   Annexes

Annex 1. List of health facilities by districts implementing recent infection surveillance, Lesotho

District	Health Facilities	Community Sites	Total Sites
Berea	Bethany H/C	Baylor (Drop-in center)	25
	Berea Hospital		
	Bophelong private clinic		
	CEHAL Private Clinic		
	Good Shepherd H/C		
	Immaculate Conception H/C		
	Khubetsoana		
	Koali		
	Kolojane H/C		
	Lenkoane H/C		
	Lesotho Correctional Services		
	Mabote		
	Mahlatsa H/C		
	Maqhaka		
	Maluti Hospital		
	Mapheleng H/C		
	Paballong H/C		
	Pilot H/C		
	Sebedia H/C		
	Sion H/C		
	St David H/C		
	St Magdalene H/C		
	Berea private clinic		
Thaba-Tseka	Auray H/C	Care for Basotho (Drop-in center)	20
	Bobete H/C		
	Ha Mokoto H/C		
	Ha Lephoi H/C		
	Katse H/C		
	Khohlo Ntso H/C		
	Linakeng H/C		
	Manamaneng H/C		
	Methalaneng H/C		
	Montmartre H/C		
	Mafa Health Post		
	Mohlanapeng H/C		
	Paray Hospital		

	Popa H/C	
	Sehong-Hong H/C	
	Semenanyana H/C	
	St James Hospital	
	St Theresa (TT) H/C	
	Thaba-Tseka Health Division	
Mafeteng	Emmaus H/C	19
	Kolo H/C	
	Lecoop H/C	
	Ribaneng H/C	
	St Andrew H/C	
	Litsoeneng H/C	
	Malea-Lea H/C	
	Masemouse H/C	
	Mount Tabor H/C	
	Sekameng H/C	
	Thaba-Ts'oeu H/C	
	LPPA	
	Mafeteng Hospital	
	Matelile H/C	
	Motsekuoa H/C	
	Mount Olivet H/C	
	Samaria H/C	
	Thabana - Morena H/C	
	Ts'akholo H/C	
Quthing	Dilli Dilli H/C	11
	Ha Makoae H/C	
	Hanson Private clinic	
	Maqokho H/C	
	Mphaki H/C	
	Quthing Correctional Services	
	Quthing Hospital	
	St Gabriel H/C	
	St Matthews H/C	
	Tsatsane H/C	
	Villa Maria H/C	
Qacha's Nek	Sehlaba-Thebe HC	13
	Matebeng H/C	
	Melikane H/C	
	Mohlapiso H/C	
	Rankakala H/C	
	Hermitage H/C	
	Tebellong Hosp	

	Sacred Heart H/C		
	St Francis H/C		
	Sekake H/C		
	Machabeng Hosp		
	Lebakeng H/C		
	LCS		
Butha-Buthe	Boiketsiso H/C		16
	Ngoajane H/C		
	Tsime H/C		
	Motete H/C		
	Muela Site H/C		
	Rampai H/C		
	LPPA		
	Lesotho Correctional Services		
	Butha-buthe Hospital		
	St. Paul		
	Seboche Hospital		
	Qholaqhoe		
	St Peters		
	Linakeng		
	Sebusiso		
	Boiketlong		
Mohale's Hoek	Bethel H/C		18
	Lithipeng H/C		
	Mootsinyane H/C		
	Mpharane H/C		
	Nohana H/C		
	Mofumaha-oa-Rosari H/C		
	Liphiring H/C		
	Mohale's Hoek Correctional Services		
	Mohalinyane H/C		
	Morifi H/C		
	Phamong H/C		
	Tsepo H/C		
	LPPA		
	Nkau H/C		
	St Claire H/C		
	Holy Cross h/C		
	Ntsekhe Hospital		
	Tlaling H/C		
Mokhotlong	Libibing H/C	Care for Basotho (Drop-in center) *[16 sites]*	16
	St James H/C		
	Malefiloane H/C		

	Moeketsane H/C		
	Molika-Liko H/C		
	Tlhanyaku H/C		
	Naleli H/C		
	Malubeluba H/C		
	Mokhotlong Hospital		
	Linakeng H/C		
	St Martins H/C		
	Mapholaneng H/C		
	Mothae H/C		
	Lesotho Correctional Services		
	Mokhotlong Private		
Maseru	Carewell Clinic	DHAOL (Drop-in Center)	60
	Maseru Correctional Services HC	Workplace – Masowe (Drop-in center)	
	Matsieng H/C	Workplace – Thetsane (Drop-in center)	
	Matukeng H/C	Workplace – Station (Drop-in center)	
	Peter Clever H/C	MATRX (Drop-in center)	
	Semonkong H/C	Care for Basotho (Drop-in center)	
	St Barnabas H/C		
	St Leornard H/C		
	Baylor Clinic		
	Dr Hansen		
	Ha Tlali H/C		
	Karabo Family Clinic		
	Kena H/C		
	Koro-Koro H/C		
	Likalaneng H/C		
	LNA Wellness Center		
	Marakabei H/C		
	Mofoka H/C		
	NUL H/C		
	PM Medic Private Facility		
	Pshatlella H/C		
	Ramabanta H/C		
	St Barnard H/C		
	St Benedict H/C		
	St Rodrique H/C		
	Queen Mamohato Memorial Hospital		
	Queen Mamohato Memorial Gateway Clinic		
	Domicilliary HC		
	Ha Pita		
	Likotsi Filter Clinic		
	Loretto H/C		

Maseru LPPA Clinic
Maseru SDA H/C
Nazareth H/C
Paki H/C
Qoaling Filter Clinic
Queen Elizabeth II Hospital
RLDF H/C
Scott Hospital
Senkatana Clinic
St Joseph Hospital
St Leo H/C
Thaba Bosiu H/C
Thamae H/C
Makoanyane Hospital
AHF H/C
Ha Seng H/C
Mohale H/C
Lesotho College of Education (LEC)
Lerotho Polytechnic
Limkokwing University of Creative Technology
Centre for Accounting Studies
Vitality H/C

Leribe   Jesse Polyclinic
Khabo H/C
Lejone H/C
Leribe Correctional Services
Linotsing H/C
Little Flower H/C
Louis Gerard H/C
Mahobong H/C
Mamohau Hospital
Maputsoe Filter Clinic
Maputsoe SDA H/C
Maryland H/C
Matlameng H/C
Medical Arts Clinic (Dr Molapo)
Motebang Hospital
Our Lady of Lourdes H/C
Palama H/C
Peka H/C
Pontmain H/C
Seetsa H/C
Sepinare H/C

Seshote H/C
St Ann H/C
St Dennis H/C
St Margaret H/C
St Monica H/C
St Rose H/C
Thaba Phatsoa H/C
Care for Basotho (Drop-in center)