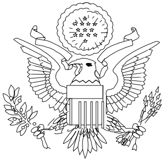

United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 14, 2020

INFORMATION MEMO FOR AMBASSADOR GONZALES, Lesotho

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2020 PEPFAR Planned Country Allocation and Strategic Direction

Dear Ambassador Gonzales:

First, I wanted to personally thank you and Deputy Chief of Mission for your dedication to PEPFAR and working every day to achieve the most possible with the United States taxpayers' dollars. The ability to translate these resources into effective and impactful programming has and continues to be core to our collective progress. Your PEPFAR team in country is extraordinary and we are fortunate to witness their passion and compassion.
We are very excited about your progress, particularly with:

- Excellent rates of viral load suppression among people who are living with HIV (PLHIV) and receiving antiretroviral therapy (ART), now at 95% nationally among those aged 15 and older.
- The dramatic expansion of viral load coverage (i.e., the percentage of PLHIV eligible for an annual viral load laboratory test who were provided a test and their results in a timely manner), from 50% at the end of FY 18 to 81% by the end of FY 19.
- High rates of PLHIV who learn of their HIV-positive status and are quickly linked to treatment, also estimated to be 95% for COP 2018.

Together with the Government of Lesotho and civil society leadership we have made tremendous progress. Lesotho should be proud of the progress made over the past 16 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

We did want to highlight both overarching issues we see across PEPFAR and a few specific to Lesotho. Full details will follow in a more comprehensive letter from your S/GAC Chair and PPM.

Throughout the PEPFAR family of supported countries and communities, five gaps are shared across the globe, which are collectively holding us back from achieving Sustainable Development Goal 3 related to controlling the HIV/AIDS epidemic:

1. Continued new HIV infections in adolescents and young women
2. Supporting key populations with prevention and treatment services

3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate))
4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed (net new on treatment and treatment current growth, (retention surrogate))
5. Ensuring all children are diagnosed and are on the best treatment regimens and virally suppressed

For the PEPFAR Lesotho program, there are also country-specific challenges that have hindered progress towards our goals. These include:

- Difficulty implementing case-finding strategies with fidelity and at the necessary scale, particularly with the index testing modality. During FY 19, just 29,635 out of an expected 50,025 were identified.
- Small net gains of PLHIV receiving ART through PEPFAR-supported programs, possibly due to the type of emerging challenges with retaining patients already enrolled in care and treatment described above.
- Stagnant performance at best in some of the programs whose primary function is to prevent the spread of disease, such as DREAMS and those serving key populations.

In a recent Office of Inspector General audit around PEPFAR coordination there were four draft preliminary recommendations based on their discussions with PEPFAR staff in the field from four countries, three of which are relevant to this Country Operational Plan planning cycle related to target-setting, tool development, and timelines. Although we just received the draft report a few days ago we did not want to wait another COP cycle to make substantive changes related to the recommendations. The first was around targets and target-setting and the need for a clear and transparent understanding and dialogue in establishing targets. To be clear, PEPFAR targets flow directly from the UNAIDS Fast Track Strategy of 2016. Since 2016, both the PEPFAR strategy and targets were directly derived from the global communities of UNAIDS, WHO, and specifically Heads of State in their commitment to SDG 3 and are aligned to support the country's specific ambition towards those goals.

The global community in 2015 through their Heads of State committed to achieving SDG 3.3 by 2030 which for HIV is ending the HIV/AIDS epidemic as a public health threat. This was followed by a United Nations High Level Meeting on HIV/AIDS in June 2016, whereby these Heads of State committed to the 90/90/90 Fast Track Strategy. Essential to the strategy was 73% community viral load suppression (VLS) by 2020 and 86% community VLS by 2030, combined with increased prevention interventions and zero stigma and discrimination to ensure all ages, genders, and risk groups have access to life saving prevention and treatment services. Also, in 2016, 22 PEPFAR-supported high HIV burden countries committed to the "Three Frees": Start Free, Stay Free, AIDS Free—with 2020 targets of reducing new infections among children to less than 20,000, reducing new infections among adolescent girls and young women to less than 100,000, putting at least 85% of pregnant women and 90% of children on ART, and providing at least 25 VMMCs. Since 2016, PEPFAR and the GF resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries in

Subject to COP Development and Approval

2016, 2017, and 2018 to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Lesotho is on track to achieve the 2020 and 2030 goals.

Over the past 4 years, PEPFAR resources were allocated based on need, performance, and specifically on the countries' and communities' desire to achieve the SDG, Fast Track Strategy, and Three Free goals and country-specific targets. Based on the OIG's recommendation, S/GAC will take a different approach this year to target-setting. Our collective hope is that together we use this moment of reflection on progress and challenges along with the realization that the end of 2020 is only 11 months away to address these overarching challenges this year through COP 2019 implementation and use COP 2020 to maintain our progress, address any ongoing challenges and finally fund ambition for greater impact. Thus, S/GAC will not assign targets to countries and will only provide notional budget levels. After the PEPFAR country team submits their targets the notional budget will then be adjusted to the presented level of ambition. Additional funding is available as ambition funding for treatment and VMMC.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2020) notional budget is $86,300,000 inclusive of all new funding accounts and applied pipeline and reflects the following:

1. Sustaining the gains in treatment services based on your projected COP 2019 treatment result (FY2020 treatment current funded in COP19) $54,700,000
    a. The care and treatment budget is determined by all of your FY18 C/T expenditure services and commodities (no RTK commodities), including all aspects of the health system inclusive of human resources, laboratory and systems, commodities (exclusive of RTKs), an upward adjustment from FY19 treatment current to the FY2020 treatment current fully burdened cost of treatment services and commodities, and 100% of program management costs and data needs
    b. This Budget is broken down by
        i. Care and Treatment services including partner program management costs, FY2020 upward adjustment, EMR and data with surveillance, recency $39,400,000
        ii. ARV drugs and treatment commodities (everything except RTKs) $4,000,000
        iii. TB preventive treatment $5,800,000
        iv. Cervical cancer $1,000,000
        v. For earmark purposes 50% of M/O costs $4,500,000
        vi. Care and Treatment qualifies for ambition funds if addresses gap #3-5
2. Continued orphans and vulnerable children funding to include DREAMS vulnerable girls less than 20-year-old. $21,300,000
    a. HKID or $8,500,000 dollars for continued historical OVC services
    b. DREAMS funding of $14,000,000 of which 85% is for vulnerable girls under 20 $11,900,000

Subject to Approval

        c. 10% of M/O or $900,000
3. Continued VMMC funding based on your percent of VMMC in the appropriate age band of >15 years old
    a. Total VMMC $1,100,000
    b. VMMC qualifies for ambition requests
4. Dramatic expansion of DREAMS programming $14,000,00 as noted above, of which $11,900,000 is for vulnerable girls under 20 and the remaining $2,100,000 is for other DREAMS programming.
5. Continued expansion of Key Populations prevention and expansion of PrEP depending on country submitted targets
    a. Key Population (non-treatment) $1,000,000
    b. PrEP total: $2,400,000 dollars
6. RTK and service support to ANC HIV testing $100,000
7. Remaining 40% M/O based on COP19 $3,600,000

Total COP2020 notional budget of **$86,300,000** (comprised of **$83,259,688** new and **$3,040,312** pipeline).

Overall, across the PEPFAR portfolio, we have dramatically increased DREAMS funding to address and prevent new infections in adolescent girls and young women, because for the first time we have seen declines in new diagnoses of HIV in young women across all districts currently implementing DREAMS. These funds should be used to expand to the highest burden districts not currently covered and saturate in urban areas.
Teams will develop their own targets across PEPFAR program areas described above, with the treatment current target no less than the result that was to be achieved in COP 2019. Testing support outside of ANC should be consistent with any targets above FY 2020 treatment current levels and be submitted with any ambition funding proposals. Targets reflect expectations of continued and sustained OVC programming and KP programming. For DREAMS, PrEP, cervical cancer, and Preventive TB, increased targets should be consistent with the level of increased budgets.

Again, the team has received a notional budget as noted above and a final budget approval will be contingent on the team's desired targets. As always funding is associated with performance targets that will be achieved with those resources. Targets and the subsequent approved budget should reflect the level of ambition of the PEPFAR team in concert with the levels of progress the Government of Lesotho and civil society of Lesotho believe are necessary to reach sustainable epidemic control.

Additionally, country teams, including specific agencies within those teams, can submit requests for additive funds in their OU FAST files, based on their stated increased ambition in the areas of Treatment and OVC, with commensurate increased partner level targets. This funding is available to agency partners who have historically performed at the highest levels and evidence that they are addressing one of the critical gaps outlined above. Budget requests must be consistent with the cost of expanded targets and address one of the gaps in programming #3-5 above. These requests should be discussed with the S/GAC chair and PPM during the January strategic retreat and tentatively approved and be included with the team's DataPack and FAST

Subject to COP Development

tool submissions. The final budget and associated country level targets will be discussed and approved during the Johannesburg meeting.
We are hoping this new approach to target-setting and budgeting will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partners accountable to that achievement. In addition, this new approach to target-setting gives high performing partners and agencies with additional aspirations the opportunity to do more to achieve even greater impact with additional ambition resources.

In the next 48 hours, more detailed descriptions of Lesotho's programmatic successes and challenges will be conveyed to your wider PEPFAR team by the S/GAC Chair and PPM in a phone call, after which the detailed planning level letter will be immediately released.

Again, thank you for your work, and we are looking forward to working with you to achieve your Fast Track Strategy and ultimately the SDG 3.3 goal.

Together we can.

Deborah Birx

Subject to COP Development and Approval

United States Department of State

Washington, D.C. 20520

Subject to COP Development and Approval

UNCLASSIFIED January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR REBECCA GONZALES, LESOTHO

SUBJECT: Fiscal Year 2020 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Gonzales,

We are grateful as always to you and Deputy Chief of Mission Katz for continuing your incredible support and engagement with the PEPFAR-Lesotho team, the Government of Lesotho, and many key stakeholders to maximize the impact of PEPFAR's programs during this past year. We thank you for your continued leadership and vigilance in working with our governmental and implementing partners to make sure that they follow through on their vital commitments, such as ensuring that all Basotho living with HIV have timely access to lifesaving treatment services. Finally, we appreciate your excellent PEPFAR team in country and the exceptional level of interagency cooperation that they continue to exhibit, which is a model for other PEPFAR countries.

We have just completed a thorough review of indicators that measure the progress of PEPFAR-Lesotho's programs over time and are pleased to share our findings with you in this letter. In conducting our review, we relied in large part on the assessments provided by the PEPFAR-Lesotho field team during their quarterly POART reviews and the agency self-assessments provided by Lesotho's interagency Country Accountability and Support Team (CAST) in December. As we begin to plan for the Country Operational Plan (COP) 2020, which will get underway at the start of FY 2021, our focus was on evaluating the end of year results from COP 2018 and the implementation so far of COP 2019.

During the past year, the PEPFAR-led efforts to control the HIV/AIDS epidemic in Lesotho have seen numerous successes. Perhaps the most impressive is Lesotho's excellent viral load suppression levels among people who are living with HIV (PLHIV) and receiving antiretroviral therapy (ART). Among those aged 15 and older, Lesotho's overall viral load suppression rate (i.e., the rate at which those on treatment have an undetectable viral load and are therefore healthier and will not transmit their disease) is 95%. Remarkably, these rates stay exceptionally high across Lesotho's 10 districts and among various age and sex disaggregates.

During FY 2019/COP 2018, viral load coverage (i.e., the percentage of patients eligible for an annual viral load test who were provided a test and their results in a timely manner) expanded dramatically, from 59% at the end of FY 2018 to 83% by the end of FY 2019. Linkage rates, the

percentage of PLHIV who learn of their HIV-positive status and are quickly linked to treatment, also remain commendably high, with an estimated overall rate of 95% for COP 2018. It is these strengths that have pushed Lesotho towards the cusp of epidemic control.

Despite these successes, overall results from the past year were decidedly mixed, due in large part to a handful of mostly familiar challenges that have hindered progress towards PEPFAR's goals. Although PEPFAR's implementing partners continue to identify PLHIV who were previously unaware of their HIV-positive status at a steady pace, they have been unable to implement case-finding strategies with fidelity and at the scale needed to accelerate that pace. This is particularly true for the index testing modality, which at this stage of the effort to control the epidemic should be the means by which most HIV-positive Basotho who are currently unaware of their status are found. Without improvement, it will be nearly impossible to get enough new PLHIV on treatment and reduce transmissions in a way that would certainly and sustainably control the epidemic by the end of FY 20 as planned.

In the past year, Lesotho was also not immune from PEPFAR's program-wide challenges with losing patients under our collective care. In combination with case-finding challenges, these patient losses meant that a far lower caseload was supported by PEPFAR than anticipated at the beginning of the year: At the outset of FY 2019, approximately 218,000 Basotho were actively receiving treatment supported by PEPFAR programs, but there was only a net gain of about 8,000 by the end of the year—well short of the target of 83,000. This is attributable in part to explainable factors, such as the adoption of a stricter definition of who is actively receiving treatment and the government of Lesotho's inability to meet some of its commitments, namely maintaining sufficient stocks of antiretroviral drugs and ensuring patients had access to large facilities administered through public-private partnerships (PPPs). However, such a very small net patient gain for the year may signal an emerging issue with retaining PLHIV on treatment that must be monitored closely.

While we recognize the difficult economic environment that the Government of Lesotho has faced, the delays in fully implementing policies and meeting commitments (e.g., to procure HIV and TB commodities at sufficient levels, ensure that multi-month drug supplies are reliably dispensed to PLHIV, and guarantee patients' access to all treatment facilities under MOH and PEPFAR auspices, including those administered through PPPs) have also been an obvious challenge. Fortunately, we can now also characterize part of this story as a success, since determined efforts by your Embassy Maseru front office and field team have led to recent progress on several pressing issues. On that note, we are hopeful that we can leverage the Global Fund's recent agreement to purchase ARVs to make universal multi-month drug dispensing a reality.

Finally, performance along some of the programs whose primary function is to prevent the spread of disease, such as Tuberculosis Preventive Therapy (TPT), DREAMS, and voluntary medical male circumcision, have not expanded at the rates needed to hit established targets or expectations. We hope that those programs' progress will accelerate during the current COP cycle.

Subject to COP Development and Approval

In the sections below, we have provided detailed information about proposed budget levels for Lesotho's COP 2020, performance during the past year, the latest status on progress towards meeting PEPFAR's minimum program requirements, and technical directives and priorities for COP 2020. Should you or anyone on the team have any questions, we would be very happy to answer them.

Subject to COP Development and Approval

SECTION 1: COP 2020 PLANNING LEVEL

Based upon our current analysis of spending levels, information submitted for PEPFAR's End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP 2020 planning level is the sum of the various figures listed in Table 1 (please note that all pipeline numbers were provided and confirmed by each agency).

Table 1. COP 2020 Budget Including Applied Pipeline

	Bilateral		Central	TOTAL
Lesotho	FY 20	Unspecified	Unspecified	TOTAL
Total New Funding	**$ 83,259,688**			**$ 83,259,688**
GHP-State	$ 82,747,188			$ 82,747,188
GHP-USAID				
GAP	$ 512,500			$ 512,500
Total Applied Pipeline		**$ 2,292,547**	**$ 747,765**	**$ 3,040,312**
DOD		$ -	$ -	
HHS/CDC		$ 1,698,960	$ -	$ 1,698,960
HHS/HRSA		$ -	$ -	
PC		$ 35,314	$ -	$ 35,314
State		$ -	$ -	
USAID		$ 558,273	$ 747,765	$ 1,306,038
TOTAL FUNDING	**$ 83,259,688**	**$ 2,292,547**	**$ 747,765**	**$ 86,300,000**

Subject to COP Development and Approval

SECTION 2: COP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

The expectation based on the notional budget provided in Part 1 of the PLL is that Lesotho should plan to program for the full Care and Treatment (C&T) level of $54,700,000 and the full Orphans and Vulnerable Children (OVC) level of $21,300,000 that are listed. The levels listed in Table 2 below are subsets of these total amounts, which must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

Table 2. COP 2020 Earmarks

TABLE 2: COP 2020 Earmarks by Fiscal Year *

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$ 44,000,000	$ -	$ -	**$ 44,000,000**
OVC	$ 18,500,000	$ -	$ -	**$ 18,500,000**
GBV	$ 230,250	$ -	$ -	**$ 230,250**
Water	$ 550,000	$ -	$ -	**$ 550,000**

*Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. The earmark controls listed above represent the ***minimum*** amounts that must be programmed in the given appropriation year.

Table 3. Total COP 2020 Initiative Funding

Lesotho	
COP 2020 Initiatives	
VMMC	$ 1,100,000
Cervical Cancer	$ 1,000,000
DREAMS	$ 14,000,000
HKID Requirement	$ 8,500,000
Total Initiative Funding	**$ 24,600,000**

***See Appendix 1 for detailed budgetary requirements and other budgetary considerations.*

Subject to COP Development Approval

SECTION 3: PAST PERFORMANCE – COP 2018 Review

Table 4. OU-Level FY 2019 Program Results (COP 2018) and FY 2020 Targets (COP 2019)

Indicator	FY 19 result (COP 18)	FY 20 target (COP 19)
TX Current Adults	218,536	293,238
TX Current Children	8,054	19,761
VMMC among males 15 years or older	12,071	14,827
DREAMS	29,275	n/a
Cervical Cancer	26,100	46,048
TB Preventive Therapy	7,782	132,461
TB Treatment of HIV Positive (TX TB)	192,076	159,829
PrEP_New	12,143	18,460

Table 5. COP 2018/FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
Lesotho			
DOD	$ 548,357	$ 636,803	$ (88,446)
HHS/CDC	$ 35,299,354	$ 31,018,208	$ 4,281,146
PC	$ 808,792	$ 756,178	$ 52,614
State	$ 339,451	$ 199,845	$ 139,606
State/AF	$ 150,000	$ 144,871	$ 5,129
USAID	$ 45,363,901	$ 44,715,573	$ 648,328
HHS/CDC (Central)	$ 1,276,389	$ 0	$ 1,276,389
USAID (Central)	$ 1,914,331	$ 1,915,317	$ (986)
Grand Total	**$ 85,700,575**	**$ 79,386,795**	**$ 6,313,780**

**Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

Subject to COP Development and Approval

Table 6. COP 2018/FY 2019 Implementing Partners with Over-Outlays Versus Approved Budgets

Mech ID	Prime Partner	Funding Agency	COP 18/FY 19 Budget (New funding + Pipeline + Central)	Actual FY 19 Outlays ($)	Over/Under FY 19 Outlays (Actual $ - Total COP 18 Budget $)
17431	University Research Co., LLC	HHS/CDC	$ 1,334,432	$ 1,450,698	($116,266)
17429	Population Services International	DOD	$ 0	$ 559,107	($559,107)

**Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

Table 7. COP 2018/FY 2019 Results & Expenditures

Agency	Indicator	FY 19 Target	FY 19 Result	% Achievement	Program Classification	FY 19 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	348,547	404,790	116%	HTS Program Area	$7,680,850	72%
	HTS_TST_POS	22,375	14,161	63%			
	TX_NEW	15,555	9,967	64%	C&T Program Area	$11,664,987	77%
	TX_CURR	112,642	82,536	73%			
	VMMC_CIRC	n/a	n/a	n/a	VMMC Subprogram of PREV	n/a	n/a
	OVC_SERV	n/a	n/a	n/a	OVC Major Beneficiary	n/a	n/a
DOD	HTS_TST	2,582	3,910	151%	HTS Program Area	$7,559	78%
	HTS_TST_POS	219	133	61%			
	TX_NEW	169	93	55%	C&T Program Area	$118,325	40%
	TX_CURR	1,785	1,359	76%			
	VMMC_CIRC	500	532	106%	VMMC Subprogram of PREV	$70,663	40%
	OVC_SERV	n/a	**n/a**	n/a	OVC Major Beneficiary	n/a	n/a
USAID	HTS_TST	462,019	512,571	111%	HTS Program Area	$3,841,939	56%
	HTS_TST_POS	27,431	16,282	59%			
	TX_NEW	29,536	18,086	61%	Area	$12,742,757	55%
	TX_CURR	187,679	142,695	76%			
	VMMC_CIRC	36,219	28,618	79%	VMMC Subprogram of PREV	$2,683,531	97%
	OVC_SERV	84,577	97,385	115%	OVC Major Beneficiary	$1,726,041	76%
					Above Site Programs	$4,017,400	
					Program Management	$15,120,031	

Programmatic Performance

Overall:

• PEPFAR-Lesotho continues to make slow but steady progress towards the 95-95-95 targets, but underachieved against several key annual targets, even with additional funding and expenditures. Some challenges in particular stood out:

  • Partners are still testing too many people through low-yield modalities (e.g., PITC) and testing too few people through high-yield modalities (e.g., index testing)
  • Despite recent improvements, there is reportedly still a lingering lack of cooperation between the facility and community testing partners, for fear of losing credit for newly-identified cases
  • As a consequence of the low level of achievement on the first part of the clinical cascade, achievement on the rest of the subsequent cascade indicators, such as new and current on treatment, similarly lagged
  • A problem with retaining patients on treatment may be emerging, since there was a surprisingly low number of net new cases added to the TX_CURR total, even after accounting for some expected losses, e.g., as a result of patient quotas imposed at facilities administered by PPPs and the definition revision to TX_CURR

• Expenditures were at or under total outlay levels across agencies and implementing partners, and type of service
• Across program areas, a relatively high portion of PEPFAR's expenditures (about 70%) are on service delivery
• Personnel costs still comprise a high percentage of PEPFAR's total expenditures in Lesotho, which suggests the team should be actively working to identify prospective local partners who can help to reduce costs without comprising the quality of programs

Testing:

• All agencies came up far short of HTS_TST_POS targets
• Only 29,635 PLHIV were discovered during COP 2018, compared to an annual target of 50,025 (just 59% achievement of target)
• Index testing is the most important means by which to improve overall yield and case-finding, but programmatic data make it clear that index testing is still not close to being fully implemented at scale and with fidelity

Treatment and Viral Suppression:

• Linkage remains strong overall, but implementers should be especially vigilant about maintaining high levels of retention given evident losses during COP 2018 across PEPFAR programs and within Lesotho
  • The most recent national linkage estimate is 95%
  • The current retention proxy estimate is 92%
• Challenges with linking and retaining adolescents and young adults, however, still remain (i.e., the retention proxy estimate is just 81% for those 15-19 years old, 77% for 20-24 yos, and 81% for 25-29 yos)
• Viral load suppression measures have been exceptionally strong across all districts and across virtually all age and sex disaggregates

Subject to COP Development and Approval

• There was a significant expansion of viral load coverage during COP 2018, rising from 59% to 83% for PLHIV 15 and older, and it is expected to continue to rise to 100% during COP 2019
• Efforts to prevent PLHIV from becoming infected with tuberculosis are far off track, with only 7,782 PLHIV being provided TB preventive therapy (TPT) during COP 2018 despite a target of 39,671, just a 20% rate of achievement

Prevention:

• Performance across primary prevention programs was mixed. In most program areas, progress has stagnated, or at a minimum, there is still significant room for expansion. The following data in key areas typifies these findings:

- • VMMC: 29,151 voluntary medical male circumcisions were performed during COP 2018, roughly 79% of the target for the year, but far too high a percentage of those performed were in the 10-14 year old age band when guidance states that the primary focus should be on those between 15 and 30 years of age
- • KP programs: There were two promising KP programming developments during COP 2018—significantly more new diagnoses among KPs (rising from 221 in COP 17 to 779 in COP 2018) and over 1,000 KPs who were initiated on PrEP; however, there is still significant room for expansion
- • DREAMS: Again, while some incremental progress was made, higher percentages of DREAMS beneficiaries should be completing the full primary package of services

Partner Performance:

• Virtually across the board, partners spent at or below their allocated amounts during COP 2018—however, this does not excuse performance falling short since expenditures were still up since COP 17

• Partners that have consistently fallen significantly short of targets require additional scrutiny, and their performance may warrant the issuance of performance improvement plans (PIPs) and/or a reduction in funding. Some specific partner issues that merit close observation and potential intervention during COP 2019:

- • EGPAF (via both CDC and USAID) handles a significant amount of testing and treatment activities in Lesotho. Testing yield remains too low across testing modalities, gender, and age groups. Testing practices across multiple modalities continue to be problematic. Fewer than expected new cases have contributed to a TX_CURR figure that is far off track through the end of COP 2018 (reaching just 226,590 compared to expected total of 302,106, just 75%)
- • PSI is the other major testing partner and also came up far short of targets, and appears not to be practicing index testing as prescribed. The reported lack of cooperation between EGPAF and PSI in carrying out index testing with fidelity at the facility and community levels has also been troubling
- • JHPIEGO continued to fall short of circumcision targets and has focused too much on non-priority age bands

Subject to COP Development and Approval

SECTION 4: COP 2020 DIRECTIVES

This section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully, including the minimum program requirements and specific country directives. The COP 2020 directives include targets for Treatment Current and TB Preventive Therapy. Targets for VMMC, DREAMS, cervical cancer and PrEP should be set based on FY 2019 performance. Funds for these programs have been allocated based on FY 2019 performance (see Table 4).

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP 2019 implementation. Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

For COP 2020, the failure to meet any of these requirements will result in reductions to Lesotho's budget. (See Section 2.2. of COP Guidance)

Table 8. COP 2020 (FY 2021) Minimum Program Requirements

Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment		
1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Test and Start has been adopted and fully implemented across all age, sex, and risk groups.	

Subject to COP Development and Approval

2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all Nevirapine-based regimens.[2]	Transition to TLD has started, but it has been very slow, with fewer than 5% of the TX_CURR caseload transitioned to TLD. Nevertheless, the government and PEPFAR-Lesotho team report that full transition is anticipated by August 2020. NVP-based stocks are being reduced to zero, but 20% of CLHIV are still currently on NVP-based regimens.	MOH has not yet completed revision of the June 2019 national HIV treatment guidelines to include the WHO July 2019 updated guidance. It plans to shortly and will disseminate to health providers thereafter.
3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	The 3 to 6-month MMD policy has been adopted for Lesotho, but it is not yet close to full implementation. 6-month MMD is reportedly prioritized for Basotho who go to South Africa for extended periods of work.	Implementation at the site and facility level has been challenging due to lack of adequate stock and general fear of stock-out. As a policy, MOH needs to endorse MMD for all clients, with a goal of 6 month dispensing for stable patients. The Global Fund has agreed to

[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

Subject to COP Development and Approval

		front-load funds for ARVs for FY 2020. Annual disbursement of funding to ensure adequate stock of ARVs will encourage implementation of this policy at the facility level.
4. All eligible PLHIV, including children, should have been offered TB preventive therapy (TPT) by the end of COP 2020; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	With adequate stock of TPT, the team anticipates that all eligible PLHIV including children should complete TB preventive treatment by the end of COP 2020. Lesotho committed to providing the new WHO-recommended TPT regimen (Rifampetine/Isoniazid (3HP) weekly for 3months), formally updating their national TB guidelines in July 2019. Cotrimoxazole, where indicated, is fully integrated into the HIV clinical care package at no cost to the patient.	The government of Lesotho has had difficulty accessing 3 HP regimens at competitive prices, and has not procured them at sufficient levels.
5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual	Laboratory instrument mapping, network optimization, and integrated sample transport exercises for VL, EID and TB diagnosis are completed. Roll out plan for integrated TB/HIV services and POC VL	As a policy, MOH needs to endorse the implementation of integrated TB and HIV testing services across the laboratory network. In order to optimize diagnostic services, the team reports that funding gaps for laboratory personnel and LIS

Subject to COP Development and Approval

4 Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

viral load testing and results delivered to caregivers within 4 weeks.	testing for PBFW are also completed.	connectivity must be addressed.
Case-Finding		
6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Index testing is being gradually scaled up across all IPs, in community and facility settings, and for children of HIV-positive biological parents. Lesotho only received adequate national stocks of self-testing kits in October 2019. HIV self-testing began in facilities in January 2020.	
Prevention and OVC		
7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations, and adult men engaged in high-risk sex practices).[6]	PrEP is currently being offered to all HIV-negative clients at elevated risk of HIV acquisition.	

Subject to COP Development and Approval

[5] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing- guidelines/en/

[6] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) Actively facilitating testing for all children at risk of HIV infection, 2) Providing support and case management for vulnerable children and adolescents living with HIV, and 3) Reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	All three services are currently included in the OVC package. Case management will be strengthened in COP 19. The OVC partner is now present in all 10 districts, and is in the process of reducing risks for adolescent girls by expanding services that emphasize primary prevention of sexual violence and HIV into the 5 highlands districts.	
Policy and Public Health Systems Support		
9. Elimination of all formal and informal user fees in the public sector for access to direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services.[7]	There are no formal or informal user fees in the public sector for direct HIV services and medications, or related services.	
10. Assurance that program and site standards are met by integrating Continuous Quality Improvement	PEPFAR partners have institutionalized CQI in HIV programming, particularly for HTS, care and treatment, and	

Subject to COP Development and Approval

[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

(CQI) practices into site and program management. CQI is supported by IP work plans, agency agreements, and national policy.[8]	VMMC. Partners ensure CQI through data reviews, use of the SIMS tool to monitor program performance, conducting root cause analyses and developing remedial action plans for sites, establishing QI projects, and providing continuous supervision and/or mentorship to staff at sites.	
11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	PEPFAR's treatment partner, EGPAF, has been disseminating U=U messaging at the health facility level.	The MOH still has not yet put forward or endorsed an integrated, national strategy for U=U and related messaging to reduce stigma and encourage HIV treatment and prevention.
12. Clear evidence of agency progress toward local, indigenous funding of prime partners.	PEPFAR-Lesotho reports that it is transitioning to local partners with caution in order to minimize risk. USAID did recently select a local partner for an OVC/DREAMS award, and transmitted portions of its care and treatment portfolio to local partners, such as Baylor (in two districts) and m2m (which is	The team reports that there is a limited number of local partners in Lesotho that possess the technical and organizational capacity to implement PEPFAR programs and manage USG funds.

Subject to COP Development and Approval

8 Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

	providing PMTCT services). CDC moved its treatment and laboratory cooperative agreements into recompete status, with a new award date of October 1, 2020 for both. In both instances, local applicants are being given preference points. The Notice of Funding Opportunity announcements were published on January 9, 2020.	
13. Evidence of the host government assuming greater responsibility of the HIV response including demonstrable evidence of year-over-year increases in resources expended.	In recent years, as PEPFAR's budget for Lesotho has increased, the estimated percentage and total funding towards the HIV response by the GOL has gone down (e.g., approximate funding from the host government decreased from 30% of the overall HIV budget in 2015 to 20% in 2019). In the future, the share of the government's functional and financial responsibilities will be monitored through the biennial completion of the responsibility matrix.	Years of political turmoil, financial woes, and poor fiscal decision-making have contributed to the government's level of functional and financial support.
14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR-Lesotho has been reporting on the following MER indicators since their introduction: TX_ML for HIV treatment outcomes; CXCA_SCRN and CXCA_TX for the secondary prevention of	Procurement of thermal coagulators and LEEP equipment delayed the expansion of the screen-and-treat services, which is now underway.

Subject to COP Development and Approval

	cervical cancer; and TB_PREV for the treatment of latent TB infections among people living with HIV/AIDS. The cervical cancer program has been scaled up to all high-volume sites at the outset of COP 19, including 4 regional LEEP treatment centers.	
15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Phased roll-out of recency testing to all 10 districts over the course of COP 19 is planned. Lesotho currently has eRegisters in 114 sites (the goal is 172 by the end of COP 19). In order to reach full functionality, IPs are currently working on feeding data from eRegisters at individual sites into a national, shared registry of unique identifiers and health records.	

Subject to COP Development and Approval

Summary of Lesotho's Status and Country-Specific Technical Directives for COP 2020

With an overall community viral suppression rate of approximately 74%, Lesotho remains on the cusp of epidemic control, but gaps in key programs remain. Indeed, even after significant increases in funding over the last several years, program data through the end of COP 2018 suggest that progress has stagnated across many of the critical cascade indicators that are essential to sustainable epidemic control, and many of the challenges that were present last year remain unmitigated.

To reach the COP 2019 targets in FY 2020 through the achievement of the 95-95-95 goals (i.e., that 95% of PLHIV be aware of their positive status, that 95% of those who are aware of their status receive antiretroviral therapy (ART), and that 95% of those who receive ART maintain suppression of their HIV), PEPFAR-Lesotho and its implementing partners must address the several gaps that remain during this fiscal year. At the COP 2019 planning meetings, PEPFAR-Lesotho adopted a strategy dubbed its "18- month sprint to epidemic control" in order to ensure they can reach COP 2019 objectives during FY 2020. Through the first 6 months of that strategy,

case-finding remains too low, and because of the nature of the clinical cascade, without accelerated rates of case-finding, other related indicators will lag. Index testing will be at the heart of the effort to identify positive individuals given Lesotho's high ART coverage; it also serves as an essential strategy for finding previously unidentified positive men and those in younger age bands.

While final treatment-related targets for COP 2020 are still to be determined, they must be no lower than the COP 2019 targets. Therefore, for the remainder of COP 2019, efforts must be made to rapidly increase the TX_CURR caseload in order to reach assigned targets. Consequently, major partners such as EGPAF must not only focus on scaling their efforts to identify all remaining PLHIV who are not yet aware of their status, they should also renew their attention towards retaining patients already enrolled in care and treatment services. And if partners do not meet performance milestones or expected standards, PIPs should be drawn up.

Performance across many of the key indicators primarily geared towards preventing the transmission of the disease are also considerably off track. The commitments to which governmental and implementing partners agreed during COP 2019 planning imply that COP 2019 targets will be reached across many program areas. However, achievements through COP 2018 suggest that on some measures they may come up short. During our review of these program areas, several themes were evident, so with an eye towards the remainder of COP 2019 and as necessary, the COP 2020 cycle, it will be essential to reach the benchmarks and/or adopt the approaches prescribed below.

On many of the most critical policies (TPT, MMD, transition to TLD), progress is far behind what was pledged during the past cycle, so each enters COP 2019 well off track. These must be accelerated through a variety of strategies, including improved procurement practices and supply chain management. With particular respect to MMD and TLD, by stepping in to fill the ARV procurement gap in late 2019, the Global Fund has given Lesotho a crucial opportunity to ensure that stocks are sufficient going forward. Since Lesotho has also been selected as a country that will receive DTG for children from global supplies, that should also help to address historically insufficient buffer stocks.

Other policies that will position Lesotho to be far better prepared to sustain gains towards epidemic control, such as EMRs, unique identifiers, and recency testing, are no less important. Progress, e.g., on EMRs, has been commendable, but expectations remain high. During the current COP 2019 cycle, the expansion to all sites should continue without interruption, and all sites should be equipped to feed into a central database so that there is a true national e-registry with unique identifiers. With better EMR data, less direct supervision may be needed at sites, and resources can then be freed up for other needed programming.

During the last several months, uncertainty about the degree to which Lesotho relies on PEPFAR and other funders for their HRH workforce have repeatedly arisen for a variety of reasons. For example, there have been recent signals that too few trained laboratory personnel are available, and questions surrounding corporations' use of healthcare workers funded by PEPFAR at facilities where patient quotas were imposed. In order to better understand what personnel are being funded through PEPFAR as a transition to more host country responsibility is planned, it is

Subject to COP Development and Approval

essential that an HRH inventory is performed, either during the remainder of the COP 2019 cycle or at the beginning of the COP 2020 cycle.

Since DREAMS is expected to continue to rapidly expand in Lesotho, and it is anticipated that additional funding will be made available during COP 2020 that is commensurate with that expansion, several actions will be necessary. For instance, funding should be used for PrEP, so that it can be scaled up significantly for AGYW in DREAMS districts. In order to receive additional funds, Lesotho must present a timeline and strategy at the COP meeting that at minimum includes the following components and initiatives:

- Hire a dedicated DREAMS Coordinator (100% LOE)
- Hire a DREAMS ambassador for each district to support DREAMS coordination and oversight
- Implement approved, evidence-based curricula in line with the current DREAMS guidance
- Ensure a fully operable layering database with unique IDs across IPs and SNUs
- Ensure a full geographic footprint in all districts
- Address challenges and ensure DREAMS implementation in all districts with fidelity (e.g. add education subsidies to the core package)

In addition, for the remainder of COP 2019 implementation and beyond, DREAMS Lesotho should focus on the provision of layered services, conduct advance reporting and analysis of layering data (including for AGYW_PREV), and ensure that the new tablet and online platform for case management tracks both clinical and community interventions for DREAMS AGYW.

During COP 2018, the overall OVC_SERV achievement relative to the target for OVC beneficiaries under age 18 was 113%, but this masked just a 7% achievement level for the IP affiliated with the Peace Corps. During COP 2019, a rapid improvement in performance and/or corrective action will be necessary, since all agencies and implementing partners should reach OVC_SERV achievement levels of 90% or higher. Further, by COP 2020, OVC and clinical implementing partners in Lesotho should work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC districts are offered the opportunity to enroll in the comprehensive OVC program.

Between FY 2018 Q4 and FY 2019 Q4, the percentage of males 15+ years on treatment in Lesotho increased by only 5%. In FY 2019, the percentage increase of men on treatment was only 1% in the 25-29 year age band, and there was a decrease of 7% in the percentage of males on treatment in the 30-34 year old age band. Meeting clients where they are with what they need at each stage of the treatment cascade will be critical to advancing life-long continuity of ART. This requires a better understanding of client needs in order to remove barriers to treatment. Please see the newly released MenStar Guidance Document and Compendium for recommended strategies, interventions, and examples.

PEPFAR-Wide COP 2020 Technical Priorities

Client- and Family-Centered Treatment Services

Subject to COP Development and Approval

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients and make it easy for patients on ART to continue treatment. PEPFAR requires the development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (Dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. OUs must ensure 100% "known HIV status" for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-Led Monitoring

During COP 2020, all PEPFAR programs are required to develop, support, and fund a community-led monitoring activity through the State Department's small grants program in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations, and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those who have tested negative via index testing but remain at increased risk of HIV acquisition by virtue of unprotected exposure to PLHIV with unsuppressed viral loads. These include key populations, such as sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, pregnant and breastfeeding women, serodiscordant couples, and those who are in areas with high HIV incidence.

TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP 2020; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

DREAMS

DREAMS funding is allocated within your COP 2020 planning level and must be used exclusively for the goal of HIV prevention among AGYW in DREAMS districts in accordance with all DREAMS and COP 2020 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP 2020 DREAMS implementation include: systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR), and accelerating PrEP uptake for AGYW.

Subject to COP Development and Approval

OVC
To support the Minimum Program Requirement described above, in COP 2020 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memorandum of understanding (MOU), outlining the roles and responsibilities of each member of the multidisciplinary care team and addressing key issues such as bidirectional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

VMMC
Funds have been provided to conduct VMMC for males 15 years and older. The team is reminded of the revised guidance which allows surgical VMMC under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:
Funding in this program area is intended only for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referrals between sites should be facilitated and outcomes of the referral tracked to ensure appropriate treatment and to allow reporting of results.

PEPFAR-Lesotho's cervical cancer team should work with the MOH to reestablish the cervical cancer TWG and to revise guidelines to shift away from Pap smear screening, given the lack of infrastructure to support this method of screening. In addition, they should work with the MOH to increase laboratory capability for LEEP specimens; strategize on how to target women living with HIV for screening and maximize the provision of treatment services at screening sites; work with community groups, WLHIV networks, faith communities, etc. to increase awareness of cervical cancer risk and screening for women living with HIV; and work with partners to streamline data systems and to ensure that all partners are providing similar services.

PLHIV Stigma Index 2.0
If the revised Stigma Index 2.0 has not already been implemented, PEPFAR teams are required to either fund host country PLHIV networks to implement it, or to complement the financing of the Global Fund or other donors should they finance its implementation. This revised U.S. government compliant version will facilitate the collection of baseline data that can be used to evaluate the future impact of interventions on reducing stigma, and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in an OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 2020, whether supported by PEPFAR or other resources.

Subject to COP Development and Approval

COP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners, and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2020 remains a requirement for all PEPFAR programs, and as such the COP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP 2020 tools, guidance, results, and targets, as well as the proposed trajectory and strategy for COP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. PEPFAR investments to support the national response must be planned intentionally with the Global Fund to ensure that complementarity is achieved in order to maximize the impact on the HIV/AIDS epidemic.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, Georgia, USA, where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Specific guidance for the 2020 meeting delegations has been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2020 development and finalization process. As in COP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2020 Guidance for a full list of requirements and engagement timelines.

Subject to COP Development and Approval

APPENDIX 1: Detailed Budgetary Requirements

Table 9. COP/ROP 2020 New Funding Detailed Controls by Initiative

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	**$ 82,747,188**	**$ -**	**$ 512,500**	**$ 83,259,688**
Core Funding	$ 74,247,188		$ 512,500	**$ 74,759,688**
COP19 Performance	$ -			**$ -**
HKID Requirement ++	$ 8,500,000			**$ 8,500,000**

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

<u>Care and Treatment</u>: If there is no adjustment to the COP/ROP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.<u>Orphans and Vulnerable Children (OVC)</u>: Countries must program to the full OVC amount from Part 1 of the planning level letter across all funding sources. Lesotho's OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

<u>HKID Requirement</u>: Lesotho's COP 2020 minimum requirement for the HKID budget code is reflected in Table 3 above and is a subset of the OVC earmark. Lesotho's COP 2020 HKID requirement is derived from the approved COP 2019 HKID level inclusive of budget codes related to OVC and prevention intervention for children under 19. The COP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

<u>Gender Based Violence (GBV)</u>: Lesotho's COP 2020 <u>minimum requirement</u> for the GBV earmark is reflected in Table 2 above. The GBV earmark requirement is calculated as the total new FY 2020 funding programmed to the GBV cross-cutting code. Lesotho's COP 2020 earmark is derived by using the final COP 2019 GBV earmark allocation as a baseline. The COP 2020

Subject to COP Development and Approval

planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Lesotho's COP 2020 minimum requirement for the water earmark is reflected in Table 2 above. Your water earmark requirement is calculated as the total new FY 2020 funding programmed to the water cross-cutting code. Lesotho's COP 2020 earmark is derived by using the final COP 2019 water earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transition to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal ***by agency*** *by the end of FY 2020. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU-level agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY 2020 as appropriate through their COP 2019 submission.*

COP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Lesotho should hold a three month pipeline at the end of COP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2019 implementation (end of FY 2020) with a pipeline in excess of three months is required to apply this excessive pipeline to COP 2020, decreasing the new funding amount to stay within the planning level.

Subject to COP Development and Approval