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INFORMATION MEMO FOR AMBASSADOR REBECCA E. GONZALES, LESOTHO

FROM: S/GAC – Michael Ruffner, Chair
Matt Wollmers, PEPFAR Program Manager

THROUGH: Ambassador Deborah L. Birx, MD

SUBJECT: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Gonzales,

I sincerely hope that this note finds you and your team well, safe, and healthy. We are grateful for your leadership protecting staff through this difficult time.

This year has brought unprecedented challenges with the COVID-19 pandemic impacting the entire global community. Despite obstacles faced, what has remained unwavering is the tireless commitment and incredible resiliency of our PEPFAR program, partners, and team across the over 50 countries in which we work. This includes rapid program adaptations, emerging innovations, and client-centered solutions to ensure continuity of HIV services. As the threat of COVID-19 has impacted PEPFAR countries, PEPFAR country teams and programs have proven to be focused and resilient in the face of dual HIV and COVID-19 pandemics.

Those implementing PEPFAR programs over the past year have made tremendous efforts in order to maintain clients on treatment, initiate and accelerate client-centered service delivery adaptations, and do what was possible in HIV prevention programs despite them being deeply affected by COVID-19 shutdowns. The following themes have emerged across all PEPFAR-supported countries:

As the economic impact of COVID continues to be seen at both national and community levels, it is more important than ever to use granular data and expand what is working in specific SNUs for viral load coverage and suppression. We saw differential progress in this area independent of the impact of COVID19. Focus groups and deep analytics of clients returning to care to ensure we are addressing critical persistent and new structural barriers. It is essential to focus on areas of recent treatment interruption to understand how COVID may have created or exacerbated barriers to access and treatment continuity. Across all countries we see persistent gaps in pediatric diagnosis, treatment and viral suppression. Particular attention should be paid to the pediatric cascade and identifying challenges by district and country for clear and actionable plans. In addition, we must leverage OVC, DREAMS and other resources for clear accountability to work with mothers and improve early infant diagnosis by two months of age and strengthen resiliency among at-risk women and girls. Community-led monitoring must raise visibility and appropriately respond to the needs of populations already vulnerable before COVID. The assessment of needs and strategies to reinforce OVC caregivers and HIV-affected families in crisis should contribute to budget and activity planning for care and treatment, DREAMS, OVC and wraparound resources. Furthermore, analyzing expenditures at levels of implementing mechanisms and program areas is critical, as is the work that teams have done to build relationships and co-planning with your partner government, the Global Fund, UN organizations and other donors. These relationships and planning efforts are essential to supply chain stability for key commodities as well as understanding

COVID relief and other potential funding available in country to ensure the most effective and efficient use of PEPFAR's contributions to the national HIV response in COP 21.

We understand that specific programs will have carryover and others may not and these funds will be critical to ensure stabilization and expansion of critical prevention programming.

The COVID pandemic also laid bare the depth and breadth of inequities still present across the globe and has provided clear evidence that when constrained, Ministries of Health and governments make choices that differentially impact specific programming areas and specific populations. The pandemic revealed vulnerabilities in our non-public sector community efforts that we knew were present, and are now fully exposed, as these specific activities were the first to be dropped. Communities of women and children, and key populations, including men who have sex with men, transgender individuals, sex workers, people who inject drugs, and people in prisons and other closed settings are not being adequately and sustainably supported by public-sector mechanisms. We have lost ground in our provision of prevention services for all populations and for our most vulnerable and marginalized populations, and must make every effort to recover.

Despite the disruptions caused by the COVID-19 pandemic, countries have shown such determination that a number of them have managed to achieve epidemic control of HIV during the past year, and others are on the brink of epidemic control status. With continued implementation, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach Country Operational Plan 2021 planning and implementation: advancing client-centered services; engaging with communities; implementing resilient and adaptive approaches; and supporting capacities for sustainable epidemic control.

We commend you and your team for your attention to the adoption and implementation of the public health policies that have the greatest impact on HIV, particularly as these very policies are critical to ensuring sustained HIV services during COVID-19. We also appreciate your role in supporting PEPFAR teams through this challenging period, and continuing to hold implementing partners accountable for their performance.

We are grateful to your incredible PEPFAR team in country, working together across agencies to ensure the most effective and efficient use of U.S. taxpayer dollars. We know there are strengths and weaknesses across the board and across the implementing agencies; and we look forward to working together to support those strengths and address any evident challenges.

More specifically, we are very excited about your progress during the past year, including in the following areas:

- The release of the "LePHIA 2" results confirmed Lesotho's remarkable progress across the treatment cascade, with topline results of 90-97-92 (i.e., 90% of Basotho people living with HIV (PLHIV) are aware of their positive status, 97% of those who are aware of status are on antiretroviral treatment, and 92% of those who are on treatment are virally suppressed)
- Even in the face of the many challenges associated with the COVID-19 pandemic, the field team and our government, multilateral, and implementing partners managed to continue to provide lifesaving HIV services virtually without interruption, in large part by rapid adaptations such as expanding multi-month dispensing of antiretroviral (ARV) drugs (i.e., the share of PLHIV receiving at least 3 month supplies of ARVs rose from 47% in FY 20 Q1 to 85% of PLHIV in

Q4) and standing up decentralized drug distribution points for easier access to ARVs in communities
- As demonstrated by both the PHIA and PEPFAR program data, other sub-components of Lesotho's treatment cascade also help it to stand out as a leader among its peers (e.g., linkage, retention, PMTCT, and early infant diagnosis rates are all exceptionally high)

Together, with the Government of Lesotho and civil society leadership, we have made tremendous progress together. Lesotho should be proud of the progress made over the past 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, there are no substantial changes in program direction. While assessing possible deficits in programming arising from COVID-19, our fundamental challenges continue and we again highlight 5 overarching issues we see across PEPFAR:

1. Addressing 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
4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed
5. Ensuing all children are diagnosed and are on the best treatment regimens and virally suppressed

We also note the following specific key challenges for PEPFAR-Lesotho:

- There has been limited progress in the use of recency testing and in the implementation of case-finding strategies with fidelity and at the necessary scale; although elicitation has improved and the distribution of positive cases from index testing has increased to 27%, there is still room for further growth
- Despite the strong performance across the treatment cascade, program data indicate that there were only small net gains of PLHIV receiving ART through PEPFAR-supported programs in the past year, still leaving a significant gap between the overall number of estimated Basotho PLHIV and those on treatment
- Stagnant or sub-optimal performance in some of the program areas whose primary function is to prevent the spread of disease, such as VMMC, PrEP, OVC, DREAMS, and those that serve key populations. Some of these challenges can be attributed to COVID-related shutdowns, but others have been persistent prior to this year.

A fuller set of details, including funding earmarks and specific program directives, are included in the accompanying COP 21 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from last year, PEPFAR teams will once again be responsible for setting their targets in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals. Since 2016, PEPFAR and Global Fund 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. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets, with commensurate increased funding to countries to achieve the goals set out by Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. As evidenced by the PHIA results, Lesotho has achieved the 2020 goals, and is

on track to achieve 2030 goals early, which means that sustaining the amazing gains will need to be our constant focus.

S/GAC will not assign targets to countries, but only provide notional budget levels sufficient to achieve the full SDG goals and sustain gains made. **Teams will develop their own targets across PEPFAR program areas, with the treatment current target no less than the result that was to be achieved in COP 2020.** After the PEPFAR country team submits their COP 21 targets, the notional budget will then be adjusted to the presented level of ambition.

The PEPFAR Country Operational Plan (COP 2021) **notional budget for Lesotho is $75,200,000,** inclusive of all new funding accounts and applied pipeline. All earmarks and program directives provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team (in collaboration with the Government of Lesotho and civil society of Lesotho) believes is critical for the country's progress towards controlling the pandemic and then maintaining control.

We hope this approach to target-setting and budget 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.

PEPFAR, with partner governments, multilateral partners, and communities, continues to move rapidly toward control of the HIV pandemic and plan for sustainability of programs. Achieving epidemic control for HIV will be a remarkable accomplishment, saving millions of lives, significantly lowering the burden of HIV/AIDS in countries and communities, reducing the future costs required to sustain the HIV response, and building sustainable public health systems capacity in host countries.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will plan to review this planning letter and details contained herein with your wider PEPFAR country team. Where PEPFAR successfully navigated disruption due to COVID-19 during 2020, it was a result of strong teams, local partners, communities, dedicated health and community workers, and leveraging longstanding capacities and platforms established by PEPFAR. Our teams, partners, and communities worked together to adapt and further innovate program implementation and models of service delivery so that the adverse impacts of a dual pandemic threat on essential HIV services were mitigated. Stakeholder engagement is essential for a productive and impactful planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual 2021 COP planning and approval process.

I am so grateful to you and your entire team for your leadership and engagement in the planning, review and implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) program, along with the community and Government to enhance PEPFAR's program impact.

Sincerely,

Deborah Birx

Attachment: **Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction Summary**

CC: **S/GAC – Michael Ruffner, Chair**
Matt Wollmers, PEPFAR Program Manager
Carol Holtzman, PEPFAR Country Coordinator

Overview: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

With input from the field team through the quarterly POARTs, the agency self-assessments, and from the Headquarters Country Accountability and Support Team (CAST), a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2019 and current COP 2020 implementation as we plan for COP 2021.

SECTION 1: COP 2021 PLANNING LEVEL

Based upon current analysis of spending levels, information submitted for the End-of-Fiscal Year 2020 (EOFY) tool, and performance data, the total COP 2021 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency. Due to increased costs in FY 2020, including those due to COVID, and correspondingly lower applied pipeline going into COP 21, COP envelopes have been decreased in some OUs so that S/GAC has funds reserved to address program gaps identified by PHIAs that have yet to be completed and to address other potential future requirements as the impacts of COVID on the program are better known. These funds will be allocated to OUs at a later date as appropriate.

TABLE 1: All COP 2021 Funding by Appropriation Year

	Bilateral				Central				Total
	FY21	FY20	FY19	Unspecified	FY21	FY20	FY19	Unspecified	TOTAL
Total New Funding	$ 67,564,324	$ -	$ -	$ -	$ 200,000	$ -	$ -	$ -	$ 67,764,324
GHP-State	$ 67,051,824	$ -	$ -		$ -	$ -	$ -		$ 67,051,824
GHP-USAID	$ -				$ 200,000				$ 200,000
GAP	$ 512,500				$ -				$ 512,500
Total Applied Pipeline	$ -	$ -	$ -	$ 7,435,676	$ -	$ -	$ -	$ -	$ 7,435,676
DOD				$ 355,847				$ -	$ 355,847
HHS/CDC				$ 4,916,368				$ -	$ 4,916,368
PC				$ 1,164,542				$ -	$ 1,164,542
State/AF				$ 998,919				$ -	$ 998,919
TOTAL FUNDING	$ 67,564,324	$ -	$ -	$ 7,435,676	$ 200,000	$ -	$ -	$ -	$ 75,200,000

SECTION 2: COP 2021 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

PEPFAR-Lesotho should plan for the full Care and Treatment (C&T) level of $39,000,000 and the full Orphans and Vulnerable Children (OVC) level of $16,900,000 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that 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 2021 Earmarks by Appropriation Year*

	Appropriation Year			
	FY21	FY20	FY19	TOTAL
C&T	$ 39,000,000	$ -	$ -	$ 39,000,000
OVC	$ 16,900,000	$ -	$ -	$ 16,900,000
GBV	$ 300,000	$ -	$ -	$ 300,000
Water	$ 630,000	$ -	$ -	$ 630,000

**Only GHP-State and GHP-USAID will count towards the Care and Treatment and OVC earmarks. **Only GHP-State will count towards the GBV and Water earmarks.*

TABLE 3: COP 2021 Initiative Controls

	Bilateral	Central	TOTAL
Total Funding	$ 75,000,000	$ 200,000	$ 75,200,000
Core Program	$ 59,250,000	$ -	$ 59,250,000
Cervical Cancer	$ 1,000,000	$ -	$ 1,000,000
Community-Led Monitoring	$ -	$ -	$ -
Condoms (GHP-USAID Central Funding)	$ -	$ 200,000	$ 200,000
DREAMS	$ 14,000,000	$ -	$ 14,000,000
HBCU Tx	$ -	$ -	$ -
One-time Conditional Funding	$ -	$ -	$ -
Surveillance and Public Health Response	$ -	$ -	$ -
VMMC	$ 750,000	$ -	$ 750,000

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	$ 404,686	$ -	$ -	

SECTION 3: PAST PERFORMANCE – COP 2019 REVIEW

Table 5. COP OU Level FY 20 Program Results (COP 19) against FY 21 Targets (COP 20)

Indicator	FY 20/COP 19 Result	FY 21/COP 20 Target
TX Current <15	7,442	10,067
TX Current >15	224,862	302,961
VMMC >15	5,811	20,426
DREAMS (AGYW PREV)	55,575	n/a
Cervical Cancer Screening	36,863	60,063
TB Preventive Therapy	50,784	65,954

Table 6. COP 2019 | FY 2020 Agency-level Outlays versus Approved Budget

Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
DOD	950,000	737,115	212,885
HHS/CDC	43,008,387	35,912,348	7,096,039
PC	930,112	514,576	415,536
State	601,255	225,691	375,564
USAID	48,547,401	39,208,975	9,338,426
Grand Total	94,037,155	76,598,705	17,438,450

Table 7. COP 2019 | FY 2020 Implementing Partner-level Significant Over-Outlays versus Approved Budget

There were no COP 19 IMs in Lesotho that out-layed in excess of 110 percent of their approved level

Table 8. COP 2019 | FY 2020 Results & Expenditures

Agency	Indicator	FY 20 Target	FY 20 Result	% Achievement	Program Classification	FY 20 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	178,127	191,756	108%			
	HTS_TST_POS	14,336	7,940	55%	HTS	$9,397,398	80%
	TX_NEW	10,173	6,874	68%			
	TX_CURR	114,102	85.086	75%	C&T	$11,919,744	81%
DOD	HTS_TST	1,951	1,386	71%			
	HTS_TST_POS	143	139	97%	HTS	$48,051	88%
	TX_NEW	164	89	54%			
	TX_CURR	1,565	1,455	93%	C&T	$145,891	68%
	VMMC_CIRC	1,576	580	38%	PREV	$133,300	42%
USAID	HTS_TST	148,841	286,669	193%			
	HTS_TST_POS	10,840	10,532	97%	HTS	$2,246,023	71%
	TX_NEW	15,384	12,479	81%			
	TX_CURR	197,332	145,763	74%	C&T	$14,793,083	79%
	VMMC_CIRC	28,498	7,726	27%	PREV	$2,462,697	99%
	OVC_SERV	95,765	103,851	108%	SE	$3,665,790	60%
					Above-Site Programs	$6,283,210	n/a
					Program Management	$14,461,367	n/a

Review of Programmatic Performance

Overall:

During the past year, PEPFAR-Lesotho managed to make steady progress across a variety of program areas despite the many challenges associated with the COVID-19 pandemic. It is especially exciting to see all of the team's good and hard work over the last several years be validated by the release of the "LePHIA 2" results. The preliminary data show ongoing progress across Lesotho's treatment cascade, with current estimates of 90-97-92, equivalent to an overall community viral suppression rate of 80%. These PHIA results place Lesotho as a leader among its peers not only across the main "95-95-95" elements, but on a variety of treatment cascade sub-elements, such as linkage and retention. Since PEPFAR program indicator data would suggest that there actually are some continuing challenges that have been identified during previous programmatic reviews (e.g., patients lost to follow up, very modest numbers of net new patients added to treatment rolls, etc.), it will be important to complete the implementation of Lesotho's new health information systems components (e.g., EMRs, unique patient IDs, etc.) in order to help reconcile the seemingly contradictory PHIA and programmatic data.

The adaptability and resiliency of the field team and its partners during the course of the COVID-19 pandemic has been commendable, especially with respect to preserving lifesaving ART services amid difficult circumstances. The rapid scale up of multi-month drug dispensing (MMD), from 47% of PLHIV receiving at least 3 month supplies of ARVs as of FY 20 Q1 to 85% by Q4, was critical, as has been the introduction of far more decentralized drug distribution points. Over the course of the next year, the various strides made to better serve clients in the communities in which they reside should continue to expand, with even higher shares of PLHIV receiving 3 and 6 month supplies of ARVs and accessing them at more decentralized distribution points.

There have also been a variety of programmatic shortfalls over the past year. Some of the program areas where these challenges occurred have been exacerbated by the COVID-19 pandemic, while the challenges in other areas preceded the dual epidemic status in which Lesotho currently resides. For example, case finding still presents the largest remaining gap in the treatment cascade, with indications that the elicitation portion of the index testing modality continues to present a particular challenge. In part due to a modest number of new patients entering the treatment cascade, along with other potential factors, Lesotho's overall "net new" annual figure of 5,690 continued to lag behind treatment targets and what is needed to reach the overall community viral suppression rate of 86% that is associated with the 95-95-95 targets. While recency testing has been disrupted due to COVID restrictions, it should also be fully scaled as soon as possible since it is an essential element of epidemic control. Prevention-oriented program areas, including DREAMS, PrEP, VMMC, and those serving key populations, mostly came significantly short of annual targets. Some of this is clearly attributable to COVID-related shutdowns, but lagging performance relative to targets across a number of prevention indicators has been a multi-year challenge. More detailed analysis across program areas follows below:

Testing:

• Partners are still testing too many people through lower-yield modalities (e.g., PITC) and testing too few people through higher-yield modalities (e.g., index testing)

• While HTS_POS achievements relative to targets may appear better for COP 19 than previous years, that is largely a reflection of the progress that was assumed to have been made through COP 18 when those targets were set (i.e., TX_CURR was assumed to be over 300,000 to start the COP 19 implementation year when in fact it only started at 227,000—therefore the gap was significantly greater than the target of 25,319 suggested, putting the COP 19 HTS_POS achievement figure of 18,095 in a less positive light)

• Index testing remains the most important means by which to improve case finding, so while both COVID-19 and program-wide interruptions that were meant to ensure that safe and ethical index testing practices are in place can help to explain some of the COP 19 gaps, efforts to remediate any shortcomings should continue during COP 20 and 21, as needed

• There was a less than 1:1 ratio of pediatric cases elicited from female index clients during COP 19, and therefore partners should focus on improving elicitation of biological children and expand use of HIV self-testing to reach more potential pediatric cases

• The team should also work with partners to increase testing yield for adults and children, particularly in the "Other PITC" modality, through the use of screeners and other tools

Treatment and Viral Suppression:

• Linkage remains strong overall, as evidenced by both PHIA results and the PEPFAR linkage proxy estimate of 104%; notably, there were positive linkage trends among children <15 years old and females 15-19 during COP 19

• The current retention proxy estimate is 98%, and retention in care among children and adolescents again improved

• Challenges with linking and retaining young adults, however, still remain (i.e., the retention proxy estimate is just 82% for 20-24 yos)

• PMTCT and EID data remain very strong, with exceptionally high rates of PMTCT_ART coverage (partners consistently link 100% of HIV-positive pregnant women to ART) and to a lesser extent, EID performance (81% testing coverage); nevertheless, the team should aim to scale up point of care EID testing and improve overall EID testing coverage

• Viral load suppression measures have been exceptionally strong across all districts and across virtually all age and sex disaggregates, with overall rates at 97% for the year for those >15 years old and 93% for those <15 years old, likely explained in part by the almost finished TLD transition among adults (increased from 14% to 87% in the past year); by COP 21 the team should aim for 95% suppression across all age/sex groups, including children in every age range and pregnant and breastfeeding women

• After viral load coverage expanded significantly during COP 18, from 59% to 83%, it stagnated during COP 19, with just 84% of eligible PLHIV receiving a VL test in the past year. This should be increased to 100% during COP 20

• Rates of PLHIV who need TB preventive therapy receiving it improved dramatically from COP 18 (when there was a 20% rate of target achievement) to COP 19 (when 77% of the target was achieved), but a gap of 15,170 remained and needs to be addressed during COP 20

• A higher percentage (91%) of PLHIV on ART were screened for TB during COP 19, and with the improvements in TPT, an estimated 85% of Lesotho's TX_Curr total have now completed TPT

Prevention:

• Performance across primary prevention programs was again mixed during the past COP year. 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: 8,308 voluntary medical male circumcisions were performed during COP 19, roughly 28% of the target for the year, and among those, only 5,811 were in the 15+ year old age band. While VMMCs were effectively put on hold for the second half of the year, Q1 and Q2 achievement were still off pace of targets, with too high a percentage of circumcisions performed in the <15 year old population

• KP programs: While PrEP_New and PrEP_Curr performance against targets was better in COP 19 than COP 18, PrEP_Curr was still at just 78% of the annual target, suggesting that room for growth remains; some KP performance improved, including across linkage rates (97% in FY 20) and VLS (93%)

• DREAMS/OVC: DREAMS data again suggest that while some incremental progress was made during the past year, even despite COVID-related challenges, higher percentages of DREAMS

beneficiaries should be completing the full package of services. While the program has reached or nearly reached saturation at younger age bands in Berea, especially, performance is lagging in Maseru and particularly within the 20-24 age band in both districts. OVC performance data are also again mixed, but it will be critical to increase the rate of CLHIV receiving OVC services (as of FY 20 Q4, only 47% were). In order to achieve at least 90% of CLHIV receiving services, the OVC program must continue to strengthen OVC partner and clinical collaboration during COP 20

• Cervical cancer: PEPFAR-Lesotho oversaw a successful surge campaign during COP 19; however, screening achievement relative to targets was 80% and linkage to treatment remained at just 74%, leaving space for improvement during COP 20 and beyond

Partner Performance:

• Virtually across the board, partners out-layed at or below their allocated amounts during COP 19, explained in part by COVID-related programming delays—however, this does not excuse performance that in some cases fell well short of targets

• Partners that have consistently come 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 20:

• EGPAF (via both CDC and USAID) handles the vast majority 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 remains off track through the end of COP 19. After LePHIA 2 data and program/APR data are reconciled, a process that will yield more precise estimates of PLHIV that will in turn lead to better refined testing and treatment targets, partner performance should be reexamined and any new steps that are necessary to remediate performance taken

• JHPIEGO continued to fall short of circumcision targets and has focused too much on non-priority age bands

SECTION 4: COP 2021 DIRECTIVES

The following section has specific directives for COP 2021 based on program performance noted above. Please review each section carefully, including the minimum program requirements and specific country directives.

Minimum Program Requirements (MPR)

All PEPFAR programs – bilateral and regional– were expected to have the following minimum program requirements in place by the beginning of COP 20 implementation (FY 2021). Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school, community). 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.

All PEPFAR programs are expected to meet all of the requirements below, and the COP 21 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP 21 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY 2021. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY 2022 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table on the following page.

Table 9. COP 2021 (FY 2022) Minimum Program Requirements

Minimum Program Requirement	Status and issues hindering Implementation
Care and Treatment	
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Test and Start has been adopted and fully implemented across all age, sex, and risk groups.
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 who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	Significant progress was made during the past COP year, with 87% of adults on TLD as of FY 20 Q4. NVP regimens for CLHIV have finally been fully removed.
3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	In part out of necessity due to the COVID-19 pandemic, partners successfully increased MMD throughout the year (it rose from 47% to 85% of PLHIV receiving at least 3 month supplies of ARVs from FY 20 Q1 to Q4) and after initial delays, stood up decentralized drug distribution points for easier access to ARVs in communities.
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP 21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	TPT coverage increased significantly during COP 19, and with an adequate supply of TB drugs now available, there should be no hindrances to performance going forward.
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 viral load testing and results delivered to caregiver within 4 weeks.	Laboratory instrument mapping, network optimization, and integrated sample transport exercises for VL, EID and TB diagnosis have been previously completed, as has a rollout plan for integrated TB/HIV services and POC VL testing for PBFW.
Testing	
1. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Index testing still needs to be further scaled up with fidelity, particularly with respect to elicitation rates among key groups. This must be done while adhering to safe and ethical index testing practices, to include certification from all sites that they are now compliant with prescribed practices.

	There is also still room for expanded scale-up of self-testing.
Prevention and OVC	
1. 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*)*	PrEP continues to be offered to all HIV-negative clients at elevated risk of HIV acquisition.
2. 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) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 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 of the listed OVC services continue to be included in the OVC package. The percentage of CLHIV who are eligible for OVC services but not receiving them must be reduced significantly during the current and future COP cycles.
Policy & Systems	
1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	There are no formal or informal user fees in the public sector for direct HIV services and medications, or related services.
2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.	PEPFAR partners have institutionalized CQI in HIV programming in Lesotho, particularly for HTS, care and treatment, and 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.
3. 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 materials at health facilities. However, the Lesotho MOH has at last report not yet put forward an integrated, national strategy for U=U and related messaging to reduce

	stigma and encourage HIV treatment and prevention.
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	The field team has reported 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. However, it has endeavored to identify local partners where available, and selected them, e.g., for OVC/DREAMS and PMTCT awards.
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased 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 and annual completion of the resource alignment activity.
6. 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 cervical cancer; and TB_PREV for the treatment of latent TB infections among people living with HIV/AIDS.
7. Scale-up of case 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 was planned but not fully implemented. As of December 2020, Lesotho had eRegisters at 176 sites (exceeding the goal of 172 by the end of COP 19). In order to reach full functionality, IPs continue to work on feeding data from eRegisters at individual sites into a national, shared registry of unique identifiers and health records.

In addition to meeting the minimum requirements outlined above, it is expected that Lesotho will consider and align with all of the following technical directives and priorities:

COP 2021 (FY 2022) Country-Specific Technical Directives

The release of the "LePHIA 2" results confirmed that Lesotho has entered the initial phases of epidemic control status, given its 90-97-92 topline results and an implied community viral suppression rate of 80%. While we can now conclude that the PEPFAR-Lesotho team has successfully completed the strategy that had been dubbed the "18-month sprint to epidemic control" at the COP 19 planning meetings, our work is far from done, and the PHIA results have many implications for Lesotho's future HIV programming.

Looking forward to the COP 21 cycle, first and foremost, it will still be critical to continue to identify and address any remaining programmatic gaps. This will be true across various disaggregates (i.e., geography/age/sex) in some program areas, such as the first 95, while in others, it will be a matter of finding and mitigating any isolated pockets of weakness that remain (e.g., a relatively small number of sites that are lagging far behind others in VLS or VLC). It will also be important to build on the many evident successes of COP 19, despite the myriad challenges thrown Lesotho's way, including a problematic supply chain system entering the year, and dual pandemics, healthcare worker strikes, etc. during the year. This strategy will include the innovative and adaptable practices that enabled providers to rapidly expand MMD and ARV distribution points, and the adoption and implementation of standard best practices, such as the establishment of the supply chain management directorate. It also includes continued progress in fully implementing each of the minimum program requirements reviewed in Table 9 above. Finally, and essentially, Lesotho's epidemic control status means that we are at a critical inflection point for the program, and business as usual is not an option. In order to continue to drive at any remaining gaps and to sustain all of the many gains that have been made, a variety of programmatic pivots during the current and future COP years will be necessary. The team's completion of Lesotho's "sustainability grid" in December was a helpful initial step forward, and a series of discussions in earnest on this subject will continue during January and will be a principal focus of COP 21 planning meetings. With an eye towards those discussions, while being mindful of the need for even more detailed, thoughtful analyses across every program area in the near future, a look forward, with technical directives across program areas, follows below.

During COP 20 and going forward, index testing must remain at the center of efforts to address any remaining gaps in the clinical treatment cascade. As soon as possible, partners must certify that all sites are compliant with safe and ethical index testing standards. We need to understand who we are missing on treatment coverage, where the infections are occurring, and layer strong prevention programs on top of testing, treatment, and lab efforts. Lesotho's exceptionally high prevalence levels require a well-considered longer-term strategy that maintains robust prevention efforts in order to quickly identify and mitigate any potential fast-moving outbreaks. In order to sustain gains that have been made in both the present and future, some new programming should be adopted that builds up the core competencies of our government and institutional partners in order to better capacitate them to do the necessary work on the ground (i.e., we should implement a small but significant project that works with district-level government staff on building up disease surveillance capabilities, responsibility for oversight of clinics, etc.).

A number of efforts led by PEPFAR-Lesotho will also provide new, key data on which future programming decisions should be based. For example, data from the recently concluded HRH inventory will inform key decisions about expenses and HCW staffing decisions that can ensure more efficient and effective delivery of HIV services. As these data are considered, the team should also conduct a review of activities and implementing mechanisms and determine which were necessary during the phase up scale

of HIV service provision, but are no longer necessary now. For example, a significant amount of non-service delivery costs, such as basic trainings for service providers, should now be needed in fewer numbers. In developing COP 21, Lesotho should review needs for testing counselors and retention counselors—but when making programming changes, keeping HRH workers at the site level who provide treatment services should be prioritized over non-service delivery spending. Some "Table 6"/above-site activities that have been supported in the past are also likely no longer needed. Since it is expected that only a small gap to VMMC saturation will remain by the end of COP 20, that program area also warrants consideration for being scaled back. A review of HRH data should also make it possible to make more refined determinations about what a right-sized HRH workforce will be in the near- and longer-term. Further, in order to better determine the actual costs of programming rather than simply what PEPFAR has historically paid, during COP 21, an activity-based costing and management (ABC/M) effort should be initiated.

Part of this process will also require a review of barriers to local control. Therefore, the team should work with other development partners to create a long-term plan for government financing and sustainability for HIV prevention, treatment, and care. By the end of the first quarter of COP 21, in conjunction with the Government of Lesotho and civil society, the team will develop a review of functional and financial barriers to local responsibility for HIV epidemic control, with a goal of initiating a process to increase the sustainability of the national and local HIV response.

By and during the COP 21 planning meetings, an effort to further reconcile LePHIA data, program data, and major epidemiologic estimates (e.g., PLHIV, prevalence, incidence, etc.) should also be completed. This has significant implications for COP 21 target-setting and will simply provide a much-needed, better understanding of what the remaining programmatic gaps are. To inform this effort, the completion as soon as possible of new health information systems components, such as EMRs, unique identifiers, Lesotho's national health registry, and recency testing will be critical.

PEPFAR-Wide COP 2021 Technical Priorities

Client-Centered Treatment Services

COP 21 planning must ensure treatment continuity for all current and new clients. To do this, programs must specifically and thoroughly address the challenge of interrupted antiretroviral treatment, especially after initiating ARVs and through young adulthood. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous adherence to ART for an adult population that is 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 free, fit the lives of the clients, and empower clients on ART to stay the course. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including client education on the benefits of lifelong treatment, optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient and safe ARV access arrangements, and community and client participation in design and evaluation of services.

Pediatric- and Adolescent-Centered Services

In COP 21, PEPFAR programs are required to demonstrate improvement in pediatric case finding, including safe and ethical index testing, to close HIV treatment gaps across age and sex bands. Programs must move forward with the introduction and broad use of pediatric DTG formulations in FY 21 (COP 20), with full implementation expected to occur during the first quarters of FY 22 (COP 21). Programs need to further advance pediatric- and adolescent-specific continuity of treatment programming, including age-appropriate differentiated models of care and leveraging bidirectional synergies with clinical and OVC implementing partners. OUs must develop a comprehensive plan to achieve ≥ 90% viral load

coverage and viral load suppression across all age and sex bands. To further reduce morbidity and mortality, clinical programs should include an evidence-based advanced HIV disease package of care for children and adolescents.

Community-led Monitoring

In COP 21, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through the State Department Ambassador'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)

In COP 2021, PrEP should continue to be made widely available, with a focus on getting PrEP (including possible new PrEP options) to the people who need it. Groups to be prioritized for PrEP include HIV negative partners of index cases, key populations including sex workers, men who have sex with men, transgender persons, people in prisons and other closed settings, people who inject drugs, adolescent girls and young women, pregnant and breastfeeding women, people in areas with high HIV incidence or with higher risk partners, and other identified sero-discordant couples. Groups should be tailored to the OU's epidemic context.

TB/HIV

TB/HIV services must be integrated, including DSD and MMD models for both TB and TB preventive treatment (TPT). All PLHIV must be routinely screened for TB and have access to molecular diagnostic testing and/or point of care tests such as LF-LAM. TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP 21; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

Advanced HIV disease

The advanced disease package of care should be fully integrated into clinical care and includes diagnostics and therapeutics for tuberculosis and cryptococcal meningitis as well as cotrimoxazole. Countries should budget adequately for commodities including urinary LAM, CrAg, amphotericin B and flucytosine. Please see section 6.5.2 of the COP guidance.

DREAMS

DREAMS funding is allocated within your COP 2021 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2021 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP 21 DREAMS implementation include systematically identifying and engaging AGYW who are most vulnerable to HIV acquisition; particularly pregnant AGYW and those who are mothers; improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR); ensuring that evidence-based curricula are implemented with quality and fidelity; enhancing mentoring selection, training, compensation and supportive supervision processes; and accelerating PrEP uptake for AGYW in DREAMS SNUs.

OVC

To support the Minimum Program Requirement described above, in COP 21 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary

care team and addressing key issues such as bi-directional referral protocols, pediatric case finding, case conferencing, shared confidentiality, joint case identification, and data sharing. In high volume clinics within high burden SNUs, at least 90% of children (<age 19) in PEPFAR-supported treatment sites should be offered enrollment in OVC programs. OVC staff placed in clinics (e.g., as linkage coordinators, case managers, etc.) should have the capacity to assess child and family needs (including food and economic security) and to offer appropriate referrals. 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 or older. The team is reminded of the revised guidance which allows surgical VMMC for those 15 or older. While Shang ring may be considered for those below age 15 with headquarters approval, it should be limited to those age 13 or above who are able to understand the procedure and provide informed consent, along with parental consent as dictated by local laws. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:

Funds have also been provided 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 and report into the cervical cancer MER indicators. 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 referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

Condoms and Lubricants

Condoms are key to a successful combination HIV prevention approach and are a cost-effective tool for preventing other sexually transmitted infections and unintended pregnancies. PEPFAR's goal is to ensure high levels of use, equitable access to, and sustained demand for condoms and lubricants among key and priority populations and low-income groups. In COP 21, through the Condom Fund, GHP-USAID will provide $20.3 million in assistance to PEPFAR-supported countries to procure and deliver condoms and lubricants to address key condom supply and demand issues. This funding is in addition to funds allocated for condom programming and additional condom/lubricant procurement in each country from COP 21 country funding as determined during the COP planning process.

Lesotho will have access to $200,000 from the Condom Fund in COP 21/FY 22, contingent upon adequate justification of need. Coordination with other donors that provide commodities, including the Global Fund, is also critical and expected. The process for estimating your country's total condom and lubricant need is outlined in the COP 21 guidance. Among other items, this justification should include an outline of how Lesotho will support condom programming in FY 22 with funds from your base COP 21, the Condom Fund, the GF and/or other donors, and the host-country government. Please note that in FY 22 there will also be limited funding available to cover unexpected or emergency condom and/or lubricant requests from PEPFAR-supported countries. Access to these funds will be provided on a first come, first served basis, and OUs will be required to provide a justification for why their special request is being made.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised PLHIV Stigma Index 2.0 utilizing the standard methodology, or complement Global Fund or

other donors financing implementation of the PLHIV Stigma Index 2.0, if it has not already been implemented in the OU. If the revised PLHIV Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 21, whether supported by PEPFAR or other resources. Completion of the PLHIV Stigma Index 2.0 should be accompanied by a response and action plan discussed and agreed upon by all stakeholders that will address findings. Where the PLHIV Stigma Index 2.0 has already been conducted, COP 21 focus should be on concerted action to address findings.

Human Resources for Health (HRH) and Sustainability

Using data from the HRH Inventory completed in COP 20 Q4, OUs are expected to complete a comprehensive HRH analysis to optimize staffing at the site- and above-site-levels. PEPFAR programs in countries that will be near to or reach 95/95/95 during the COP 20 implementation cycle are required to develop and implement plans to sustain their progress and effectively retain clients in quality HIV treatment programs. Results from the Sustainability Index and Dashboard (SID) 2019 should inform the OUs on their progress and gaps related to the policies and technical areas for inclusion in the sustainability plans. Resource alignment data should be used to understand the HIV funding landscape—especially with a more granular understanding of PEPFAR and GFATM investments—including who is paying for what services in order to enhance strategic collaboration and coordination and avoid duplication during the program planning cycle.

Cross-HIS Data interoperability - Use and Analysis

Improved data visibility and analysis are essential for better understanding the HIV epidemic and reaching epidemic control.

PEPFAR-Lesotho should 1) Consistently and continuously use and analyze data at the individual patient level with aim of program improvement (e.g. use patient level data to understand retention differences across patient cohorts and create more tailored risk models and intervention); and 2) Utilize available data interoperability solutions to harmonize and triangulate data across EMRs, commodities, pharmacy dispensation, laboratory data, HRH and other data.

Systems Investments

PEPFAR teams are expected to align systems investments with key systems barriers to achieving epidemic control. System investments should also be aligned to achieving and maintaining minimum program requirements for COP including adoption and use of unique identifiers, building country capacity in disease surveillance and other core competencies to achieve and maintain epidemic control, including the country's ability to perform continuous quality improvement. Systems investments that have achieved their goals should be candidates for countries to assume responsibility to achieve the minimum program requirement for increased responsibility and increased government expenditures.

Faith and Community Initiative (FCI)

Building upon PEPFAR's standing principle to ensure "every dollar is optimally focused for impact," OUs with continuing FCI investments should continue implementing best practices in accordance with FCI and COP 21 Guidance. Priorities for COP 21 FCI implementation for addressing gaps in reaching men and children include: coordination through an Inter-Faith Steering Committee to advance treatment literacy; and decentralized, continuing care through faith-engaged community posts, faith-engaged highly targeted HIV self-testing, and/or community adolescent treatment programs for youth living with HIV.

Innovative solutions and adaptive practices

There are extraordinary examples of innovation by our field teams and partners during COVID. These include adaptations and lessons learned that span across many of our technical and program areas as well as all countries we work in. Teams should look at ways to strengthen and improve our capacity to

innovate, design, and create within the communities we serve. This includes systematically looking at the evidence base and how to learn from these examples as well as strengthen our methods to help scale proven strategies and interventions.

COP 2021 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. 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.

As in years past, civil society organizations are considered essential and invited to participate both in the virtual COP 21 strategic planning meetings, as well as virtual approval meetings.

This engagement, of both civil society and of faith-based organizations/faith communities, specifically includes the sharing of FY 2020 Q4 and FY 2020 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2021 in order to introduce and discuss all COP 2021 tools, guidance, results, and targets, as well as the proposed trajectory and strategy for COP 2021. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund, with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2021, PEPFAR will convene virtual meetings 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, faith-based organizations/faith communities, and multilateral partners. Specific guidance for the 2021 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP 2021 development, finalization, and implementation. As in COP 2020, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with both CSO and FBO stakeholders for their input and comments at least 48 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2021 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment (C&T): Lesotho's COP 2021 minimum requirement for the C&T earmark is reflected in Table 2. If there is no adjustment to the COP 2021 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): Lesotho's COP 2021 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% of DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative
- 100% of OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors. The written justifications should be uploaded as 'Budgetary Requirements Justification' to the document library of FACTS Info.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: **community mobilization, behavior, and norms change** (all populations)

+

50 % Prevention: **Not disaggregated** (all populations)

Gender Based Violence (GBV): Lesotho's COP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2021** funding programmed to the GBV cross-cutting code. Your COP 2021 earmark is derived by using the final COP 2020 GBV earmark allocation as a baseline. The COP 2021 planned level of new FY 2021 funds for GBV can be above this amount; however, it cannot fall below it.

Water: Lesotho's COP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2021 funding** programmed to the water cross-cutting code. Your COP 2021 earmark is derived by using the final COP 2019 water earmark allocation as a baseline. The COP 2021 planned level of new FY 2021 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 transitioning 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 21, and must meet 40% by FY 20. 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 agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY 21 as appropriate through their COP 2020 submission.

State ICASS: Table 4 shows the amount that the OU must program under State for ICASS Costs.

COP 2021 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Lesotho should hold a 3 month pipeline at the end of COP 2021 implementation whenever possible in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain a 3 month buffer. Any agency that anticipates ending COP 2020 implementation (end of FY 2021) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2021, decreasing the new funding amount to stay within the planning level.