Lesotho Country Operational Plan (COP) 2018

Strategic Direction Summary

March 15, 2018

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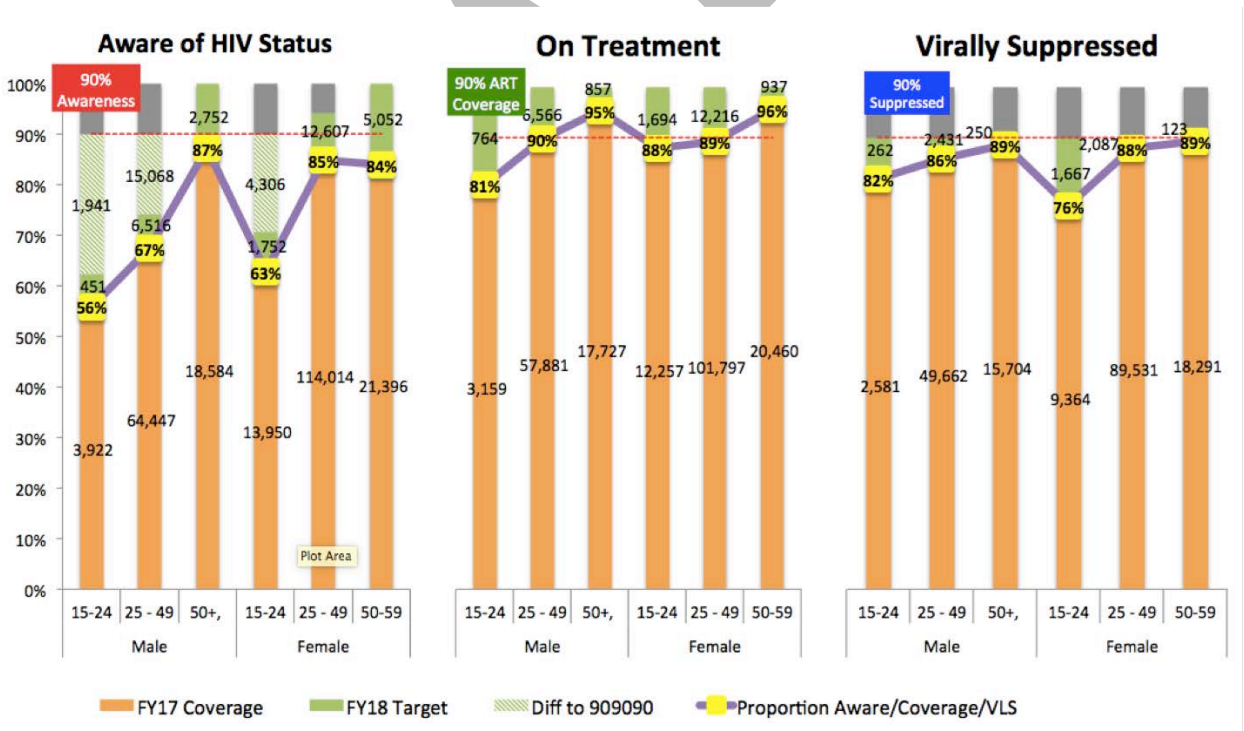
1.0 Goal Statement

The Country Operational Plan (COP) 2018 is an expansion of the COP17 approach. The goal is to achieve UNAIDS 90-90-90 targets in all age and sex bands and *national* 95-95-95 targets, which will result in 90% treatment coverage overall for people living with HIV (PLHIV) in Lesotho and a decline in HIV related deaths. Reaching epidemic control – the point at which new HIV infections fall below the number of AIDS-related deaths – remains the overall PEFPAR goal, and one the USG program will support Lesotho to achieve. The recent Lesotho Population Based HIV/AIDS Impact Assessment (LePHIA) results show that in terms of progress towards the UNAIDS 90-90-90 goal, Lesotho is at 77/90/88, with 77% of PLHIV knowing their status, 90% of those who know their status on treatment, and 88% of those on treatment being virally suppressed. For the first 90 (knowledge of status), however, the gap between men and women remains. Lesotho has the second highest national HIV prevalence in the world, but the LePHIA results show that progress towards epidemic control is being made.

Figure 1.1: Progress Towards 90-90-90[1]



Building on the results of the LePHIA, in COP18 the PEPFAR Lesotho program will expand facility-based testing, care, and treatment to cover 99% of the PLHIV. COP18 investments will expand antiretroviral therapy (ART) coverage across all ten districts in Lesotho to 90% in order to achieve saturation across all age groups and sexes. PEPFAR Lesotho is going to optimize HIV

[1] LePHIA, 2016-2017

testing channels and strategies to better identify PLHIV – particularly in adolescents and men – through expansion of index testing and partner notification, as well as scale-up of innovative approaches such as HIV self-testing. Lastly, COP18 will scale up men's clinics in order to reach 90-90-90 in this specific population.

PEPFAR Lesotho has worked with a wide range of stakeholders in developing COP18. Open and frank dialogue with civil society, monthly performance monitoring meetings with implementing partners, and close collaboration with the Government of Lesotho (GOL) and The Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) has become the norm. Through the biannual health summits and quarterly PEPFAR Oversight and Accountability Review Team (POART) meetings the program aims to successfully achieve our shared goals and ensure synergy between national HIV programs and development partner projects. With enabling policies and a commitment to provide the ARVs, both for treatment and pre-exposure prophylaxis (PrEP), the Ministry of Health (MOH) is again demonstrating its commitment and partnership in addressing the HIV epidemic.

2.0 Epidemic, Response, and Program Context

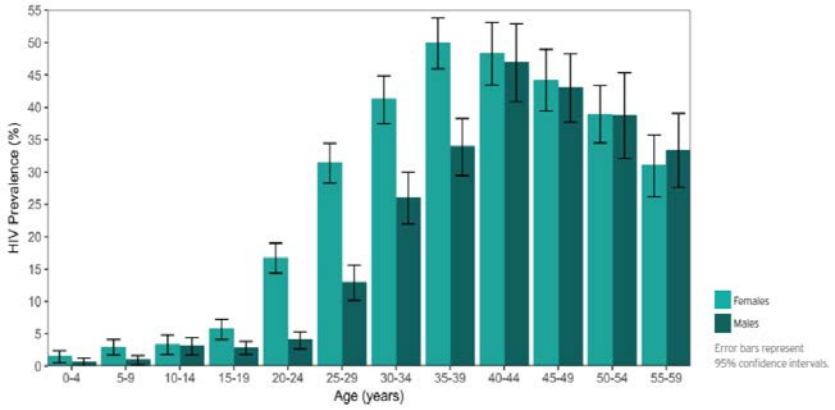
2.1 Summary statistics, disease burden, and country profile

Lesotho has a total population of 2,007,201 people, 51% of whom are women and 32% of whom are under the age of 15.[2] The country is divided into ten districts. Lesotho is classified as a lower middle-income country with a Human Development Index of 0.497[3] and a Gross National Income (GNI) per capita of $1,210.00. Sixty-six percent of the population lives in rural areas.[4]

Lesotho completed a national census in 2016, and these updated numbers have been incorporated into our population-level estimates. UNAIDS Spectrum estimation and projection package (EPP) and the LePHIA results were used for PEPFAR planning. Prevalence among men and women 15-59 is 25.6%. LePHIA results showed that women have a higher HIV prevalence among men at all ages (Figure 2.2.1).

[2] Lesotho Census, 2016
[3] http://hdr.undp.org/en/data
[4] http://data.worldbank.org/country/lesotho

Figure 2.1.1 HIV Prevalence by Age and Sex (LePHIA 2016-2017)



Beginning in COP18, all ten districts of Lesotho will be "scale-up saturation" districts. PEPFAR Lesotho will support 208 sites across the ten districts with PMTCT, HIV testing, and HIV care and treatment. Voluntary medical male circumcision (VMMC) services will be synergized between PEPFAR Lesotho and GF, with services provided in the five lowland districts (Leribe, Berea, Maseru, Mafeteng, Mohale's Hoek) by PEPFAR Lesotho and in the five highland districts (Butha-Buthe, Mokhotlong, Thaba-Tseka Qacha's Nek, and Quthing) by GF. Key population (KP) activities will remain in Maseru and Leribe where female sex workers (FSW) and men who have sex with men (MSM) are concentrated.

Lesotho continues to be ranked second highest in HIV prevalence and highest in incidence among people 15-59 years. Incidence has seen a reduction from 1.9% in the 2014 Demographic and Health Survey (DHS) to 1.5% in 2017.[5] Lesotho was the first country in Africa to implement Test and Start (June 2016). In 2017, Lesotho adopted multi-month dispensing for stable patients. During COP18, Lesotho will continue to scale up PrEP, HIV self-testing (HIVST), and differentiated models of care.

Lesotho's government has been supportive of PEPFAR efforts overall, however stigma remains a barrier to HIV testing and treatment. Awareness of status among males 15-59 is low (71.0%) and urgently needs to be addressed to reach the 90-90-90 goals in this population. Frequent changes in key personnel at MOH and ongoing political issues threaten the success of Lesotho's national HIV program. The GOL's revised National Strategic Plan for HIV and AIDS (NSP) 2011/12 – 2017/18 endeavors to halve new infections by 2020 by focusing on four core programs:

1. Treatment, care and support;
2. Elimination of mother-to-child transmission;
3. VMMC, condom promotion and distribution, and;
4. Prevention of new infections among key populations through targeted programs and other critical enablers and development synergies.

[5] LePHIA, 2016-2017

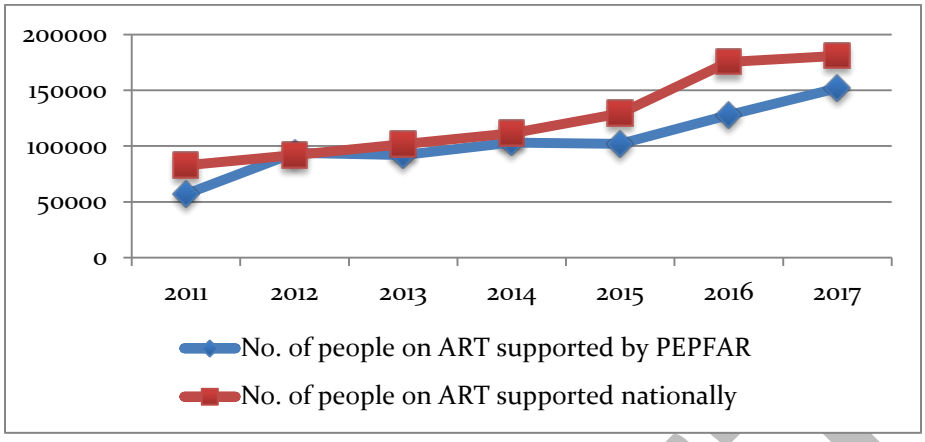
Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	2,007,201	100	318,819	15.9	318,625	15.9	204,092	10.2	205,041	*10.2*	502,157	25.0	458,342	22.8	2016, BOS
HIV Prevalence (%)		25.6		2.6		1.5		11.1		3.4		30.4		20.8	2017, LePHIA (25+ is 15-59)
AIDS Deaths (per year)	4,908		439		454		244		148		1,990		2,026		2017, Spectrum
# PLHIV	319,400		8,289		4,779		22,654		6,971		152,656		95,335		2017, LePHIA
Incidence Rate (Yr)		1.47		---		---		1.81		0.13		1.74		1.22	2017, LePHIA (25+ is 15-59)
New Infections (Yr)	13,000														2017, LePHIA (15-59)
Annual births	52,861	---													2017, Spectrum
% of Pregnant Women with at least one ANC visit	---	97.1	---	---			---	97.0			---	97.1			2017, LePHIA (25+ is 15-49)
Pregnant women needing ARVs	12,335	---													2017, Spectrum
Orphans (maternal, paternal, double)	111,538		58,231		58,231		---		---		30,290		30,290		2017, Spectrum (15+=15-17)
Notified TB cases (Yr)	16,000														2017, Global TB Report
% of TB cases that are HIV infected	525/100,000	---	---	---	---	---	---	---	---	---	---	---	---	---	2017, Global TB Report
% of Males Circumcised	409,496	68.4			---	---			141,068	68.8			261,769	66.5	2017, LePHIA (15-59); 25+ is 25-59
Estimated Population Size of MSM*	10,845	---													2014, PSI
MSM HIV Prevalence	---	33.3													2014, PSI
Estimated Population Size of FSW	5,986	---													2014, PSI
FSW HIV Prevalence	---	71.9					---	---			---	---			2014, PSI
Estimated Population Size of PWID	No data	---													---
PWID HIV Prevalence	No data	---													---

Estimated Size of Priority Populations (Prisoners)	2,447	31.4 prev													2014, LCS
Estimated Size of Priority Populations Prevalence (Taxi Drivers)	4,947	---													2017, in-country estimate (15+)
Estimated Size of Priority Populations (Miners)	24,439	---													2017, TEBA

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	2,007,201	25.6[1]	319,400	246,577	222,412	90.2	88.3	816,904	47,335	*40,920*
Population <15 years	637,444	2.1	13,900	---	11,903	85.6	85.3	260,943	1,714	*1,504*
Men 15-24 years	205,041	3.4	6,971	3,918	3,130	79.9	81.7	97,674	1,834	*1,221*
Men 25+ years	598,679	20.8	124,525	88,412	79,040	89.4	88.4	291,557	18,257	*15,249*
Women 15-24 years	205,092	11.1	22,765	13,978	12,538	89.7	76.4	193,757	7,824	*6,083*
Women 25+ years	599,281	30.4	182,181	148,478	134,521	90.6	88.2	517,301	28,597	*25,671*
MSM	10,845	33.3	3,611	---	---	---	---	---	---	---
FSW	5,986	71.9	4,304	---	---	---	---	---	---	---
PWID	No data	---	---	---	---	---	---	---	---	---

[1]for 15-59 year olds, not total population

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment



2.2 Investment Profile

The HIV response in Lesotho is primarily funded by the GOL, GF, and the United States Government (USG) through PEPFAR. Over the past few years, PEPFAR Lesotho's budget has significantly increased from $34 million in COP15 to $82.5 million in COP18. The program is matching expenditure to budget with almost 100% of COP16 funding expended in that same year. PEFPAR's percentage of the national HIV response has therefore increased. In contrast, GF grant expenditure has been low at about 50% of the budget. Slower than anticipated contracting of sub-recipients and tendering has led to reduced GF disbursements. The GOL has maintained their commitment to the HIV response, especially the procurement of ARVs.

Table 2.2.1 shows that the total HIV expenditure in 2017 was $114,130,129. Half of the expenditure is spent on care, treatment, and support, directly contributing to efforts to meet the 90-90-90 goals.

Table 2.2.1 Annual Investment Profile by Program Area

Program Area	Total Expenditure	% PEPFAR[1]	% GF[2]	% Host Country[3]	% Other[4]
Clinical care, treatment and support	$50,125,864	49%	18%	33%	0%
Community-based care, treatment, and support	$6,393,456	70%	19%	0%	11%
PMTCT	$4,104,107	97%	3%	0%	0%
HTS	$10,923,610	76%	22%	2%	0%
VMMC	$5,314,176	98%	2%	0%	0%
Priority population prevention	$6,304,828	47%	45%	8%	0%
Key population prevention	$7,765,796	5%	12%	83%	0%
OVC	$8,327,818	68%	0%	32%	0%
Laboratory	$10,494,049	58%	26%	14%	1%
SI, Surveys and Surveillance	$1,562,037	27%	67%	0%	6%
HSS	$2,811,389	43%	21%	31%	5%
Total	**$114,130,129**	**55%**	**18%**	**25%**	**1%**

[1]PEPFAR Expenditure Analysis 2017
[2]Global Fund Expenditure Analysis
[3]Ministry of Health flat lined from 2016
[4]SolidarMed and CHAI self-reported

Table 2.2.2 shows that GF and GOL procure the majority of the commodities, with a particular note around the continued commitment for the procurement of ARVs (including those for PrEP). PEPFAR continues to secure buffer stocks for rapid test kits, as well as the majority of viral load commodities.

Table 2.2.2 Annual Procurement Profile for Key Commodities				
Commodity Category	**Total Expenditure**	**% PEPFAR[1]**	**% GF[2]**	**% Gov. of Lesotho[3]**
ARVs	$ 14,239,626	0%	63%	37%
Rapid test kits	$ 1,730,833	2%	98%	0%
Other drugs	$ 407,568	0%	59%	41%
Lab reagents	$ 2,289,787	24%	19%	57%
Condoms	$ 25,445	0%	100%	0%
Viral Load commodities	$ 3,747,134	82%	18%	0%
VMMC kits	$ 191,678	100%	0%	0%
MAT	$ -	0%	0%	0%
Other commodities	$ 396,011	0%	100%	0%
Total	**$ 23,028,082**	**17%**	**54%**	**29%**

[1]PEPFAR Expenditure Analysis 2017
[2]Global Fund Expenditure Analysis
[3]ARVs, Lab Reagents, and VL Commodities: Ministry of Health self-reported, Others: Flat lined from 2016

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration*					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
Peace Corps	$1,585,942	$1,585,942	1	$774,501	Funding for Peace Corps Lesotho
Total	**$1,585,942**	**$1,585,942**	**1**	**$774,501**	

*The only USG non-PEPFAR-funded investment is Peace Corps.

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP*						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
Cervical Cancer – Central Funds	$3,190,720	$0	$3,190,720	2	$0	Cervical cancer screening for 37,500 HIV positive women over 30 in Lesotho
Vodafone PPP	$0	$576,804	$576,804		$0	Last payment for Vodafone PPP due October 15, 2018.
Health Information Systems for Impact	$3,000,000	$0	$3,000,000	4	$0	Robust monitoring of clinical programs
Violence Against Children Study	$3,000,000	$0	$3,000,000	1	$0	Conduct a violence against children study
Provide Miner Friendly Services for Integrated TB/HIV Care (PROMISE)	$999,998	$0	$999,998	1	$0	Assess impact of enhanced TB/HIV services to miners and their families
Comprehensive TB and HIV Program Evaluation	$150,000	$0	$150,000	1	$0	Evaluate the national TB and HIV programs and implement a package of TB infection control practices
Implementation and evaluation of differentiated HIV care and treatment for people with advanced HIV disease in Lesotho	$150,000	$0	$150,000	1	$0	Determine impact of core interventions for PLHIV initiating ART with CD4<200
Lesotho Population HIV Impact Assessment (PHIA)	$7,500,000	$0	$7,500,000	1	$0	Population based HIV impact assessment.
HIV Drug Resistance Survey	$380,000	$0	$380,000	1	$0	Determine levels of drug resistance to facilitate program and national planning efforts towards 90-90-90
Total	**$17,070,720**	**$1,876,802**	**$18,947,522**		**$0**	

*The majority of the PEPFAR non-COP resources are for evaluations and research projects. The only central funding for COP18 are the Cervical Cancer funds. The only PPP is the Vodafone PPP which will have its last payment in October 2018

2.3 National Sustainability Profile Update

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 89 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across four domains (1. governance, leadership, and accountability; 2. national health system and service delivery; 3. strategic investments, efficiency and sustainable financing; and 4. strategic information) and a total of 15 elements within these domains. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

PEPFAR Lesotho completed a SID to assist with identifying areas of weakness that are critical to the HIV and AIDS response and the attainment of epidemic control in Lesotho. The SID process for COP18 began with the formation of the SID technical working group (TWG), co-chaired by UNAIDS Lesotho. The SID TWG was composed of PEPFAR Lesotho, UN Agencies, MOH senior management, Civil Society Organizations (CSOs), PEPFAR implementing partners (IPs), and PEPFAR technical staff. PEPFAR Lesotho oriented the TWG during a one-day workshop on the matrix of the tool. The COP18 SID workshop was well-attended and well-engaged. The TWG members were allocated to each of the four domains and provided responses to the elements with supportive documentation. The draft SID generated by the TWG was circulated widely to a broader stakeholder group in the health sector, and received overwhelming feedback. MOH senior management buy-in into the SID was secured, and the SID was finalized in November 2017.

Among the 15 sustainability elements, "planning and coordination" scored "sustainable" (green), "policies and governance" and "civil society engagement" scored "approaching sustainability" (light green), and the remaining 12 elements scored "emerging sustainability" (yellow). With 20% of the elements scoring "sustainable", the Lesotho HIV/AIDS response is moving towards sustainable epidemic control.

The elements that scored "emerging sustainability" (yellow) included private sector engagement, public access to information, service delivery, human resources for health, commodity security and supply chain, quality management, laboratory, domestic resource mobilization, technical and allocative efficiencies, epidemiological and health data, financial/expenditure data, and performance data. Of note, "public access to information" regressed from sustainable (green) in COP15 to "emerging sustainability" (yellow) in COP17 due to changes in assessment criteria.

Following up on COP15 investments and Test and Start agenda, PEPFAR Lesotho will continue to invest in policies, governance activities, and service delivery. PEPFAR Lesotho will focus investments in commodity and supply chain management, epidemiological and health data, and laboratory commodities and systems due to sustainability vulnerabilities in these areas. In COP18, PEPFAR Lesotho will continue to support the MOH to strengthen these elements, which are in

line with the PEPFAR Lesotho 2015-2020 strategic plan. PEPFAR Lesotho will provide technical support and capacity building to the MOH through the Supply Chain Coordination Unit (SCCU), District Health Management Teams (DHMTs) and the National Drug Services Organization (NDSO) to ensure that there is a fully functional GOL-led HIV/AIDS commodities and supply chain management (SCM) system, which can guarantee 100% commodity security for all HIV-related commodities, such as pharmaceuticals, laboratory commodities, and condoms. Optimization of information systems such as electronic registers and DHIS2 at the health facility level will ensure timely, complete, and accurate data management to inform programmatic planning by the host country. Several surveys scheduled for COP18, such as the Violence Against Children Survey (VACS) and the HIV resistance survey, will provide the epidemiological data needed for improved programming. Finally, support to laboratory services will include continuous quality improvement, optimization of laboratory referral services, improving efficiency of laboratory information systems for effective patient care, and laboratory equipment maintenance and inventory to reduce service interruptions (refer to Section 6.0 for more details).

PEPFAR and GF have synergized resources in Lesotho to address gaps in sustainable epidemic control. GF invests directly into the Ministry of Finance as a prime partner and the MOH as a sub-recipient. Therefore, it has been able to build capacity from within the finance and health sectors, addressing elements of "domestic resource mobilization", "policies and governance", "service delivery", "quality management", and "financial/expenditure data".

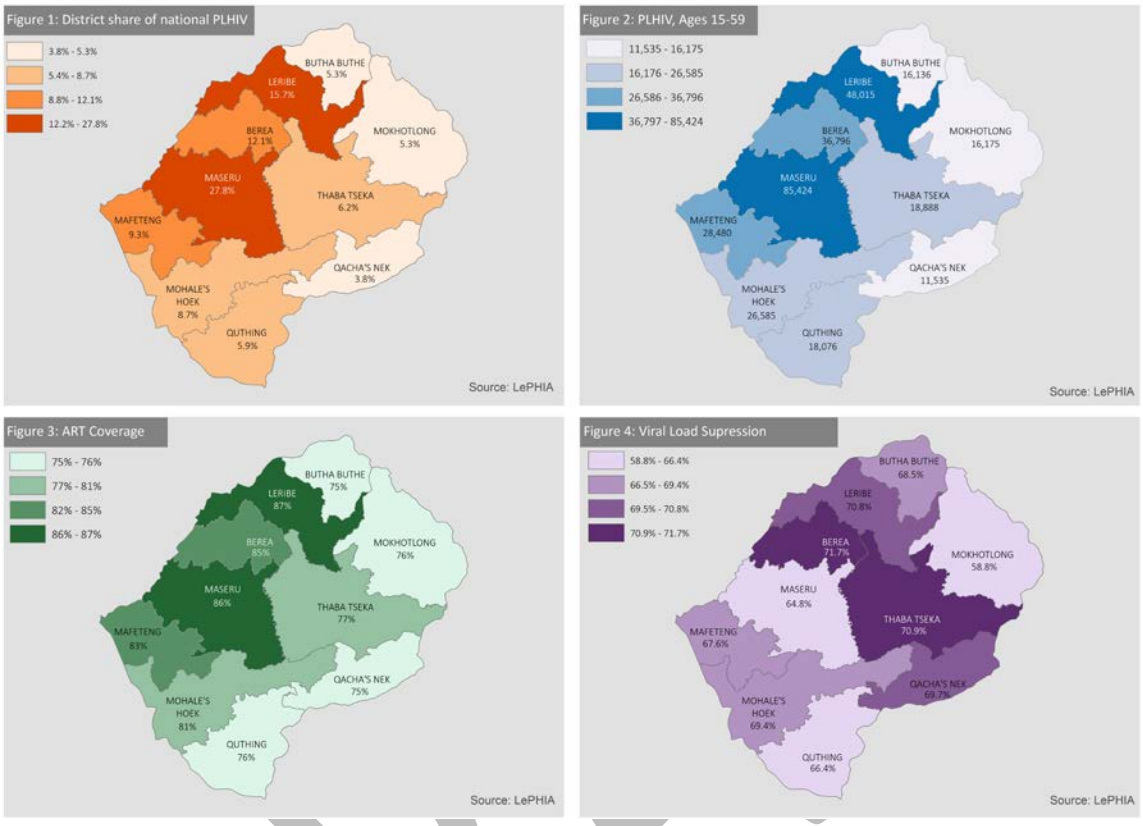
2.4 Alignment of PEPFAR investments geographically to disease burden

According to LePHIA 2016-2017, HIV prevalence is similar among most districts in Lesotho, ranging from 23% in Berea to 29% in Mohale's Hoek. The exception to this is Butha-Buthe where the prevalence is 18%. The HIV burden in Lesotho, however, remains in the more densely populated and more urban lowlands to the west and southwest of Lesotho, which encompasses the districts of Maseru, Leribe, Berea, Mafeteng, and Mohale's Hoek. These five districts account for 74% of all PLHIV and have been PEPFAR "scale-up" districts since COP15.

Maseru, Leribe, and Berea are the top three districts with the largest percentage of PLHIV nationally (28%, 16%, and 12%, respectively). As such, PEPFAR investments are strategically allocated to these districts, which accounted for 38%, 19%, and 19% of all district-specific funding in COP16, respectively. In COP18, both Maseru and Berea will remain DREAMS districts.

It is expected that the districts of Berea and Mafeteng will reach 90% ART coverage by the end of COP17. Therefore, PEPFAR plans to expand to 45 sites in the five highland (formerly "sustained") districts during the remainder of COP17 using a technical assistance approach to provide enhanced service delivery to an additional 35,000 PLHIV on ART, leading to 99% PEPFAR coverage. PEPFAR investments in these sites will result in improved case-finding (e.g. index testing, self-testing, partner notification) in the catchment areas of these health facilities, including opportunities for expansion of facility-based PrEP and men's clinics, in order to reach national 95-95-95 targets and epidemic control in Lesotho.

Figure 2.4.1 Lesotho: People Living with HIV (PLHIV), Treatment Coverage, and Viral Load Suppression, FY17



2.5 Stakeholder Engagement

COP18 development included various stakeholders from the Ministry of Health, Ministry of Social Services, CSOs, GF, National AIDS Commission, United Nations Agencies, Christian Health Association of Lesotho, and other select local non-government organizations in its three-day, in-country planning meeting from 30th January to 2nd February. CSOs that participated included Lesotho Network of AIDS Services Organizations (LENASO), Lesotho Network of People Living with HIV and AIDS (LENEPWHA), MATRIX, Lesotho Council of NGOS (LCN), Lesotho Inter-Religious AIDS Consortium (LIRAC), SkillShare Lesotho, Care for Basotho, and Phelisanang Bophelong (PB). Prior to this meeting, COP18 guidance, along with an abbreviated version of the funding level letter and critical data and materials (including POART FY17 Q4 data) were disseminated to all stakeholders to allow them to come prepared with a baseline understanding of PEPFAR achievements and gaps and to allow for enhanced input. This three-day, in-country planning meeting was well-attended and well-engaged. Stakeholders expressed general agreement with many of the COP18 strategic priorities and provided helpful feedback and commitment for the way forward.

Representatives from the MOH, CSOs (LENASO and LENEPWHA), GF, WHO, and UNAIDS participated in the five-day, regional planning meeting (RPM) in Johannesburg from 19th to 23rd

February. Stakeholders contributed to effective discussion and agreed on the collaborative objectives and approaches for COP18. In addition, GF has been particularly involved in COP18 development processes due to their grant-making (which was occurring at the same time), in order to maximize synergy with PEPFAR Lesotho.

The wider CSO community was briefed on updates from the Johannesburg RPM on 13th March 2018. Draft versions of the strategic direction summary were circulated to them for comment three days prior to final submission on 15th March 2018. The following are their concerns and considerations for PEPFAR Lesotho:

1) HIV prevention activities: prevention plays a significant role towards attaining epidemic control and decreasing HIV incidence. PEPFAR should consider increasing their efforts and funding towards prevention activities.
2) Support for local organizations: investments in local organizations are cost-effective, and can promote innovation, ownership, and sustainability. PEPFAR should consider directly supporting indigenous organizations and make mandatory that all international organizations receiving PEPFAR funds partner or sub-grant with local CSOs.
3) Cervical cancer screening: PEPFAR should consider funding local CSOs to provide cervical cancer screening, as well as demand creation for it.
4) COP18 strategic direction summary (SDS) review: PEPFAR should consider allowing CSOs at least one week to sufficiently scrutinize the SDS in order to provide meaningful contributions.

3.0 Geographic and Population Prioritization

Consistent with the PEPFAR pivot, PEPFAR Lesotho focused activities in five of the ten districts in COP15 and COP16. These "scale-up" or lowland districts (Maseru, Berea, Leribe, Mafeteng, Mohale's Hoek) accounted for approximately 75% of the HIV disease burden; 120 treatment sites were supported. In COP17, PEPFAR Lesotho expanded treatment activities to 18 high-volume sites in the five "sustained" or highland districts (Butha-Buthe, Mokhotlong, Thaba-Tseka, Qacha's Nek, Quthing), along with another 28 sites in the lowland districts. Altogether PEPFAR Lesotho is now supporting 161 treatment sites. In COP18, PEPFAR Lesotho will provide additional direct service delivery support for public and private facilities in the five highland districts, which will account for ~99% of all PLHIV currently on treatment in Lesotho. All districts will be considered "scale-up saturation" in COP18. A total of 208 treatment sites will be supported with nearly all facilities having a minimum of 200 PLHIV on treatment. The additional funding in COP18 will allow PEPFAR Lesotho to increase the capacity and quality of HIV services nationwide, thereby making attainment of the national 95-95-95 goals more likely.

As of quarter 1 in COP17, PEPFAR Lesotho had not reached attained status for ART for any of the ten districts. However, results of the 2016-2017 LePHIA showed good progress towards the UNAIDS 90-90-90 goals with national coverage of 77% of PLHIV being diagnosed, 90% of those on treatment, and 88% virally suppressed. Unfortunately, program data currently available shows substantially lower results. This makes it difficult to accurately measure our progress. In COP18, populations to be prioritized include adolescents/young adults and males as they currently have the lowest coverage rates for ART. The goal in COP18 is to achieve at least 81% treatment coverage in all age and sex bands and 90% treatment coverage overall for the national population of PLHIV.

Efforts to reach priority populations (males and adolescents/young adults) include establishment of men's clinics and adolescent corners in high-volume sites. Preliminary data indicate that these efforts have been successful in attracting greater numbers of PLHIV in these two groups. We have been able to achieve high HIV testing services (HTS) yield, linkage to treatment, and retention. We plan to scale these up significantly in COP18.

In COP17, PEPFAR is providing VMMC in the five lowland districts, with a target population of 15-29 year olds. Overall coverage as of COP17 Q1 was 55%, ranging from 34% in Mohale's Hoek to 69% in Maseru. Efforts in COP18 will strategically focus on males <20 years of age in these five districts in order to provide VMMC before males become old enough to attend initiation schools where they undergo traditional circumcision. Providing VMMC to men who have already undergone traditional circumcision has had limited success. GF provides support for VMMC in the other five highland districts of Lesotho. The COP18 goal is to achieve 80% VMMC coverage among males 10-29 years of age in the five lowland districts supported by PEPFAR.

Table 3.1 Current Status of ART Saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP18**	**# Current on ART (FY17)**	**# of SNU COP17 (FY18)**	**# of SNU COP18 (FY19)**
Attained	N/A	N/A	N/A	N/A
Scale-up Saturation	332,900 / 100%	222,816	10	10
Scale-up Aggressive	N/A	N/A	N/A	N/A
Sustained	N/A	N/A	N/A	N/A
Central Support	N/A	N/A	N/A	N/A

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 Finding the missing, getting them on treatment, and retaining them

Lesotho's HIV incidence rate of 1.5% and prevalence of 25.6% among adults aged 15-59 years show that the country is facing a high HIV disease burden. The GOL has adopted the UNAIDS 90-90-90 goals for epidemic control. The national HIV/AIDS response shows significant improvements with 77% Basotho living with HIV diagnosed, 90% of those diagnosed are on treatment, and 88% of those on treatment virally suppressed.

The national policy framework provides a conducive environment to aggressively scale up treatment coverage to 90% by 2020. The HIV testing and counseling policy guidelines have lowered the age of consent to 12 years and emphasize age- and gender-specific modalities for HIV case identification. The MOH has already adopted the policy for HIV self-testing (HIVST), partner notification, and index testing. The national rollout of the Test and Start policy in June 2016 has continued to increase treatment uptake for all PLHIV, irrespective of CD4 counts, and the policy shift for treatment monitoring has increased uptake of routine viral load (VL) monitoring.

PEPFAR Lesotho's COP18 strategic goal for epidemic control is to contribute to the national HIV response to achieve 95% of people living with HIV identified, 95% of those identified on treatment, and 95% of those on treatment virally suppressed. PEPFAR will focus on finding the PLHIV who don't know their status, getting them on treatment, and retaining them in care to achieve sustained viral suppression, reduce new HIV infections, and improve quality of life. PEPFAR Lesotho will continue to leverage the GOL and GF to procure HIV test kits, ARVs, essential drugs, therapeutic/supplementary feeding, and other medical supplies for adult, pediatric, and adolescent HIV services. The MOH is committed to providing leadership on policy transitions on the use of more efficacious ART regimens that are aligned to WHO guidelines. PEPFAR Lesotho will support the MOH in the policy shift to offer tenofovir/lamivudine/dolutegravir (TLD) as the preferred first-line ART for adolescents (>= 10 years old and body weight >= 30 kg) and adults.

In COP18, Lesotho will implement HIV recency surveillance using a commercial point-of-care (POC) recency test.

The section below provides key programmatic activities across both genders and all age groups that will be implemented during COP18 to reach national 95-95-95 targets.

4.1.1 Children aged <15 years

PEPFAR Lesotho's pediatric and adolescent treatment services are aligned to the revised national strategic plan, whose goal is to attain 90% treatment coverage for children living with HIV/AIDS by 2020. Over the last three years, PEPFAR's Accelerating Children's HIV/AIDS Treatment (ACT) initiative implemented in the five lowland districts has significantly contributed to improved pediatric treatment coverage from a baseline of 15% (APR2014) to 70% coverage based on LePHIA. The ACT initiative was a two-year initiative that ended in COP 2016 and all activities have been integrated in COP planning. The mother-to-child transmission (MTCT) rate of HIV of 1.6%, per APR2017, demonstrates that the prevention of mother-to-child transmission of HIV (PMTCT) program is significantly contributing to reduced new pediatric infections. This rate is lower than the 30% MTCT rate in the context where PMTCT services are not provided. HTS-to-treatment linkages for children aged below 15 years continue to be high at 89%.[6] Health care workers, especially in the five ACT districts, have received on-going training and mentorship, which improved their competencies on pediatric treatment.

Despite these achievements, the unmet need for treatment is still high at 50% for adolescent boys, 43% for adolescent girls, and 24% for children aged 0-14 years.[ibid.] The adolescent and pediatric clinical cascade shows programmatic gaps that must be addressed. The cost per pediatric positive identified is high and it is influenced by the low pediatric HIV prevalence of 2.1%, low HTS yield, and the gains of the PMTCT program. As a result, HIV case identification for the remaining undiagnosed children and adolescents should be targeted using modalities that provide the highest yield and volume. Program data shows that 12-month retention rates have significantly improved to >80% for children aged 1-14 years, but remains low for infants at 65%.[ibid.] The APR2017 results show that VL uptake is highest in children aged 10-14 years at 76% with viral suppression rates at 90%.[ibid.]

During COP18, PEPFAR Lesotho remains committed to scaling up pediatric ART coverage, building on achievements of the ACT initiative, and expanding programming to all ten districts. The COP18 pediatric programmatic priorities include: 1) sustain the momentum of early infant diagnosis (EID) coverage for HIV exposed infants aged <2 months to at least 90%; 2) optimize HTS in all service outlets at facility and community levels; 3) scale up of family index testing for pediatric case identification; 4) expand treatment coverage to 90% in children and adolescents living with HIV; 5) strengthen retention to 90% for children living with HIV (CLHIV) on treatment; 6) increase uptake and coverage of routine VL monitoring; and 6) expand TB/HIV services to improve TB prevention and treatment for all TB/HIV co-infected children.

[6] LePHIA,2016-2017

In order to achieve these goals, family-centered and integrated service delivery models will be scaled up in all PEPFAR-supported sites. PEPFAR Lesotho will continue using the direct service delivery approach in all sites providing pediatric and adolescent-friendly HIV services. Critical site-level staff will be supported to improve service uptake (i.e. nurse clinicians, professional counselors, lay counselors, records officers, and adolescent youth ambassadors). In the community, PEPFAR Lesotho will continue to work with mentor mothers, community navigators, OVC community service providers, and focal persons to increase service uptake. Through Mothers 2 Mothers, PEPFAR Lesotho has mentor mothers at 36% of the sites in the five lowland districts. These sites have the largest percentages of newly identified HIV positive pregnant women. A district-level, multi-disciplinary team comprised of a pediatrician, psychologist, social workers, program performance improvement officers, and strategic information and evaluation officers will provide supportive supervision and capacity building on pediatric and adolescent HIV management.

HIV case identification will be enhanced using community- and facility-based modalities. Targeted mobile, community index testing, and testing of orphans and vulnerable children (OVC) at community level will be scaled up. At facility level, provider-initiated HIV testing and counseling (PITC) services will be saturated at all entry points (i.e. maternal and child health (MCH), pediatric inpatient wards, outpatient departments (OPD), and TB clinics) and index testing in the ART clinics. Community mobilization and bi-directional referrals for treatment will be enhanced using the existing community linkage navigators, OVC, service providers, village health workers, mentor mothers, and focal persons. Longitudinal tracking of mother-infant pairs will be strengthened to increase EID uptake for all HIV exposed infants aged <2 months of age. PEPFAR will leverage on the UNITAID POC machines to increase EID uptake. Until UNITAD transitions, PEPFAR will continue supporting QA/QI activities. Following the transition, PEPFAR will coordinate with the MOH and GF. The expectation is that PEPFAR will provide partial support for reagents and supplies as part of VL/EID commodities and the MOH and GF will support maintenance and replacement of POC instruments and parts.

PEPFAR Lesotho will continue to support comprehensive on-the-job trainings and mentorships to improve skills and competencies of health care workers in pediatric and adolescent treatment, including provision of efficacious regimens, same-day ART initiation, pediatric adherence counseling, disclosure of HIV status support, retention support, and treatment monitoring for early detection of treatment failure. Technical support will be provided to decentralize 2ndline pediatric management of ART to district level.

CLHIV will receive a core essential HIV care and support package to reduce pediatric morbidity and mortality that includes: 1) TB screening, prevention, and treatment; 2) cotrimoxazole prophylaxis; 3) nevirapine prophylaxis for exposed infants; 4) growth monitoring; 5) infant and young child feeding counseling; 6) nutrition assessment, counseling, and support (NACS); 7) linkage to immunization services; 8) treatment of opportunistic infections; 9) linkage to OVC services; and 10) micronutrient supplementation based on age.

Adolescent-friendly health care services will be scaled up through either designated adolescent corners located in high volume sites or integrated in routine ART clinics for medium- to low-volume sites. The service package for adolescents living with HIV includes: 1) index testing and partner notification; 2) sexually transmitted infections (STIs) screening and management; 3) clinical prevention through cotrimoxazole prophylaxis, TB preventive therapy, and cryptococcal screening for late-presenters; 4) integrated PMTCT services for pregnant adolescents; and 5) voluntary family planning services and condoms. In addition, all adolescents will be provided with routine opt-out PITC, post-exposure prophylaxis (PEP) as necessary, and linkage to PrEP and VMMC services for eligible adolescents.

Adherence and retention support will be enhanced through differentiated models of care that include: multi-month dispensing for stable older children and adolescents, weekend or extended clinic hours, family-centered community adherence groups, and peer support through adolescent ambassadors. Retention and VL uptake for infants will be improved through same-day appointments with their PMTCT mothers or caregivers and PEPFAR will introduce the use of dry blood spots (DBS) for VL monitoring. Ariel clubs, teen clubs, adolescent clubs, and caregiver support groups will be expanded targeting high-volume sites. Cohort monitoring for retention, aging-out, and successful linkage to adolescent or adult HIV treatment program will continue to be strengthened through the use of innovative approaches like electronic registers, unique identifiers (of mother-infant pairs and children/adolescents on treatment), mobile health (mHealth) technology, and active community follow-up of defaulters.

At the national level, PEPFAR Lesotho will continue supporting the MOH national coordination framework for pediatric treatment through the PMTCT/Pediatrics TWG, and collaborate with MOH to provide oversight on pediatric training and supportive supervision. At district level, PEPFAR Lesotho will continue to provide technical support to the DHMT to improve and monitor the quality of care delivered to CLHIV through site mentorships, supportive supervision, and performance monitoring using patient outcome measures. Collaborative quality improvement (QI) approaches will be used to improve site-level pediatric cascade linkages.

4.1.2 Adult male 15+ years

COP18 treatment, care, and support will focus on identification of undiagnosed men to break the cycle of transmission to partners, families and broader sexual networks. The LePHIA showed an HIV annual incidence rate of 1.2% and HIV prevalence of 20.8% among males aged 15-59. Despite lower HIV annual incidence and HIV prevalence, only 71% of adult males aged 15-59 know their HIV status in comparison to females at 81.5%. Analysis of DHS 2014 demonstrated that adult males in Lesotho were less likely to seek health care services, and thus have inadequate uptake of HIV testing and other related services. Once men are identified, however, treatment and suppression rates are similar to their female counterparts according to LePHIA. Adult males are more likely to be late presenters to HIV treatment and care services. The LePHIA indicated that

25.9% of adult males previously diagnosed and not on ART had a CD4 cell count of less than 200 cells/µl at the time of the survey.

Key programmatic gaps include: 1) low coverage of initiatives to identify men living with HIV, which includes partner testing/partner notification, men's clinics, mobile testing to target workplace and other sectors, and self-testing; 2) low ART coverage for men, especially aged 25-34 years; 3) low coverage of same-day community ART initiation in male-dominated settings; and 4) inadequate linkages of HIV-positive adult men to treatment and HIV-negative adult men to VMMC and PrEP services.

The focus of COP18 funds will be used to scale up COP17 initiatives that have demonstrated to be effective in closing the gaps for meeting 90-90-90 targets in this population.

PEPFAR Lesotho will scale up HIV case identification strategies that have demonstrated potential to identify more HIV-infected adult males in the COP17 implementation period. In COP18, PEPFAR support will continue to scale up index family mapping and testing for all patients currently on treatment. In COP17, PEPFAR Lesotho is supporting a patient file audit to establish the current coverage for index testing for all patients' current on treatment. PEPFAR testing IPs (facility and community) are ensuring that all index cases are listed, family members are registered, and those eligible are provided HIV testing, including other sexual partners. These services will be available at both the facility and community and will ensure that identified positives are initiated on ART promptly. The positivity yield among partners of newly diagnosed patients was at 30% in facilities COP17 Q1. The overall coverage for index testing hasn't been established, hence the need for the patient file audit. Scale-up of this strategy in COP18 is critical to identifying adult men aged 25-34 as they are less likely to present at facilities.

PEPFAR-supported HIV testing partners will scale up assisted partner notification services (APS), which includes notification and HTS for sexual partners of newly diagnosed HIV-positives (index cases). Lesotho has already adopted the policy for partner notification. PEPFAR Lesotho will support assisted partner notification methods, such as face-to-face communication, phone calls, text messages, and WhatsApp-based video messaging, and will ensure that the different options of notifying partners (client referrals, provider referrals, contract referrals) are available at supported sites.

Lesotho is currently piloting HIVST. Preliminary data have demonstrated high uptake, especially among males aged >20 years. The priorities for COP18 are to expand channels for HIVST kits distribution at facility and community levels, introduce open access for HIVST, and ensure male-dominated workplaces are adequately covered. Targeted HIV testing for men (including hot spot areas where men congregate) have resulted in high absolute numbers of HIV positive men identified. This intervention will be scaled up and integrated with HIVST, particularly in areas with lower ART coverage for men. While PEPFAR Lesotho will provide buffer stock for HIVST kits, it will leverage resources from MOH and GF to ensure a consistent supply of HIVST kits.

To get men on the fast track for treatment, PEPFAR Lesotho will scale up the current eight facility-based, men's clinics to 17 by the end of COP17, and an additional 18 will be established during the COP18 period. At the end of COP18, PEPFAR will support the establishment of a total of 35 men's clinics as a strategy to increase access to services. Thus far, the men's clinic initiative has demonstrated high HIV testing uptake of >98%, linkage to treatment of 100%, and improved retention and VL suppression. This is a collaborative effort with the host government, which includes establishment of dedicated space within a health facility. Health care workers are trained on men's issues and male staffs are usually deployed in these corners to provide health services. The package offered includes: 1) STI screening and treatment; 2) HIV testing, care and treatment; 3) PrEP for men at substantial risk of acquiring HIV (including those in sero-discordant couples); 4) screening and treatment for TB, opportunistic infections (OIs) and other co-morbid conditions; 5) condom distribution; 6) counseling on healthy relationships; 7) counseling on HIV prevention; 8) education on PMTCT and index family testing; and 9) referrals for VMMC. PEPFAR resources will be used to support HIV- and TB-related services, while host government resources will be leveraged to provide a wide range of primary care services, including multi-disease screening for conditions that affect men (diabetes, hypertension, and cardiac disease).

In addition to the establishment of men's clinics, PEPFAR Lesotho will continue to support provision of critical staff related to meeting the adult male 90-90-90 targets at all supported sites. These include clinicians, counselors, record assistants, and linkage facilitators. These staff are critical to providing baseline assessments, treatment preparedness and education, diagnosis and treatment of OIs, and tracking linkages and retention. Late presenter's service package implementation will be enhanced at supported sites. Placement of critical staff is a collaborative effort between PEPFAR and key stakeholders, such as MOH, GF, DHMTs, and health facility leadership.

Same-day community ART initiation, a collaborative effort between the MOH, PEPFAR clinical partners, PEPFAR testing partners, and DHMTs, has demonstrated high uptake of HIV services. COP18 funds will be used to scale up community ART teams that will be stationed in settings frequented by adult males. PEPFAR community partners will enhance coordination with community structures, including chiefs and church leaders, to generate demand and promote uptake of HIV services, disseminate quality messages for community ART initiation, and address harmful social, structural and gender norms. Targeted areas for adult males for community ART same-day initiation include workplaces and areas where men congregate (such as high traffic cross-border points, mines, construction sites, taxi ranks, and corporate sectors). COP18 resources will also be used to enhance features of the mHealth application (CommCare, DiMaagi) to enhance tracking and linkage to health facilities for continuation of ART.

To fast track national 95-95-95 goals, optimized ART regimens are critical for increasing coverage among adult males through improved treatment outcomes, adherence, VL suppression, and quality of life. Linked with the overall national TLD transition plan, PEPFAR Lesotho will ensure that adult males are prioritized in the transition plan. In addition, HIV-infected adult males are

more likely to present with TB and will require an additional 50mg dolutegravir twice daily. PEPFAR will advocate for its availability in country.

Both LePHIA and program data demonstrate that once identified and initiated on ART, retention on ART and VL suppression rates of males is similar to their female counterparts. During COP18, PEPFAR Lesotho will support initiatives critical for attaining 95% retention and 95% VL suppression among adult males to break the infection cycle. Interventions implemented in COP17 will be scaled-up to improve the 3rd 90 among adult males.

PEPFAR Lesotho, in collaboration with the DHMTs, will scale-up community ART distribution/re-fills through integrated outreaches. This cost-effective intervention will be scaled-up in COP18 to cover all applicable supported sites in the ten districts. Multi-month dispensing is critical for stable adult patients to improve adherence to treatment and reduce costs of accessing ART. Many Basotho frequently travel to South Africa for work, study, and other reasons and have difficulties in accessing refills for their ART supply. PEPFAR clinical partner will work with the PEPFAR supply chain partner and relevant MOH departments to ensure that 90% of the stable ART adult males transition to multi-month dispensing.

Through community partners, PEPFAR Lesotho will support the scale-up of adult men community ART groups (CAGs). In addition, PEPFAR will continue to support training of male CAGs on TB screening, gender norms impacting men's health, and overall well-being of CAG family members.

PEPFAR-supported clinical sites will be required to achieve 90% enrollment of all adult males in the mHealth program. This is critical to support retention by sending reminders for adherence to medication and clinic visits for ARV drug refills and VL monitoring. In addition, the mHealth application will be used to provide targeted adult male health messages for psychosocial support and to generate demand for HIV prevention services.

PEPFAR-supported clinical and laboratory partners, in collaboration with MOH, will implement the current Lesotho VL strategic plan. This collaboration will ensure that VL testing coverage for adult males is increased to 95% through improved specimen referrals and increased access to DBS VL. At site level, the clinical implementing partner will ensure completion of VL registers, expedite tracking of unsuppressed adult males, provide enhanced adherence counseling, and ensure that adult male ART patients who require a switch to second line treatment are smoothly transitioned.

4.1.3 Adult Women 15+ years

HIV prevalence among women aged 15-59 years is at 30.4% compared to 20.8% in their male counterparts.[7] Women are particularly affected during their peak years of work productivity, with prevalence peaking in the 35-39 and 40-44 year olds at 49.9% and 48.3% respectively.[7] HIV prevalence is higher among women who are widowed at 59.9% and divorced or separated at

[7] LePHIA, 2016-2017

51.3%.[7] GOL adopted the UNAIDS fast-track goals for HIV epidemic control and current national results demonstrate that 82% of women living with HIV have been diagnosed, 91% of those who know their HIV status are on treatment, and 88% of those on treatment are virally suppressed. Program results show high uptake of facility-based HTS with >95% of adult women who present at health facilities (in OPD, in-patient, MCH, and adolescent corners) knowing their HIV status. National results show that treatment uptake has steadily increased and adult women aged >15 years account for 61.6% (112,750) of the total patients on treatment.[8]

Although the majority of patients on treatment in Lesotho are adult women, their unmet need for treatment is still high at 26.2%, with women aged 15-39 years of age accounting for 77% (29,608) unmet need to attain 90% treatment coverage.[9] Population viral suppression rates among women aged 15-59 years are still below the UNAIDS goal at 70.5%.[ibid.] Programming gaps are aligned to the clinical care cascade and include: 1) low coverage of partner notification and index testing services; 2) inadequate coverage of HIVST; 3) sub-optimal linkages from HTS to treatment, especially for 7.6% adult women who know their HIV status and are not yet on treatment;[ibid.] 4) and low retention rates due to inadequate documentation, internal and cross-border migration, and ART refill appointments that coincide with busy work schedules. The use of manual data collection and reporting systems further affect cohort monitoring.

COP18 strategic goals for this target population are to: 1) identify 95% of women living with HIV; 2) attain national level treatment coverage of 90% among adult women; 3) improve retention rates to 95% for new and those already on treatment; and 4) and attain viral suppression rates of 90%. The program will build off gains made in COP17 relating to the national rollout of Test and Start, use of the direct service delivery model to close cascade gaps, and provision of differentiated service delivery models to improve retention and viral suppression rates.

COP18 strategies to identify undiagnosed adult women will focus on expanding HTS modalities that result in high yield and high volume of HIV-positive women. Program data show 68% of OPD and 76% of inpatient admissions are women and the overall yield in these settings is high. PEPFAR Lesotho will continue optimizing PITC services through the use of a screening tool and risk assessment to determine eligibility for testing at all service outlets.

HIVST will be used to complement all other testing approaches, including partner notification and index family mapping and testing which will be scaled up at facility and community levels as a strategy to identify HIV-positive partners who need treatment. HIVST services will be scaled up targeting FSWs and women in the corporate sector, tertiary institutions, and prisons. In addition, HIVST will be rolled out in the health facilities (especially adolescent corners) for those who decline PITC. Facility and community index testing will contribute to at least 20% of the total HTS results. Assisted partner notification methods, such as face-to-face communication, phone calls, text messages, and WhatsApp-based video messaging will be supported. PEPFAR Lesotho

[8] MOH November 2017 DHIS II ART Report
[9] LePHIA, 2016-2017

will ensure that the different options of notifying partners (client referrals, provider referrals, contract referral) will be available at supported sites. At community level, PEPFAR will scale up targeted mobile testing so as to identify underserved adolescent girls and young women (AGYW), FSWs, and women in hard-to-reach areas. Demand creation for HTS services will be scaled up through village health workers and community focal persons. PITC officers will provide mentorship and supervision of lay counselors, monitor site-level PITC coverage rates, and oversee the Quality Assurance/Quality Improvement systems of facility-based HTS services.

PEPFAR Lesotho will continue to improve the high HTS-to-treatment linkages to >90% in the supported districts. Same-day ART initiation for adult women who are ready to start treatment will be scaled up through active escort of patients within health facilities, and expansion of the community ART initiative targeting community counsels that identify a high number of positive adult women. Linkage navigators will actively track community-facility linkages using unique identifiers for the newly diagnosed women living with HIV (WLHIV). Pregnant women with a confirmed HIV positive status will be linked to the PMTCT program for on-going ART, antenatal care, and mother-infant pair support. The mHealth application will be utilized to track women who defer ART initiation at facility or community levels and will provide short message service (SMS) reminders for the two-week facility appointment for beneficiaries of the community ART initiative.

During COP18, PEPFAR Lesotho will continue scaling up non-facility-based HIV treatment services and increase treatment access targeting underserved WLHIV. The program will: 1) expand the number of units providing adolescent-friendly health services; 2) continue to leverage MOH and GF resources to expand the factory program; 3) expand treatment services and programs for FSWs and women in prison settings, tertiary institutions, and corporate and public sector institutions.

Adult WLHIV will continue to receive the PEPFAR Care and Support core package which includes: 1) cotrimoxazole prophylaxis for patients with WHO stage III or advanced HIV disease; 2) clinical and laboratory monitoring using routine VL testing; 3) management of OIs; 4) screening and management of TB, including TB preventive therapy (TPT); 5) screening and management of STIs; 6) screening and management of cryptococcal meningitis, including secondary prophylaxis; 7) NACS; 8) voluntary family planning services based on informed choice; 9) condom provision; and 10) adherence counselling and support.

Retention on treatment will be strengthened through client-centered services and delivery of differentiated models of care. The number of clinics that provide extended working hours, including weekends will be increased to reach WLHIV who are not able to access services during normal working hours. Multi-month dispensing will be expanded to at least 90% of sites as a strategy to extend clinic visits to 3-6 months. Fast-tracking of pharmacy refills and CAGs will be expanded to at least 90% of PEPFAR–supported health facilities. Pharmacy technicians will streamline site level commodity forecasting and ordering that is matched to the extended drug

refills. Integrated outreaches for hard-to-reach areas will be expanded and mobile clinical teams (along with community ART refills) will be utilized to increase access to treatment services (e.g. workplace, tertiary institutions and corporate organizations).

Focal persons and records assistants will utilize the mHealth application to provide SMS reminders on clinic appointments for both newly-enrolled and current-on-treatment and document patients who need active community tracking. Collaborative QI approaches will be used to improve cohort monitoring, including documentation in ART registers, updating of tracking outcomes, and documentation of VL uptake for WLHIV. Cohort monitoring will be further strengthened using the electronic registers that will have unique identifiers of women on treatment.

Site level staff will triage all adult women currently on ART to identify those eligible for VL testing based on national guidelines. Special attention will be provided for AGYW and pregnant women who currently have the lowest uptake of VL monitoring. [10] Their ART refill appointments will be aligned to the laboratory sample transport days. PEPFAR Lesotho will also explore the use of VL DBS, particularly for beneficiaries in hard-to-reach areas. Records assistants, counselors, and nurse clinicians will be actively engaged in ensuring that all laboratory forms are adequately filled, results from the central/regional laboratories are tracked and filed, and beneficiaries receive timely feedback of VL results. PEPFAR Lesotho will support the fast-tracking and return of unsuppressed VL results and will ensure enhanced adherence counseling is provided on time. Women with confirmed treatment failure will be switched based on national ART guidelines.

PEPFAR Lesotho will continue to finalize the data alignment systems with the MOH and implement electronic individual patient level data entry at high volume sites. Site, district, and partner-level performance reviews will be continued, which include: 1) monthly performance reviews to monitor coverage of index patient testing coverage; 2) ART enrollment rates; 3) clinical cascade linkages; 4) TB/HIV integration activities; 5) community tracking activities; 6) site-level commodity status; and 7) quarterly cohort monitoring for retention, VL uptake, and management of patients with unsuppressed VL.

4.1.4 Pregnant and Lactating women and HIV Exposed infants

The Lesotho national strategic goal for PMTCT is to eliminate new pediatric HIV infections and improve MNCH and survival in the context of HIV. The primary goal of the PMTCT program is to reduce MTCT rates to less than 5%. Lesotho continues to be among the top 20 countries with the highest global burden of HIV among pregnant women with a prevalence of 24.6%.[ibid.]

LePHIA shows significant improvements in the national PMTCT response; 97.1% of pregnant women have attended at least one antenatal care (ANC) visit. The 2014 DHS shows that 77.8% of

[10] LePHIA, 2016-2017

women attended at least four ANC visits and 76.5% of births occur at health facilities.[11] The number of new pediatric infections due to vertical transmission continues to decline from 1,600 in 2014 to 1,242 in 2016.[12] This could be attributed to the high PMTCT coverage where 95.6% of women (aged 15-49 years) who gave birth 12 months prior to the LePHIA survey knew their HIV status and 98.5% of HIV-positive pregnant women received ARVs for PMTCT.[13]

This performance trend is mirrored by PEPFAR program data that show high uptake of PMTCT services within health facilities. The APR2017 results show that 95% of pregnant women who attended their first ANC visit in the PEPFAR-supported sites know their HIV status and 93% of the identified HIV-positive pregnant women received ARVs to prevent MTCT. Program data show that the MTCT rate among HIV exposed infants (HEI) aged <2 months of age is 1.2%.

Lesotho has a strong national policy framework for scaling up PMTCT services. The NSP, PMTCT policy guidelines, and the Test and Start policy continue to have a positive impact on the national PMTCT program. Program trends show that 67% of positive pregnant women have a known HIV positive status and 72% of pregnant women were already on ART for their own health. The uptake of EID has continued to increase with >80% of HEI receiving EID services by two months of age.

In order to attain the virtual elimination goal, there is a need to consolidate the gains made in the national response while bridging the PMTCT clinical cascade gaps. Although Lesotho has a low birth rate of 3.3% and long birth intervals of 45.8 months, childbearing starts early with 19% of adolescent girls aged 15-19 years already having their first child.[11] During APR2017, 54% of new pregnancies identified were from AGYW aged 15-24 years with an HTS yield of 15% (for both known positives and newly diagnosed). Knowledge of PMTCT services is varied across different sub-populations. At least 76.9% of women aged 15-49 years know that HIV can be transmitted by breastfeeding and that a mother taking her ARVs during pregnancy can reduce the risk of MTCT. Knowledge of PMTCT services is lower in men aged 15-49 years (at 58.4%) and adolescent girls aged 15-19 years (at 65.2%), which affects early uptake and male-partner engagement.[11] Adherence and retention of mother-infant pairs is critical to attainment of the national virtual elimination goals. The retention rate for women who initiate ART in pregnancy or while breastfeeding is low, with a 12-month retention rate of 64%. Linking longitudinal tracking of mother-infant pairs to establish final PMTCT outcomes at 24 months of age is still a challenge, largely due to lack of a unique identifier, intra- and cross-border migration, and inadequate documentation in the under-five registers.

In COP18, PEPFAR Lesotho will continue supporting the national PMTCT elimination goal of attaining <5% MTCT rate in the ten scale-up districts. The COP18 strategic goals are to achieve 95% coverage of HTS, 95% treatment coverage for HIV-infected pregnant and lactating women

[11] LDHS, 2014
[12] SPECTRUM, 2016
[13] LePHIA, 2016-2017

identified, 90% uptake of EID services at two months of age, 95% retention of mother-infant pairs, and 90% viral suppression rates.

To achieve these targets, PEPFAR Lesotho's strategic shift is to expand the direct service delivery (DSD) approach from five to ten districts targeting pregnant/lactating women, their children, and partners. In addition, the program will consolidate the gains made in the existing sites, while expanding integrated service delivery for adolescents living with HIV focusing on primary prevention, prevention of unintended pregnancies among adolescents living with HIV, and providing them with HIV treatment and care services.

The PMTCT community engagement program will be restructured to increase knowledge on PMTCT and will intensify case-finding using village health workers, mentor mothers, and community health workers. During COP18, PEPFAR Lesotho will support early identification of pregnancy at the community level through regular screening for signs of pregnancy in women of childbearing age. Those who are found to be pregnant will be linked to facilities and enrolled in antenatal care as soon as possible. Mentor mothers will actively track pregnant women identified at community level who need to be linked to PMTCT services using the mHealth application and will document successful linkages. HIV-positive mothers will receive education on the benefits of health facility delivery, especially in the context of PMTCT.

Routine "opt-out" PITC will be provided within MNCH and adolescent health corners, and HIV-positive pregnant or lactating women will be offered same-day treatment initiation. PEPFAR Lesotho will continue to advocate with the MOH PMTCT unit to update the PMTCT policy guidelines so that all pregnant women with a known HIV-negative status receive HTS at their first ANC visit. Sites will continue providing HIV re-testing services during pregnancy, delivery, and postnatal periods to identify those who seroconvert. All PEPFAR supported health facilities are providing couples' testing for women who attend ANC and their partners. Index testing, partner notification, and HIVST services will be offered to partners of pregnant and lactating women, and these partners will be linked to HIV prevention (VMMC and PrEP) and treatment services based on their HIV diagnosis. Any HIV negative women with an HIV-positive partner will also be referred for PrEP services.

Adherence and retention support will be provided to all pregnant and lactating women who are on ART. At facility level, adherence assessments will be conducted at each visit, health education on the benefits of sustained use of ARVs during pregnancy and lactation will be provided, and mothers will receive routine VL monitoring to establish treatment outcomes. Pregnant and lactating women who are stable on ART will receive multi-month dispensing that is aligned to the gestational age, antenatal or postnatal visit schedule, and immunization schedule of their infants. Professional counselors will provide enhanced adherence counseling and support for all PMTCT mothers with unsuppressed VLs. District technical advisors (medical officers), will work with DHMTs and site level staff to enhance timely ART switches to second -line management for PMTCT mothers who are failing on treatment. HIV-positive lactating women aged >30 years will

receive cervical cancer screening and management based on PEPFAR and national guidelines. Support groups for various target sub-populations will be established at facility and community levels to provide peer support (i.e. for antenatal mother, post-natal mothers/caregivers of HEIs, and adolescent support groups).

During COP18, PEPFAR Lesotho will further strengthen services for HEI at facility and community levels focusing on finding them, providing the essential prevention and care package, retaining them through mother-infant pairs, and linking those who are confirmed HIV positive to treatment. The service package will include provision of mother-baby packs, nevirapine prophylaxis, cotrimoxazole prophylaxis, growth monitoring, immunizations, adherence counseling and support for parents/caregivers, and TB/HIV screening and treatment. EID services will be scaled up with a focus on increasing uptake of the first DNA PCR test to >90% at less than two months of age. PEPFAR Lesotho will leverage on the UNITAID EID POC machines to increase early uptake (within 2 months) of EID services. Infants with a confirmed HIV positive status will be fast-tracked for treatment initiation.

Retention of mother-infant pairs will be improved using peer counselors, mentor mothers, and linkage navigators who will conduct cohort tracking, actively follow up missed appointments, notify caregivers when EID results are received at sites to reduce turnaround time, and support linkage of mothers and newly diagnosed HIV-positive infants to the ART program.

HIV-positive women of reproductive age attending PMTCT, ART, and TB clinics will receive voluntary family planning education, counseling, informed consent, and voluntary access to a wide range of contraceptives levering resources from United Nations Population Fund (UNFPA) and MOH. WLHIV who wish to have children will receive safe pregnancy counseling.

PEPFAR Lesotho will continue advocating with the MOH to review the true number of pregnancies in Lesotho. The LePHIA, DHS 2014, and community PMTCT study all indicate >95% pregnant women attending at least one ANC visit, with only 4% receiving ANC in South Africa. LePHIA results show 95% PMTCT population level coverage, which is much higher than the UNAIDS 2015 report that indicated 62% national PMTCT coverage. PEPFAR will advocate with the MOH to triangulate these data sources with national census and program data to define the true denominator for PMTCT.

4.1.5 TB/HIV Priorities

Lesotho remains a high burden TB/HIV country with estimated TB incidence (including HIV/TB co-infection) of 724 per 100,000 population (16,000 incident TB cases, out of which 12,000 are estimated to be TB and HIV co-infected). With GF and World Bank support, Lesotho plans to conduct a population-based TB prevalence survey that will provide a better estimate for TB incidence. Based on the current estimates, the TB treatment coverage is estimated at 45% nationally.

For COP17, PEPFAR Lesotho's TB/HIV goals include: 1) achieve or maintain 100% HIV testing rates among all TB cases and patients with presumptive TB as a contribution to the first 90; 2) provide universal ART for all TB/HIV co-oinfected patients as a contribution to the second 90; 3) ensure timely TB diagnosis and treatment completion to ensure HIV viral suppression; 4) scale up TPT for all PLHIV without active TB disease and implementation of TB infection prevention and control interventions; and 5) support integrated and effective delivery of TB/HIV services at national, district, and site level.

Major strides were made in COP16 in achieving over 90% HIV testing coverage among notified TB cases and 90% ART coverage for TB/HIV co-infected patients. Despite the achievements in COP16, low TB treatment coverage persists (identified TB cases vs estimates by WHO) and sub-optimal TPT uptake continues to hamper performance of the TB/HIV program. The scale-up of TPT in Lesotho among PLHIV has been well below expectations (25% coverage of those eligible).

The TB/HIV national joint assessment conducted in November 2017, PEPFAR program data, and SIMS visits indicate that the low TB coverage is due to several factors, including underutilization of more sensitive rapid TB diagnostics (Gene Xpert MTB/Rif) for PLHIV, sub-optimal intensified TB case finding (ICF) among high-risk populations, low quality of screening among PLHIV, and gaps in linking the detected MDR-TB cases to treatment initiations.

COP18 TB/HIV priorities will be aligned to support the national TB/HIV response and addressing identified gaps.

To increase TB treatment coverage and identify 90% of all incident TB cases and place them on appropriate treatment, PEPFAR Lesotho will support the following programmatic activities: 1) continue to support staff for TB and HIV screening at all facility entry points (e.g. OPD, MNCH, ART, HTS) and ensure completion of cascade by "cough officers" and linkage facilitators; 2) continuous quality improvement (CQI) focused on the presumptive TB case finding register, including recording of results; 3) strengthen TB and HIV contact tracing and investigation through PEPFAR community initiatives, including differentiated care models (community ART groups, community ART initiation); and 4) support for TB/HIV nurses to promote TB/HIV co-treatment and adherence to national treatment protocols in the TB and HIV clinics.

The laboratory equipment inventory conducted in 2017 demonstrated that Lesotho has enough GeneXpert equipment to meet the testing demand. COP18 priority will be to increase, promote and optimize the utilization of current modern TB diagnostic equipment (GeneXpert/ MTB/RIF tests) by: 1) supporting update of the national tuberculosis and leprosy program guidelines, including update of the diagnostic algorithm; 2) increasing access and utilization of rapid and accurate detection of TB and drug-resistant TB; 3) supporting Riders for Health for rapid sample transportation; 4) supporting sample transportation with horses in hard-to-reach areas in collaboration with MOH; and 5) strengthening quality of TB laboratory services through MOH PEPFAR funding.

COP18 strategies will focus on supporting and strengthening the implementation of the TB diagnostic cascade at all supported sites and completion of the TB detection registers. This will ensure that facilities can accurately report on the TB diagnostic cascade on a monthly basis for the number of presumptive TB cases identified, number of presumptive TB cases tested for HIV, proportion of presumptive TB cases diagnosed with TB, proportion of TB patients initiated on TB treatment, proportion with known HIV status, and proportion initiated on TPT among those eligible. By closely monitoring the performance of districts across these indicators, it is anticipated that programming challenges will be identified early and addressed. PEPFAR Lesotho will continue to support forecasting, distribution, and ordering of TPT (isoniazid and pyridoxine for all facilities), and will support TB/HIV human resources at different levels so as to ensure eligible patients for TPT are initiated. PEPFAR Lesotho will support the review of current Lesotho guidelines for the 3Is (intensified case finding, isoniazid preventive therapy, infection control for TB). In addition, tools will be updated and health care workers retrained based on the WHO updated guidelines for latent TB infection programmatic management.

To enhance stewardship in the National TB Program and maximize resources for the achievement of the TB/HIV strategic goals, PEPFAR Lesotho will continue to support national strategic positions (TB/HIV technical advisors, TB strategic information at national level), strengthen TB/HIV management at district and site level, train and mentor healthcare workers, and support data quality improvement for TB indicators.

4.2 Prevention

4.2.1 HIV prevention and risk avoidance for AGYW and OVC

In response to the high numbers of OVC and the extreme vulnerabilities they face, the GOL has invested significantly in developing a number of supportive policies and strategies to provide an integrated response to these children. Though developed, not all of the policies and strategies have been fully implemented. The National Strategic Plan on Vulnerable Children April 2012 - March 2017 (extended to March 2018, and currently being revised) is the core guiding document for Lesotho's response to vulnerable children, coordinated by the National OVC Coordinating Committee (NOCC). Currently, the Ministry of Social Development is developing a standardized, HIV-sensitive case management system. The tools will have a particular focus on referrals to and from HIV prevention, care, and treatment, as well as on prevention of and response to gender-based violence (GBV)/violence against children. The OVC program will continue implementation using existing national frameworks.

The OVC program is geographically aligned and implemented within the five original PEPFAR Lesotho "scale-up" districts where OVC burden is also high. In COP18, the OVC program will deliver child-focused, family-centered interventions to prevent violence against children, prevent HIV, and build the resilience of caregivers and children to overcome adversity. This effort relies on the effective and efficient delivery of a range of integrated and coordinated services to achieve a specific goal, typically referred to as case management. The program will leverage all

community and health facility platforms to intensify targeting of HIV-positive children, adolescents, and their caregivers to access HIV prevention, care, and treatment services. To increase testing yield, the program will ensure that OVC sub-grantees and community case workers who conduct HIV risk assessments are using the HIV risk assessment tool in order to identify the appropriate OVC beneficiaries to be referred for HIV testing. This will ensure that HTS is targeted at those most likely to be positive.

Additionally, the program will use other community platforms, such as youth clubs and community health days, as entry points for targeting OVC. The main OVC IP will coordinate with other clinical and DREAMS partners to facilitate targeting and referrals. Both OVC and DREAMS programming substantially overlap, which helps to foster synergies. The caregivers or OVCs who are found positive will be linked with other OVC services such as psychological support, household economic strengthening, social grants, and any other social welfare services as necessary.

AGYW ages 15-24 years account for over 25% of new HIV infections in Lesotho.[14] There are widespread structural, social, and biological factors that contribute to the unique vulnerability of AGYW to acquire HIV. These factors include: social isolation, economic disadvantage, discriminatory cultural norms, orphanhood, GBV, school drop-out, stigmatization, and engagement in age-disparate and/or transactional relationships. There are various ministries, policy documents, and interventions to address sexual violence and exploitation against children. Despite this, GBV remains rife in Lesotho; a 2014 report indicates 86% of women experienced some form of violence at least once in their lifetime, including partner and non-partner violence.[15] There are also reports indicating high levels of sexual violence and exploitation against children in their communities, usually by someone known to the child.[16] The patriarchal nature of the society normalizes gender inequality; for example, a third of women in Lesotho believe that a husband is justified in beating his wife for specific reasons and 62% of men in Lesotho expressed their belief that they have the right to threaten their wives if they refuse sex.[17] Despite such high levels of GBV, the majority of victims do not report these incidents to police, seek medical attention, or legal recourse.[17]

For COP18, the DREAMS initiative will continue its implementation in the two priority districts of Maseru and Berea. Although there will be no geographical expansion of DREAMS, the Global Fund is implementing DREAMS like activities in the other 8 districts. Through $4.5 million, including catalytic funding, PACT will implement programming for AGYW and youth focused on behavior change messaging, increasing comprehensive HIV knowledge, reductions in AGYW who have a partner more than 10 years older, community testing, and expansion of PrEP. Through DREAMS, PrEP services (added in COP17 as a core DREAMS component) will continue for AGYW

[14] UNAIDS Country factsheets Lesotho 2016 http://www.unaids.org/en/regionscountries/countries/lesotho
[15] Gender Links. The Gender-Based Violence Indicators Study Lesotho - 2014
[16] Levy, Marcy, Veronica Magar, and Derrick Sialondwe. 2013. Situational Analysis on Post-Rape Care of Children in Lesotho. Arlington, VA: USAID's AIDS Support and Technical Assistance Resources, AIDSTAR-One, Task Order 1
[17] LDHS, 2014

ages 18-24 in Maseru and Berea. Comprehensive DREAMS programming will expand to the other community councils in these two districts to ensure full coverage and saturation within the districts. This will enhance effective layering of the DREAMS activities to AGYW and ensure that the majority of DREAMS beneficiaries are reached with multiple interventions, especially the core ones. There will be a greater emphasis on increasing linkage to testing services and enrollment and retention into care and treatment for those needing it. Peace Corps volunteers (PCVs) will undertake DREAMS-like activities in their villages in all ten districts, including: school-based HIV prevention and sexual reproductive health and Life Skills curricula in primary and secondary schools, OVC parent/caregiver training, and community-based economic strengthening. In addition, Peace Corps volunteers are undertaking PrEP demand creation and referral activities through their Girls Leading Our World (GLOW), Youth Optimizing Leadership Opportunities (YOLO), Boys Respecting Others (BRO), and Grassroots Soccer (GRS) camps and clubs targeting adolescents.

The comprehensive and layered services that will be provided for AGYW (9-24 years) through DREAMS are intended to address factors that contribute to girls' vulnerability to HIV. The types of services provided to AGYW are specific to different age bands: 9-14 year-olds are offered risk avoidance and reduction activities to empower them against sexual violence and any form of coercive or non-consensual sex in the community, as well as prevent early sexual debut and supporting healthy choices; 15-19 year-olds are offered condoms, HTS, school-based HIV and violence prevention, social asset building, contraceptive mix, and post-violence care; and 20-24 year olds are provided condoms, HTS, contraceptive mix, combination socioeconomic approaches, PrEP, and post-violence care. The PEPFAR Lesotho OVC program targets OVCs 0-17 years and caregivers above 18 years. Services provided to OVCs include HTS, linkage to treatment, facilitation of social grants, educational support, parenting and caregiver programs, social asset building, and combination socioeconomic approaches. The types of services offered to OVCs will be guided by care plans determined by assessments. There may be overlap between the AGYW and OVC programs as some AGYW are OVCs. All these activities have increased co-location and combined service delivery with PEPFAR clinical programs, which will foster linkages to clinical HIV service providers, better connecting AGYW and OVC beneficiaries to additional HIV prevention, care, and treatment services as needed.

PEPFAR Lesotho will provide comprehensive, coordinated, and youth-friendly HIV and sexual and reproductive health (SRH) services to high-risk OVC and their caregivers, and AGYW and their male partners. HIV testing remains the gateway to meeting the first 90 and to life-saving ART. This activity will serve as an important entry point to the clinical cascade and demonstrate contribution to HTS targets, as well as the identification of HIV-positive children and AGYW. Lesotho is not one of the countries where LAgavidity testing will be conducted; therefore, the country will rely on modeling of new infections as a proxy for new HIV infections.

Specific to DREAMS, an ambitious and multi-faceted program, PEPFAR Lesotho will hold monthly meetings for all implementing partners working on DREAMS. These monthly check-ins

are an important tool in the partner management repertoire and provide opportunities for improved collaboration, a forum for discussion and working through challenges, and sharing of ideas for strengthened programming. The OVC partner agreed that the OVC program would enhance collaboration among other clinical partners, and improve strategies and linkages for HTS and ART programming. To improve partner performance, PEPFAR facilitates joint, quarterly meetings with OVC and DREAMS IPs. In addition, PEPFAR holds monthly update meetings with OVC partners. This platform is used to share program experiences, identify programmatic bottlenecks, and map out strategies for collaboration and linkages.

4.2.2 Children

This priority population is addressed in Section 4.2.1, 4.2.3, 4.2.4, and 4.2.5.

4.2.3 Key Populations

In Lesotho, HIV-related policies and legal frameworks do not specifically address groups at high risk, such as key populations. Although these key populations exist in Lesotho, epidemiological data on them are either unavailable or remain incomplete.[18] According to the results of the Biological Behavioral Surveillance Study (BBSS) January 2015, FSW and MSM in Lesotho carry an increased burden of HIV compared to other adults of reproductive age.[19] Of the FSW surveyed in Maseru and Maputsoe, 73.3% and 70.4%, respectively, were HIV positive. HIV prevalence of MSM was lower compared to FSW, but was higher compared to the general population at 31.1% in Maseru and 35.4% in Maputsoe. Through GF support, the country will be conducting a population based IBBS this year in four districts to estimate the KP's population size, as well as evaluate the risk for HIV, STIs and TB among MSM and FSWs (e.g. characteristics, sexual behavioral patterns, access to services, stigma challenges, etc.).

During the reporting period (April- September 2017) a total of 2,981, (88%) of the annual target of 3,380 MSM and 2,050 (99%) FSWs against the annual target of 2,079 were reached with a minimum package of interventions. These included correct and consistent condom usage, benefits of accessing HTS, information on STIs, and advantages of accessing HIV care and treatment. Although PEPFAR Lesotho reached almost 100% of targets, the program was neither able to provide nor facilitate HTS and HIV treatment for KPs. Strict and firm partner management was provided to the IP implementing this program, however no progress was achieved. The IP continued to fail even after numerous discussions and tight timelines. PEPFAR Lesotho therefore transitioned the KP program to a new global partner, LINKAGES. In COP18, LINKAGES will build from its strong foundation to optimize critical key population interventions across the cascade, with a focus on innovation, efficiency, and quality.

MSM and FSWs will be targeted to reduce HIV transmission, ensure a high quality of life for KPs living with HIV, and work towards UNAIDS 90-90-90 targets in this population. The KP cascade

[18] UNAIDS, 2012
[19] Biological Behavioral Surveillance Study (BBSS), January 2015

emphasizes the intervention stages of reach, test, treat, and retain. For all KPs, the HIV cascade stresses the importance of prevention through the promotion of health-seeking behaviors, including consistent condom use, STI screening and treatment, regular HIV testing and access to PrEP (where appropriate) for those who are uninfected, and treatment as prevention for KP living with HIV. With Test and Start widely implemented in the country, PEPFAR will support KPs living with HIV by enrolling them into care and treatment.

Lesotho will build on the HIV cascade and existing KP HIV programs to implement priority interventions to address gaps, improve efficiency, and ensure quality of HIV services. These priorities include addressing structural interventions, implementing innovations in community and technology-driven service delivery (e.g. enhanced peer outreach approach, peer navigation, PrEP, HIV self-testing, and methods to reach and engage KPs online), and adaptation of state-of-the-art data use and tracking systems.

Our new KP partner will continue to provide leadership and support all of PEPFAR Lesotho's partners to tailor, adopt, and implement innovations and best practices in HIV services for KPs. Many of PEPFAR Lesotho's IPs rely heavily on CSOs for their local expertise, culturally sensitive approaches, and access to priority populations to work effectively to reach target populations and implement programming. For example, the partner working with key populations in Maseru and Leribe sub-grants to Care for Basotho and MATRIX to provide peer-to-peer prevention and outreach work with FSW and MSM and to link them to testing and treatment.

Lesotho finds itself in a situation where one partner provides a prevention outreach service, another provides an HIV test, and a third initiates ART and supports retention on ART. In the absence of a common unique identifiable code to track an individual from the community to clinic and from clinic to VL suppression, the country and the IPs will continue to struggle to demonstrate efficiency and effectiveness of HIV programming. This situation holds true for KP programming in Lesotho. PEPFAR Lesotho, after becoming increasingly frustrated that many KPs were not being reached with HTS services, made a deliberate decision to allow the current KP partner to provide both prevention services and HTS for KPs. They will also ensure coordination of all partners providing services to key populations.

The National AIDS Commission (NAC) has the national mandate to coordinate HIV prevention, but they have not been proactive in coordinating activities to align partners. They have held one KP Prevention TWG meeting with no clear plan moving forward for how to use the TWG forums to improve alignment, service coordination, and performance analysis of KP programming. PEPFAR through LINKAGES will support NAC and MOH to coordinate work focused on identifying and eliminating barriers directly faced by KPs, including structural barriers. All partners implementing KP activities will provide a monthly update on their progress and highlight implementation challenges in order to better address issues as they occur to ensure improved performance.

4.2.4 VMMC

WHO/UNAIDS recommend that VMMC be offered to men, in combination with other HIV risk reduction interventions, in settings with generalized HIV epidemics and low prevalence of circumcision. PEPFAR Lesotho is working with the GOL to scale up VMMC coverage to 80% among males 10 – 29 years in the five lowland districts, both with a high unmet need for circumcision and high HIV disease burden. GF resources will be leveraged for the expansion of services, recruitment of additional manpower, and procurement of equipment and supplies in the highland districts. In Lesotho, 73% of all men aged 10-29 live in the five lowland districts, and thus the strategic direction was made to focus intensive efforts and resources on these five districts.

COP18 funding will support DSD at fixed and outreach VMMC sites, demand creation using cost effective strategies, salary support for health care providers and mobilizers, and procurement and logistics for circumcision kits, mobile surgical vehicles, and other supplies. PEPFAR Lesotho plans to provide direct surgical service delivery to circumcise 36,719 men (Jhpiego, 36,219 and DOD, 500). This represents 80% saturation in the age pivot of 10 – 29 year olds in the five districts of Berea, Maseru, Leribe, Mafeteng, and Mohale's Hoek.

Recent policy shifts include the host country government's adoption of task shifting of VMMC services to nurses as an initiative for scaling up services in hard-to-reach areas that have shortages of medical doctors. Nurses are now providing both adolescent/adult and early infant circumcision services to clients. PEPFAR will use 5% of the allocated VMMC COP18 budget to support the integration of early infant male circumcision (EIMC) in MNCH programs in the five lowland districts that have reached 80% saturation for sustainability. In addition, the GOL has endorsed the medical/traditional male circumcision collaborative initiative, due to high prevalence and cultural significance of traditional circumcision that range from 32% to 65% of all men. To this effect, the MOH has recruited an officer to coordinate the collaboration. Jhpiego has started to provide medical circumcision to traditional initiates at health facilities prior to the rite of passage ceremonies in three of the five lowland districts. In COP18, we will expand this initiative to all five lowland districts. Traditional Circumcisions, most common among men over 20 years old, have a deep-rooted cultural signification in Lesotho. During discussions at the Johannesburg Regional Planning Meeting, OGAC determined that PEPFAR Lesotho could target the VMMC program to men under 20, before they become old enough to attend initiation schools where they undergo traditional circumcision. This will be an important strategy to medically circumcise the boys before they opt for traditional initiation circumcision.

The mobile clinic initiative will ensure that clients are able to access services and are served closer to their homes. Mobile services will increase VMMC coverage not just for hard-to-reach rural areas that do not have access to a health facility, but also to populations such as herd boys and farmers who do not have the time to travel to a facility multiple times as a result of their work.

Demand creation strategies will be scaled up in COP18 to increase access to services, and include referrals from HIV testing sites and men's clinics, as well as the strategic engagement of women

and female community groups as champions, faith-based organizations, and workplace VMMC programs. The program will also undertake time-limited campaigns in the course of the fiscal year to address the seasonal nature that the program is currently experiencing. The program will also implement Project SOAR's Geographic Information System (GIS) and Site Capacity and Utilization online tools, which will respectively enable teams to conduct community mapping, targeted community mobilization, and monitor site productivity in real-time to inform targeted demand creation among the age-pivot. Advocacy by community, traditional, and government leadership will be leveraged to create demand for the program. PCVs, working through their counterparts and with implementing partners, will link men to VMMC services and support demand creation through GRS and BRO camps and clubs.

Given the need to achieve 80% coverage and attain sustained epidemic control in priority districts, PEPFAR will prioritize focused technical assistance on selected indicators to ensure quality of services and data for decision-making. Technical assistance for robust data and service quality will involve conducting SIMS, data quality assurance (DQA), external quality assessment (EQA), and CQI on a regular basis, as well as training and mentorship of site based M&E officers, in the areas of data management and use. Use of above-site partner performance monitoring online tools which include Decision Makers Program Planning 2.0 (DMPPT), Site Capacity Utilization Analysis, and Site Performance Index will be used to monitor real-time focused age pivot impact, infections averted, and associated cost savings of VMMC services. In addition, partner performance will be tracked through weekly review reports and monthly site performance reports as well as mandatory quarterly performance presentation to the PEPFAR team to ensure the sites are performing at capacity. This strategy will provide a basis to refining programmatic approaches on an ongoing basis. The recent endorsed task shifting and provision of mobile services by MOH will be monitored to ensure geographic expansion of service delivery sites and increased access to services. Implementation of the online training hub (OTH) modules for health care providers and community mobilizers will ensure continuous professional development and refresher trainings. Effectively implementing these activities will result in achieving the COP18 target of 36,719 VMMCs to reach 80% saturation in the five lowland districts.

4.2.5 Pre-Exposure Prophylaxis

PEPFAR Lesotho is working with the GOL to scale up PrEP services nationwide. In COP18, PEPFAR aims to provide PrEP treatment to 11,208 new beneficiaries, which include AGYW in DREAMS districts, serodiscordant couples across all ten districts, and key populations in Berea, Leribe, and Maseru. The GOL has committed to procuring PrEP medication for the beneficiaries as well as guaranteed access to infrastructure, such as laboratory services, and has branded the national PrEP program. The policy has not only resulted in increased access to PrEP services, but also geographic expansion of the program.

COP17 Q1 mainly set up the groundwork for scale-up that resulted in the finalization of the Technical Implementation Framework, implementation tools, short-term demand creation strategy, information, education, and communication materials, and training of trainers. In

COP18, the program will accelerate both provider trainings and implementation of a hybrid service delivery model at health facility and community levels to increase access to services. In addition, the program will leverage on strengthened referral linkages from HTS, VMMC, family planning, STI clinics, adolescent youth corners, and serodiscordant clinics in the care and treatment services for scale-up. This will be achieved through continued support of staff salaries, DSD, HTS, risk assessment, demand creation, and procurement of POC diagnostic equipment and other supplies for serum creatinine, and CQI through Jhpiego and Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) as IPs. Partner performance will be tracked through weekly review reports and through mandatory quarterly performance presentation to the PEPFAR team. Technical assistance for robust data and service quality will involve conducting SIMS, DQA, EQA, and CQI on a regular basis, as well as training and mentorship of site-based M&E officers in the areas of data management and use.

4.3 TLD Transition

Optimizing antiretroviral regimens can increase access to treatment and improve outcomes through impact on adherence, viral suppression, and quality of life of PLHIV. This can significantly affect the speed at which national 95-95-95 targets are achieved. Dolutegravir (DTG) has been shown to be superior regarding efficacy, genetic barrier to resistance, tolerance, and treatment discontinuation from adverse drug reactions compared to efavirenz (EFV, at standard dose 600 mg /day) and boosted protease inhibitors (PIs). In addition, the fixed dose combination (FDC) of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) is currently priced as the least expensive FDC. For these reasons, PEPFAR Lesotho recommends TLD as the preferred first-line ART for adolescents (>= 10 years old and body weight >= 30 kg.) and adults. COP18 will focus on assisting the GOL to transition over to TLD as soon as possible in a coordinated fashion as supply becomes available.

PEPFAR Lesotho will assist with national rollout of TLD scheduled for December 2018 for the following patients: 1) newly diagnosed HIV-positive patients; 2) patients with virologic failure (VL > 1000 copies/mL) after 6 months of ART; 3) patients on a nevirapine-based ART regimen; 4) TB-HIV co-infected patients on a rifampicin-based TB regimen (dosage of DTG to be increased to 50 mg twice daily); and 5) stable, suppressed patients on tenofovir/lamivudine/efavirenz (TLE). Pregnant women will be transitioned based on WHO TLD Treatment Guidelines expected in July 2018. Currently, the Lesotho National ART guidelines recommend TLE as preferred first-line regimen and TLD as an alternative. A memo will be circulated to include TLD as preferred first-line, and the official guidelines will be changed in 2019. The following activities will be held in COP17 for a smooth transition process: 1) engagement of stakeholders to solicit commitment; 2) development of MOH task team consisting of pharmacy, clinical unit, supply chain, laboratory, NDSO, and strategic information; 3) TLD forecasting and qualification; 4) sensitization of patients, communities, and health care workers of eventual TLD rollout; and 5) training of health care workers and production of job aids prior to rollout.

4.4 Commodities

By end of COP18, PEPFAR Lesotho is expected to achieve saturation in all ten districts in Lesotho. To scale up HIV care and treatment services and achieve epidemic control, an uninterrupted supply of ARVs and HIV diagnostic and monitoring commodities is critical.

Figure 4.4.1. COP 2018 PEPFAR Lesotho Commodities Budget

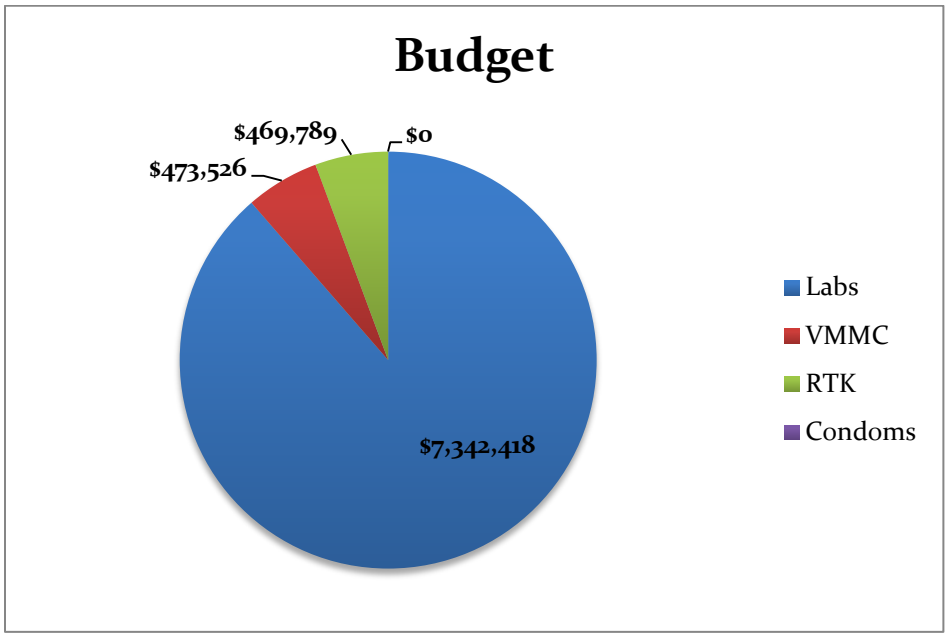


Figure 4.4.1 shows the COP 2018 commodities budget that PEPFAR Lesotho has committed towards the HIV response in Lesotho. In COP18, PEPFAR Lesotho will spend $8,285,733 to support procurement of laboratory commodities, VMMC kits, and rapid diagnostics test-kits (RTK). PEPFAR has also allocated sufficient funds for laboratory commodities to cover 75% of VL monitoring, EID and TB diagnosis needs in the ten districts. HIV tests kits, ARVs and other commodities, and logistics and distributions will be funded by GF and MOH. GF will be expected to support 25% of the laboratory commodities requirements to cover all sites in the ten districts of Lesotho.

To address stock-outs, especially for laboratory reagents and consumables, PEPFAR Lesotho will align itself to the COP18 guidance, which encourages optimization of the commodity procurement processes to include out-sourcing of single-sourced items such as VL reagents to a particular vendor. PEPFAR in COP18 is encouraging host countries and partners including GF to take advantage of equipment/reagent leases and avoid any direct purchases of equipment. In addition, building on the successes from COP17, PEPFAR will continue to provide significant levels of direct service delivery technical support to the DHMT, SCCU of MOH, and NDSO. In COP18, PEPFAR partners will begin and concentrate on skills transfer and preparation for transition to host-government staff. The Global Health Supply Chain Management (GHSC) program will continue to provide central-level, direct management support at the NDSO and

SCCU for: 1) HIV commodity forecasting, procurement and supply planning; 2) distribution; and 3) inventory management and control systems.

PEPFAR Lesotho will continue to coordinate with GF and the MOH to ensure that there is adequate budget and commodity stocks in order to attain national 95-95-95 targets across the ten districts in Lesotho. PEPFAR through the GHSC program will continue to support the Supply chain Management Technical Working Group (SCM-TWG) and its sub-committees to ensure that annual and bi-annual forecasting and supply planning activities for HIV commodities continue to be implemented as planned. The GHSC project teams are well positioned with their forecast and quantification tools (Pipeline and Quantified) to complete the needed analysis to fill in supply plans for all HIV and AIDS tracer commodities. In addition, PCVs will be leveraged to help reduce occurrence of stock-outs by improving management of supply chains in rural communities and building capacity of local supply chain staff.

Supply chain data visibility especially consumption information (dispensed to user data) from the service delivery sites continues to be a challenge in Lesotho. PEPFAR will build on the successes of COP17 activities to ensure that the country develops an electronic logistics management information system (eLMIS) which links the central medical stores (NDSO), SCCU, DHMTs, and the service delivery sites. In COP17, the GHSC program will have completed the modernization work at the NDSO, which include a Warehouse Management System (Enterprise Resource Planning (ERP) system) that has been upgraded with bar-coding capacity. In addition, the GHSC program will have also supported the MOH to implement the Informed Push (IP) in all service delivery sites, which will improve transparency of requisition data between the facilities, DHMT, SCCU and the NDSO. The IP is a report and requisition tool, which replaces the paper-based system that was challenged by lost documentation across the pipeline. The third information system is known as Channel currently supported by UNFPA. The Channel system is an electronic stock card, which would improve the visibility of stock levels within a facility. The strategic objective of the eLMIS is to ensure that the country has an integrated system which links stock availability information and stock consumption information and thereby improve forecasting, quantification and supply planning. The ultimate objective is to ensure security for all HIV commodities in Lesotho.

In anticipation of stock-outs of supplies, PEPFAR will also allocate buffer-stock funds for test-kits (RTKs and HIVST) as a stopgap measure. PEPFAR is coordinating with the GOL and GF to ensure adequate supply of HIVST kits for COP18. Through the CDC cooperative agreement, resources have been allocated to the MOH to procure laboratory reagents and supplies for VL, EID, and TB diagnosis for all ten districts in Lesotho. PEPFAR has also budgeted for male and female condoms and lubricants through the USAID Central Commodity Funds to purchase enough condoms for the PEPFAR sites in all ten districts. The lopinavir/ritonavir (LPV/r) pellets is being piloted at Baylor Center of Excellence, and national stock will be available in July 2018. Baylor will assist the MOH with national rollout of the LPV/r pellets once stock is secured.

4.5 Collaboration, Integration and Monitoring

In the past two years, there has been progress made in collaboration, integration, and monitoring. PEPFAR agency leads and the Principal Secretary of Health have monthly meetings to discuss high-level topics that need MOH or agency leadership to advance them and provide both parties an opportunity to discuss programmatic shifts or challenges. These meetings afford the opportunity to jointly discuss collaboration among donors, provide a closer view into PEPFAR priorities, and ensure alignment within the GOL strategic framework.

The quarterly POART stakeholder meetings have been very well-attended by MOH colleagues, IPs, civil society, and various other in-country stakeholders. These meetings provide the Lesotho HIV stakeholder community as well as the entire PEPFAR team an opportunity to discuss the PEPFAR program. The POART meetings have increased data quality and transparency, as well as knowledge about the PEPFAR program priorities, targets, and results.

In Lesotho, PEPFAR plays a key role in national HIV coordination. PEPFAR and UNAIDS co-chair the AIDS Development Partner meeting. This forum allows all HIV stakeholders in Lesotho an opportunity to learn about the work being done by other partners, capitalize on opportunities for collaboration, and provide technical input into Lesotho's HIV programs and results. PEPFAR is an active member of the Lesotho Country Coordinating Mechanism (CCM), the CCM Executive Committee, and the chair of the CCM Oversight Committee for GF. PEPFAR participation in these committees is key to ensuring joint planning and program coordination between the two largest donors.

Internally, PEPFAR Lesotho holds monthly meetings with their IPs that allow the team to track progress between quarterly reporting periods and improve data quality by allowing questions and concerns to be flagged. These IPs meetings are open to the entire PEPFAR team and are an opportunity for agencies to learn about and ask questions about each other's programs and performance. All high-level COP planning is done as a joint interagency team. With the exception of Peace Corps, PEPFAR Lesotho sits together in one office, with agency staff intermingled throughout the office.

4.6 Targets for scale-up locations and populations

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY19) *HTS_TST*	Newly Identified Positive (APR FY19) *HTS_TST_POS*	Newly Initiated on ART (APR FY 19) *TX_NEW*
Total Men	354,251	19,890	18,036
Total Women	531,376	29,836	27,055
Total Children (<15)	164,170	2,029	1,928

Adults			
TB Patients	*9,994*	*5,382*	*5,382*
Pregnant Women	*39,019*	*4,219*	*3,478*
VMMC clients	*36,219*	*722*	*578*
Key populations*	*2,970*	*891*	*802*
Priority Populations*			
Other Testing	*636,225*	*36,483*	*32,924*
Previously diagnosed and/or in care	0	0	0
Pediatrics (<15)			
HIV Exposed Infants	*12,228*	200	*190*
Other pediatric testing	*151,943*	*1,829*	*1,738*
Previously diagnosed and/or in care	0	0	0

*Testing targets for key and priority populations are included in other testing categories (e.g. men, women) and would be duplicative if noted separately.

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (as of APR COP16)	COP17 VMMC_CIRC Targets	Expected Coverage in COP18*
Maseru	15-29	72,923	55%	7,365	80%
Leribe	15-29	47,302	40%	15,317	80%
Berea	15-29	36,884	43%	7,230	80%
Mafeteng	15-29	25,059	36%	7,318	80%
Mohale's Hoek	15-29	23,088	27%	11,996	80%
	Total/Average	**205,255**	**40%**	**49,226**	**80%**

*Target population is 10-29 years. 80% coverage target split into 70% from ages 10-19 and 30% from ages 20-29.

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY18)	FY19 Target
MSM	5,164	4,131 (80%)	4,131 (80%)
FSW	3,085	2,468 (80%)	2,468 (80%)
AGYW	*121,690	*87,827(72%)	*87,827 (72%)
TOTAL	**129,939**	**94,426 (73%)**	**94,426 (73%)**

*Only in the DREAMS districts of Maseru and Berea

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY19Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target) OVC***
Maseru	47,860	33,817	15,747
Leribe	33,418	18,590	11,991
Berea	25,504	19,828	10,314
Mafeteng	20,741	9,809	6,644
Mohale's Hoek	20,556	7,926	5,089
Quthing	14,608	489	465
Thaba Tseka	15,885	897	852
Mokhotlong	12,311	489	465
Butha Buthe	10,940	921	875
Qacha's Nek	8,889	230	219
TOTAL	**210,712**	**92,997**	**52,660**

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

PEPFAR Lesotho has no attained or sustained districts in COP18.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

In COP18, the key areas identified for above-site systems strengthening in order to achieve sustained epidemic control include:

1) Strategic information
2) Service delivery
3) Laboratory services
4) Commodity security and supply chain

Investments in these areas will address current programmatic gaps in health systems strengthening and service delivery, which are crucial to achieving national 95-95-95 targets by the end of COP18. Support to strategic information is needed to ensure timely, complete, and

accurate data management to inform programmatic planning by the host country. In addition, the survey (e.g. VACS) and research (e.g. PROMISE) agenda are tailored to the current information gaps in Lesotho. Laboratory services will focus on quality assurance of HTS and ensure systems are in place for efficient and timely VL monitoring, which has been rapidly scaled-up since COP16. Although commodities only make up 10% of the COP18 budget and PEPFAR Lesotho does not procure ARVs, securing commodities and reinforcing the supply chain system are critical for the prevention of stock-outs of key commodities, such as isoniazid for TPT.

6.1 Strategic Information

Electronic registers

Lesotho has a large migrant population, both within and outside Lesotho. It is therefore difficult to accurately track patients along the clinical care cascade. High levels of linkage and retention are needed in order to reach national 95-95-95 targets. An electronic register and unique identifier system will increase Lesotho's ability to track individuals, help inform gaps in the continuum of care, and improve overall data quality. PEPFAR Lesotho is working with our in-country SI partners to implement an openMRS electronic register and unique identifier system in a defined number of sites in the country. Support will include system development, equipment, training, and mentorship. Mobile health technology through Dimagi's open source application, CommCare, will also be scaled up to improved patient tracking and clinical care support. Full deployment of these systems is expected to occur by the end of COP18.

DHIS2 Optimization

In order to ensure streamlined and efficient data flow, management, and use for programmatic decision-making, the open-source software platform for health programs, DHIS2, was first implemented at the district and central levels, and has now been rolled out to all public health facilities. Challenges remain, however, regarding data quality, timeliness, and completeness. PEPFAR will continue to support DHIS2 at the site, district, and central levels by providing training, equipment, and human resources. DQA of all data in DHIS2 will be conducted to resolve continuing data quality issues and discrepancies and late and incomplete reporting. Furthermore, COP18 will focus on 1) encouraging ownership and support of DHIS2 by MOH and 2) creating an interoperability layer to allow DATIM to pull from DHIS2 in order to avoid double reporting.

A robust laboratory data management system is critical to ensuring smooth and efficient flow of specimens and results and informing clinical decision-making. In Lesotho, there are disparate laboratory information systems functioning at different levels of the health system and data are not summarized and analyzed on a routine basis. In COP18, technical assistance will be provided to the national reference laboratory and district hospital laboratories to link the laboratory information system (LIS) to DHIS2 to enhance monitoring on core laboratory indicators, including VL, EID, and TB test data. Links to the national DHIS2 system will be developed to ensure indicators can be monitored by decision-makers for targeted programming.

Violence Against Children Survey

Violence against children is a global human rights violation that spans every country worldwide and affects millions of children each year. This survey will measure the physical, emotional, and sexual violence against girls and boys and will help guide the development and implementation of effective strategies and policies to both prevent violence before it starts and address it when it happens. The objectives of this study are: 1) estimate the national prevalence of physical, emotional and sexual violence perpetrated against boys and girls 2) identify risk and protective factors for physical, emotional and sexual violence against children to inform stakeholders and guide prevention efforts; 3) identify the health and social consequences associated with violence against children; 4) assess the knowledge and utilization of medical, psychosocial, legal, and protective services available for children who have experienced sexual, emotional and physical violence; 5) identify areas for further research; and 6) make recommendations to relevant ministries in Lesotho, UN Agencies, and international and national non-governmental organizations on developing, improving and enhancing prevention and response strategies to address violence against children as part of a larger, comprehensive, multi-sectoral approach to child protection.

HIV Drug Resistance Survey

In the era of Test and Start, it is important to determine effectiveness of first- and second-line ART regimens as recommended in the national ART guidelines and viral suppression in the national ART program. The HIV Drug Resistance Survey will determine: 1) prevalence of HIV drug resistance (HIVDR) among treatment-naïve and –experienced adults; 2) prevalence and pattern of acquired drug resistance mutations in those with virological failure, defined as VL ≥1000 copies/ml; and 3) prevalence of VL suppression among adults receiving ART. This survey is focused on adults because there is currently an HIV drug resistance survey among children and adolescents (0-19 years) conducted by Baylor Lesotho. These data will help inform ART program quality and may reflect gaps such as inadequate adherence assessment and counseling, interruptions in drug supply, and low retention in care.

HIV Incidence Surveillance

HIV incidence surveillance using a commercial point-of-care recency test (POC-RT) can help to identify recent HIV infections among population segments in Lesotho. Epidemiological analysis can be conducted to monitor trends and identify hot-spot locations and sub-populations associated with HIV recency to ensure that interventions are efficiently and effectively targeted to those at highest risk of acquiring or transmitting HIV infection. Results from recency testing will inform the identification of social networks correlating demographic and social risk factors related to recent infections. This will be important for prevention evaluation and planning, public health policy development, and resource allocation. This surveillance system will be initially deployed in 24 health facilities in Leribe district and eventually rolled out nationally.

6.2 Service Delivery

The following research studies have been selected for continued funding in COP18 in order to improve the quality and effectiveness of health service delivery.

The "Implementation and evaluation of differentiated HIV care and treatment for people with advanced HIV disease in Lesotho" study will determine if implementing a differentiated care model for PLHIV with advanced disease is associated with improved uptake of key interventions, as well as morbidity and mortality. The package includes key evidence-based interventions among this clinically unstable population and includes: 1) rapid initiation of ART once the risk of immune reconstitution inflammatory syndrome (IRIS) is assessed; 2) co-trimoxazole prophylaxis; 3) screening for active TB and prompt initiation of anti-TB treatment as indicated; 4) systematic screening for Cryptococcus antigen (CrAg); and 5) intensive follow-up.

The "Provide miner-friendly services for integrated TB/HIV care (PROMISE)" study aims to evaluate the effectiveness, feasibility and acceptability of integrated TB/HIV services for migrant miners and their family members provided in miner-friendly (MF) service venues. A prospective cohort study design will be used to compare the effectiveness of the MF intervention, which includes provision of family-focused, integrated TB/HIV diagnosis, care and treatment services at the Employment Bureau of Africa (TEBA) offices six days per week, to public sector health facilities, which deliver usual integrated care for TB and HIV. If proven effective, MF services should be scaled up in order to reach epidemic control in this population.

The "Outcomes of differentiated models of antiretroviral treatment provision" study will evaluate differences in retention and viral suppression outcomes after 12 and 24 months among stable HIV infected patients who 1) receive 3- or 6-monthly dispensing of ART via a community distribution model versus 2) receive 3-monthly dispensing of ART via health facilities.

6.3 Laboratory Services

PEPFAR Lesotho's COP18 objective for laboratory support is to provide quality-assured and integrated HIV diagnosis and monitoring services to attain epidemic control and achieve national 95-95-95 targets. Areas for specific activities include: 1) strengthening the laboratory system through CQI; 2) laboratory information systems and M&E system; 3) infrastructure and equipment maintenance, instrument mapping and optimization of services ; 4) HIV rapid test continuous quality improvement (RTCQI); 5) diagnostic and monitoring g services that include VL monitoring services, EID including POC EID; and GeneXpert MTB/ RIF diagnosis. PEPFAR will support the implementation of integrated national laboratory services to improve quality, efficiency and cost-effectiveness for all core laboratory services such as specimen transport, referral services, results delivery, SCM, and information systems. To increase access to hard-to-reach areas, DBS VL will be scaled up to reach 30% coverage in COP18. The provision of integrated laboratory services will allow the laboratory and clinicians to use comprehensive information for informed decision making and effective patient care.

PEPFAR Lesotho will continue to provide DSD to two reference laboratories (National Reference Laboratory and TB Reference Laboratory) and 18 clinical laboratories. The DSD includes procurement and distribution of select lab commodities, human resource support for provision of testing services, mentorship through rollout of Strengthening of Laboratory Management Towards Accreditations (SLMTA), quarterly site supervision, sample transport, referral testing, equipment maintenance and inventory management, EQA/PT schemes for HIV test, CD4, VL, EID, TB AFB, GeneXpert, TB culture and susceptibility tests. TA-SDI will also be provided to 209 health centers/clinics that provide HIV rapid testing services, of which 29 sites support POC EID. The support includes distribution of EQA/PT panels, training counselors, sample transporters, and phlebotomists, and supportive supervision to sites that are poorly performing in PT schemes.

The following are COP18 core activities:

1) Continuous Quality Improvement and Proficiency Testing (PT) program: technical support will be provided to clinical laboratories and POC sites for routine implementation of quality system elements. The facilities will be assessed and improvement monitored using the WHO AFRO Stepwise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) or the WHO/CDC Stepwise Process for Improving the Quality of HIV-Related Point-of-Care-Testing (SPI-POCT) checklist. Quality Management System (QMS) with the 12 elements of a quality system will be used as a working framework. The key areas to be reviewed include process control, corrective actions and documentation, safety and management reviews. By the end of COP18, all 18 hospital labs will be enrolled in SLMTA and 5 of them accredited by the African Society for Laboratory Medicine (ASLM). In addition, 95% of 18 clinical labs and 295 POCT sites enrolled in the PT program will have passed.
2) Referral network through tiered laboratory services (national, district, health center): supporting tiered and integrated national laboratory services will improve efficiency including specimen transport, results delivery, and SCM and information systems. Local capacity for effective sample transport, such as a sample tracking tool and e-reporting system, will be strengthened to decrease turnaround time to 2-3 weeks.
3) LIS and Monitoring and Evaluation: the current electronic LIS system will be strengthened to generate quality data and reduce turnaround time of results transmission for prompt management and monitoring of ART patients. Mentorship and supportive supervision will be provided for timely reporting and data analysis.
4) Laboratory equipment maintenance and inventory system: an inventory of standardized equipment platforms will be established. Guidelines and standard operating procedures will be developed or revised for preventive and routine maintenance of major laboratory equipment. Service contracts with manufactures for major laboratory instruments supporting VL, EID, and TB diagnosis will be developed and/or enforced. These activities will reduce equipment down time and service interruption to less than 5 days. In addition, laboratory instruments will be mapped and optimally utilized to increase efficiency and cost effectiveness.

6.4 Commodity security and supply chain

Challenges with an efficient and effective SCM system in Lesotho have led to frequent stock-outs of HIV related commodities, such as isoniazid for TB preventive therapy and VL reagents and consumables. Underpinning this is a lack of a national-level commodity procurement control structure, including: 1) lack of coordination and supply chain data visibility; 2) lengthy and bureaucratic procurement processes for key HIV commodities; and 3) non-adherence to inventory control systems, such as maximum/minimum limits.

In COP18, PEPFAR Lesotho will continue to provide technical support and capacity building to the Ministry of Health through the SCCU, DHMTs and the NDSO to ensure that there is a fully functional GOL-led HIV commodities and SCM system, which can guarantee 100% commodity security for all HIV-related commodities, such as pharmaceuticals, laboratory commodities, and condoms. PEPFAR Lesotho will increase transparency, oversight, and accountability for commodities by engaging the MOH and working with NDSO to overcome bureaucratic procurement processes for HIV commodities and especially for laboratory commodities and consumables.

The following are COP18 core activities:

1) Support the SCCU to implement annual and bi-annual quantification, forecasting, and supply planning for HIV commodities: NDSO and program managers will ensure that key HIV commodities are available at a maximum of twelve and minimum of six months, especially as the program continues to rapidly scale-up. The GHSC Program will also support the MOH to ensure that as they transition current patients on legacy ARVs they also limit the risk of wastage. They will use the current interactive forecasting and supply-planning tool to ensure that they actively monitor the transition of current patients and initiation of new patients on TLD as the preferred first line treatment for adults and adolescents. The SCCU will also ensure that there is enough TLE stock for patients opting to continue on the efavirenz regimen.
2) Appropriate warehousing and inventory control for HIV and AIDS commodities: Building on the achievements of COP17 activities, PEPFAR will continue with the STTA support in the Warehouse Management System (WMS) and migrate the new bar-coding system to all service delivery points across the ten districts. The objective is to ensure that the NDSO inventory is visible and linked to all the stock at the lower levels through the unique bar-coding system, and therefore improve transparency and accountability of all commodities procured through the national procurement system, including donor-funded commodities. Pharmacy and logistics staff at the district and facility levels will be trained in the use of the new bar-code system and provide support supervision in order to ensure commodity security for all HIV commodities required for epidemic control in PEPFAR-supported sites. PEPFAR-supported staff will continue to be attached to the NDSO with an understanding that they begin the process of transitioning their skills and support to

host-country staff. This will be done through on-the-job skills transfer and recommendation of host-country staff for specialized training.

3) Integrate a functional eLMIS for HIV commodities to the DHIS system: PEPFAR Lesotho will continue to support the conversion of the paper-based Procurement and Supply Management System (PSM) to the e-LMIS and ensure implementation by COP18. PEPFAR will support the MOH to integrate the WMS-EPR, the IP, and the UNFPA supported Channel – electronic stock card available at service delivery points. PEPFAR will provide technical assistance with revision of the current site-level SCM standard operational procedures (SOPs), in-service training, on-the-job training, and support supervision by DHMTs to the service delivery points as they implement the e-LMIS. The e-LMIS will be interfaced with the existing DHIS2 platform.
4) In-service training and mentorship for health workers to the revised SCM SOPs for efficient procurement of HIV commodities: Building on the initial work from COP17, PEPFAR will support the MOH to document all the new changes across the supply chain cycle into the new Lesotho SOPs for procurement and supply management. Some of the activities will include printing of the new SOPs and facility-level SCM data collection tools. All the PSM staff seconded to the NDSO, SCCU, and DHMTs will be expected to begin a mentorship and capacity-building process for host government staff with the hope of transitioning out of their roles by the end of COP19.

7.0 Staffing Plan

The PEPFAR Lesotho team conducted a staffing analysis to assess the degree to which the current staffing footprint is aligned with the PEPFAR program. The following factors were key in the staffing analysis undertaken by PEPFAR Lesotho: the administration and management burden of the PEPFAR business practices (such as SIMS, POART, COP, and SID) and the ambitious ART targets in the 10 scale-up to districts.

As of March 2018, PEPFAR Lesotho will have three vacant positions: two with the Department of State and one with CDC. For State, the SIMS Coordinator position was a proposed position in COP16 and stuck at the caged process due to the State Department hiring freeze. The Small Grants Coordinator position with State is a non-PEPFAR funded Eligible Family Member position in the Small Grants Office. This position was vacated in August 2017 and potential candidates have been identified. The position is currently being reclassified and we hope to have it filled soon. For CDC, the PHI Global Health Fellowship position is newly vacant since December 2017. This position should be filled by the start of COP18.

In COP18, PEPFAR Lesotho is proposing no new positions. Despite the programmatic growth, the team feels the current staff footprint is sufficient to meet the additional demands. There are no large proposed changes from COP17 management and operation costs.

APPENDIX A -- PRIORITIZATION

SNU Prioritization

Table A.1

SNU	COP	Prioritization	Results Reported	Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) overall														Overall TX Coverage
				Treatment Coverage at APR by Age and Sex														
				<1		1-9		10-14		15-19		20-24		25-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Maseru	COP 15	Scale-Up Saturation	APR 16	36%	13%	36%	13%	46%	27%	20%	34%	25%	14%	9%	15%	14%	19%	14%
	COP 16	Scale-Up Saturation	APR 17	95%	45%	95%	68%	86%	56%	77%	95%	82%	49%	41%	62%	98%	86%	61%
	COP 17	Scale-Up Saturation	APR 18	95%	97%	95%	97%	63%	36%	88%	88%	88%	88%	84%	88%	88%	88%	88%
	COP 18	Scale-Up Saturation	APR 19	98%	98%	98%	98%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Leribe	COP 15	Scale-Up Saturation	APR 16	95%	39%	95%	39%	33%	14%	41%	58%	95%	46%	31%	41%	53%	71%	42%
	COP 16	Scale-Up Saturation	APR 17	95%	95%	95%	58%	62%	24%	66%	76%	73%	92%	47%	57%	75%	95%	60%
	COP 17	Scale-Up Saturation	APR 18	95%	85%	95%	85%	56%	23%	89%	89%	89%	89%	89%	89%	87%	89%	86%
	COP 18	Scale-Up Saturation	APR 19	98%	98%	98%	98%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%
Berea	COP 15	Scale-Up Saturation	APR 16	95%	43%	95%	43%	41%	24%	61%	71%	50%	46%	40%	49%	76%	65%	50%
	COP 16	Scale-Up Saturation	APR 17	95%	20%	95%	46%	40%	18%	62%	68%	95%	52%	53%	66%	79%	90%	64%
	COP 17	Scale-Up Saturation	APR 18	95%	85%	95%	89%	56%	27%	89%	89%	89%	89%	89%	89%	85%	89%	87%
	COP 18	Scale-Up Saturation	APR 19	98%	98%	98%	98%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%
Mafeteng	COP 15	Scale-Up Saturation	APR 16	87%	40%	87%	40%	37%	24%	67%	75%	34%	42%	22%	26%	52%	66%	32%
	COP 16	Scale-Up Saturation	APR 17	95%	40%	95%	60%	61%	49%	71%	80%	26%	39%	33%	41%	74%	90%	46%
	COP 17	Scale-Up Saturation	APR 18	95%	83%	95%	83%	62%	42%	88%	88%	88%	82%	81%	84%	79%	88%	86%
	COP 18	Scale-Up Saturation	APR 19	98%	98%	98%	98%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Mohale's Ho	COP 15	Scale-Up Saturation	APR 16	95%	35%	95%	35%	29%	18%	14%	38%	15%	28%	31%	23%	62%	95%	34%
	COP 16	Scale-Up Saturation	APR 17	95%	70%	95%	58%	61%	59%	47%	79%	30%	44%	34%	43%	88%	95%	50%
	COP 17	Scale-Up Saturation	APR 18	95%	87%	95%	87%	53%	37%	53%	88%	88%	77%	72%	64%	69%	88%	72%
	COP 18	Scale-Up Saturation	APR 19	98%	98%	98%	98%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Quthing	COP 15	Scale-Up Saturation	APR 16	95%	38%	95%	38%	37%	13%	35%	61%	70%	52%	18%	24%	67%	86%	33%
	COP 16	Scale-Up Saturation	APR 17	95%	28%	89%	32%	29%	15%	37%	57%	58%	41%	18%	26%	55%	78%	31%
	COP 17	Scale-Up Saturation	APR 18	32%	16%	32%	16%	16%	5%	42%	61%	46%	34%	15%	24%	50%	68%	27%
	COP 18	Scale-Up Saturation	APR 19	98%	98%	98%	98%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Thaba Tseka	COP 15	Scale-Up Saturation	APR 16	72%	25%	72%	25%	28%	19%	18%	23%	10%	19%	12%	21%	33%	39%	20%
	COP 16	Scale-Up Saturation	APR 17	24%	63%	88%	45%	50%	26%	34%	34%	22%	35%	25%	40%	61%	76%	39%
	COP 17	Scale-Up Saturation	APR 18	38%	19%	38%	19%	20%	16%	38%	46%	74%	49%	22%	30%	47%	49%	32%
	COP 18	Scale-Up Saturation	APR 19	98%	98%	98%	98%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Mokhotlong	COP 15	Scale-Up Saturation	APR 16	52%	19%	52%	11%	28%	13%	9%	11%	6%	3%	1%	2%	2%	3%	3%
	COP 16	Scale-Up Saturation	APR 17	52%	19%	95%	55%	67%	46%	41%	51%	28%	18%	24%	27%	56%	65%	32%
	COP 17	Scale-Up Saturation	APR 18	27%	24%	27%	14%	11%	8%	35%	42%	50%	17%	29%	32%	39%	55%	32%
	COP 18	Scale-Up Saturation	APR 19	98%	98%	98%	98%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Butha Buthe	COP 15	Scale-Up Saturation	APR 16	96%	36%	96%	36%	42%	53%	46%	34%	43%	16%	7%	14%	24%	30%	16%
	COP 16	Scale-Up Saturation	APR 17	64%	71%	95%	64%	87%	99%	74%	60%	30%	40%	34%	48%	80%	95%	52%
	COP 17	Scale-Up Saturation	APR 18	9%	5%	9%	5%	5%	5%	41%	41%	36%	27%	20%	29%	50%	55%	29%
	COP 18	Scale-Up Saturation	APR 19	98%	98%	98%	98%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Qacha's Nek	COP 15	Scale-Up Saturation	APR 16	62%	34%	62%	34%	36%	37%	40%	47%	31%	42%	22%	31%	57%	72%	34%
	COP 16	Scale-Up Saturation	APR 17	16%	17%	95%	52%	64%	62%	46%	66%	42%	55%	22%	38%	76%	95%	43%
	COP 17	Scale-Up Saturation	APR 18	31%	6%	95%	40%	0%	0%	27%	25%	18%	25%	13%	17%	35%	46%	20%
	COP 18	Scale-Up Saturation	APR 19	98%	98%	98%	98%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY 18)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY19) *TX_CURR***	**Newly initiated (APR FY 19) *TX_NEW***	**ART Coverage (APR 19)**
Attained	N/A	N/A	N/A	N/A	N/A	N/A
Scale-Up Saturation	332,900	254,428	11,892	300,321	45,091	90%
Scale-Up Aggressive	N/A	N/A	N/A	N/A	N/A	N/A
Sustained	N/A	N/A	N/A	N/A	N/A	N/A
Central Support	N/A	N/A	N/A	N/A	N/A	N/A
Commodities (if not included in previous categories)	N/A	N/A	N/A	N/A	N/A	N/A
Total	**332,900**	**254,428**	**11,892**	**300,321**	**45,091**	**90%**

APPENDIX B – Budget Profile and Resource Projections

B1. COP 18 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area

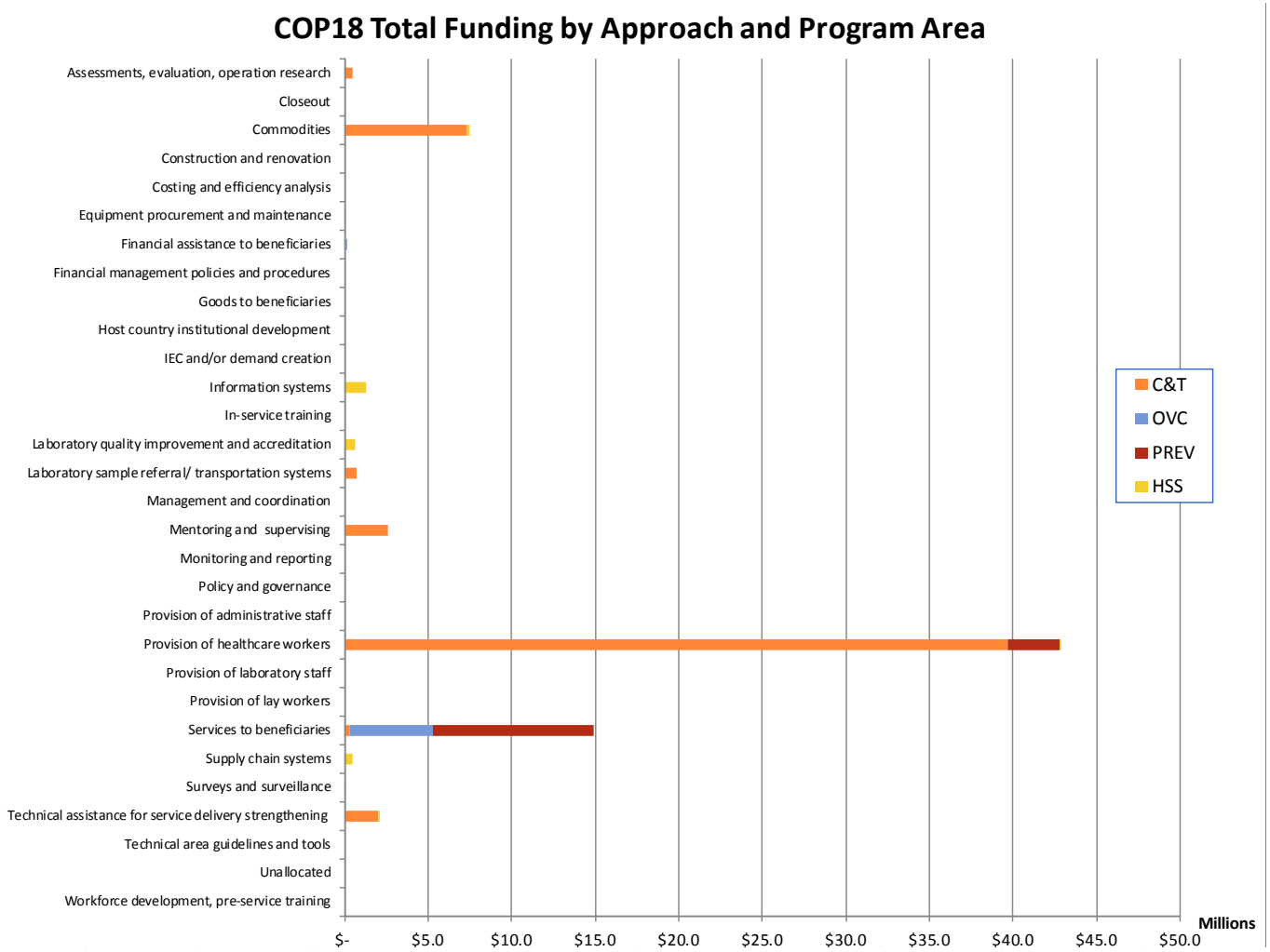


Table B.1.2 COP 18 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$2,423,750	**$80,086,105**	**$82,509,855**

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$551,099
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$10,017,660
HVOP	Other Sexual Prevention	$5,734,518
IDUP	Injecting and Non-Injecting Drug Use	-
HMBL	Blood Safety	-
HMIN	Injection Safety	-
CIRC	Male Circumcision	$5,535,122
HVCT	Counseling and Testing	$12,174,492
HBHC	Adult Care and Support	$3,239,278
PDCS	Pediatric Care and Support	$933,680
HKID	Orphans and Vulnerable Children	$5,035,777
HTXS	Adult Treatment	$28,554,504
HTXD	ARV Drugs	-
PDTX	Pediatric Treatment	$1,767,575
HVTB	TB/HIV Care	$6,409,117
HLAB	Lab	$1,042,931
HVSI	Strategic Information	$1,387,750
OHSS	Health Systems Strengthening	$884,896
HVMS	Management and Operations	$6,223,153
TOTAL		**$80,086,105**

B.2 Resource Projections

Resource projections for COP18 budgeting were done using COP17 budgets as a baseline. COP18 budgeting has moved away from the unit expenditure (UE) based budgeting done in the past. Instead, COP18 budgeting was done in an approach-based manner. When costing data was required, the PEPFAR Lesotho program used a combination of historic COP17 UEs and discussions with implementing partners on costing data.

Program Area	**Beneficiary Type**	**Site Type** (Scale-up, Maintenance, Transition)	**SNU (default national)** National SNU1 (if available) SNU2 …	**Unit Cost Applied**	**Source / Justification/ Other Notes (e.g., differed from EA UE result by X)**
FBCTS	Adult ART	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	$91.67	UE Updates: Base UE consists of COP16 CC (73.39) [this CC includes IMPACT funding] and added in the fixed budget using the COP16 UE by CC (40.91) multiplying it by the COP16 CBCTS target and then dividing the final figure by the FY16 PY Result in order to get a fixed UE of 27.28). Included an additional amount of 3.43 (15/120 sites is 15% took 22.88 from the time motion study for 120 sites approved in COP15).
	Peds ART	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$123.71	UE Updates: Base UE consists of COP16 CC (73.39) [this CC includes IMPACT funding] and added in the fixed budget using the COP16 UE by CC (40.91) multiplying it by the COP16 CBCTS target and then dividing the final figure by the FY16 PY Result in order to get a fixed UE of 27.28). Included an additional amount of 3.43 (15/120 sites is 15% took 22.88 from

					the time motion study for 120 sites approved in COP15). The calculated UE of $93.01 is further multiplied by 1.33 to account for additional costs associated with Pediatric ART services.
PMTCT	Pregnant Women Tested	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$9.39	Base UE consists of COP16 cost categories (CC) (UE=$10.54) and the CC in-service training was fixed whilst the rest of the CCs were kept variable
	Women receiving ARV prophylaxis	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$152.34	Base UE consists of EA FY 2016 cost categories (CC). The CC in-service training was fixed whilst the rest of the CCs were kept variable
	Infants Tested	N/A	N/A	$215.94	Due to lack of COP 2016 information, PEPFAR used EA FY 2016 cost categories (CCs) as proxies. The CC in-service training was fixed whilst the rest of the CCs were kept variable
	Infants receiving Care	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$0	No UEs were applied for Infants on Care
VMMC	Males Circumcised	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	$107.24	Base UE consists of EA FY 2016 cost categories (CC). The CC in-service training, vehicles and personnel were fixed whilst the rest of the CCs were kept variable
	HTC PITC	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	$2.96	Base UE consists of EA FY 2016 cost categories (CC). The CC in-service training, vehicles and personnel were fixed whilst the rest of the CCs were kept

			plus the 18 hotspots		variable
	HTC VCT	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$4.62	Base UE consists of EA FY 2016 cost categories (CC). The CCs in-service training, vehicles and personnel were fixed whilst the rest of the CCs were kept variable
	HTC CBTC	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$12.12	Base UE consists of EA FY 2016 cost categories (CC). The CCs in-service training and vehicles were fixed whilst the rest of the CCs were kept variable
	Other HTC	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$6.25	The original UE of $5.16 was adjusted to $6.25 to account for program activities as a result of the scale-up in the five priority districts. **Source:** UE Modification tool
OVC	OVC All Care	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng	$42.21	Base UE consists of EA FY 2016 cost categories (CC). The CCs equipment & furniture and other investments were fixed whilst the rest of the CCs were kept variable
PP-PREV	Prevention Priority Populations	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	5 Priority Districts; Maseru, Leribe, Berea, Mohale's Hoek and Mafeteng plus the 18 hotspots	$26.81	Base UE consists of EA FY 2016 cost categories (CC). The CC in-service training, equipment & furniture, building & rentals and personnel were fixed whilst the rest of the CCs were kept variable
	KP-FSW	1.Scale-up to Saturation SNUs 2. Aggressive Scale-up SNUs	Maseru and Leribe	$49.08	Base UE consists of EA FY 2016 cost categories (CC). The CC equipment & furniture, buildings & rentals and personnel were fixed whilst the rest of the CCs were kept variable.
	KP-MSMTG	1.Scale-up to	Maseru and Leribe	$32.28	Base UE consists of EA FY 2016 cost

		Saturation SNUs 2. Aggressive Scale-up SNUs			categories (CC). The CC equipment & furniture, buildings & rentals and personnel were fixed whilst the rest of the CCs were kept variable.

UEs Applied in COP 2018

Since the FAST guidance stated that OUs should use COP17 as the baseline; the UEs applied in COP18 are exactly the same as those used in COP17. Additional costs were mainly due to expansion of sites in the respective program areas.

APPENDIX C – Tables and Systems Investments for Section 6.0

See attachment at the end of this document for full Table 6.

APPENDIX D – Acronym List

ACT	Accelerating Children's HIV/AIDS Treatment
AGYW	Adolescent girls and young women
ANC	Antenatal care
APS	Active partner notification services
ART	Anti-retroviral therapy
ARV	Antiretroviral
ASLM	African Society for Laboratory Medicine
BBSS	Biological Behavioral Surveillance Study
BRO	Boys Respecting Others
CAG	Community Adherence Group
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control
CLHIV	Children Living with HIV
COP	Country Operational Plan
CQI	Continuous quality improvement
CrAg	Cryptococcus antigen
CSO	Civil Society Organizations
DBS	Dried blood spot
DHIS 2.0	District Health Information Software
DHMT	District Health Management Teams
DHS	Demographic and Health Surveys
DMPPT 2.0	Decision Makers Program Planning Tool 2.0
DQA	Data Quality Assurance
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe women
DSD	Direct Service Delivery
DTG	Dolutegravir
EFV	Efavirenz
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	Early Infant Diagnosis
EIMC	Early Infant Male Circumcision
eLMIS	Electronic logistics management information system
EPP	Estimation and projection package
EQA	External quality assessment
ERP	Enterprise Resource Planning
FDC	Fixed dose combination
FSW	Female sex worker
GBV	Gender-based violence
GF	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GHSC	Global Health Supply Chain Management
GIS	Geographic Information Systems

GLOW	Girls Leading Our World
GNI	Gross National Income
GOL	Government of Lesotho
GRS	Grassroots Soccer
HEI	HIV-exposed infant
HIV	Human immunodeficiency virus
HIVDR	HIV drug resistance
HIVST	HIV self-testing
HOP	Headquarters operational plan
HRH	Human resources for health
HSS	Health systems strengthening
HTS	HIV testing services
ICF	Intensified TB case finding
IM	Implementing mechanism
IP	Implementing partner
IP	Informed Push
IPT	Isoniazid preventive therapy
IRIS	Immune reconstitution inflammatory syndrome
KP	Key Population
LCN	Lesotho Council of NGOS
LENASO	Lesotho Network of AIDS Services Organizations
LENEPHWA	Lesotho Network of People Living with HIV and AIDS
LePHIA	Lesotho Population Based HIV/AIDS Impact Assessment
LIRAC	Lesotho Inter-Religious AIDS Consortium
LIS	Laboratory information system
LPV/r	Lopinavir/ritonavir
M&E	Monitoring & evaluation
MCH	Maternal and child health
MF	Miner-friendly
MOH	Ministry of Health
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
NAC	National AIDS Commission
NACS	Nutrition assessment, counseling and support
NOCC	National OVC Coordinating Committee
NSP	National strategic plan
OGAC	Office of the U.S. Global AIDS Coordinator
OI	Opportunistic Infections
OPD	Outpatient department
OTH	Online Training Hub
OVC	Orphans and vulnerable children
PB	Phelisanang Bophelong
PCV	Peace Corps Volunteers

PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PI	Protease inhibitor
PITC	Provider-initiated- HIV-testing and counseling
PLHIV	People Living with HIV
PMTCT	Prevention of mother-to-child transmission of HIV
POART	PEPFAR Oversight and Accountability Review Team
POC	Point-of-care
POC-RT	Point-of-care recency test
PPP	Public-private partnership
PrEP	Pre-exposure prophylaxis
PROMISE	Provide miner-friendly services for integrated TB/HIV care
PSM	Procurement and Supply Management System
PSNU	Primary sub-national unit
PT	Proficiency testing
QI	Quality improvement
QMS	Quality Management System
RPM	Regional Planning Meeting
RTCQI	HIV rapid test continuous quality improvement
RTK	Rapid diagnostics test-kits
SBCC	Social behavioral change communication
SCCU	Supply Chain Coordinating Unit
SCM	Supply chain management
SCM-TWG	Supply chain management Technical Working Group
SI	Strategic information
SID	Sustainability Index Dashboard
SIMS	Site Improvement Through Monitoring System
SLIP-TA	Stepwise Laboratory Quality Improvement Process Towards Accreditation
SLMTA	Strengthening of Laboratory Management Towards Accreditations
SMS	Short message service
SOP	Standard operational procedure
SPI-POCT	Stepwise Process for Improving the Quality of HIV-Related Point-of-Care-Testing
SRH	Sexual and Reproductive Health
STI	Sexually transmitted infection
STTA	Short term technical assistance
TB	Tuberculosis
TEBA	Treatment Services at the Employment Bureau of Africa

TLD	Tenofovir disoproxil fumarate/lamivudine/dolutegravir
TLE	Tenofovir/lamivudine/efavirenz
TPT	TB preventive therapy
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
USG	United States Government
VACS	Violence Against Children Survey
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WLHIV	Women living with HIV
WMS	Warehouse Management System
YOLO	Youth Optimizing Leadership Opportunities

Table 6 Attachment

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
1	HHS/CDC	ICAP Global Technical Assistance	HSS	To strengthen steamlined and efficient data flow, management and use across health systems	Information systems	Electronic register development and implementation; implementation of unique patient identifier; scale up of mHealth application
2	HHS/CDC	CDC HMIS support to the MOH	HSS	To strengthen steamlined and efficient data flow, management and use across health systems	Information systems	DHIS Site-level implementation
3	HHS/CDC	ICAP Global Technical Assistance	HSS	Support MOH to further enhance HMIS system through facility-level rollout of DHIS2 for streamlined and efficient data flow, management, and use (DHIS2)	Equipment procurement and maintenance	Support timely, complete, and accurate data from sites.
4	HHS/CDC	ICAP Global Technical Assistance	HSS	To support implementation of VACS study	Surveys and surveillance	Violence against Children Survey (VACS)
5	HHS/CDC	ICAP Global Technical Assistance	HSS	Lesotho Population-based HIV Impact Assessment (LePHIA)	Surveys and surveillance	LePHIA

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
1	No system currently in place; lack of unique identifier to track patients along cascade	Strategic Information: (13) Epidemiological and Health Data	4.6	Development of electronic register and implementation at high volume sites;implementation of unique pateint identifier; scale up of mHealth application	1 year	Implementation of system	System was funded in COP17 for one year. Given CDC delay in funding (April cycle) - the system has not yet been implemented
2	Hand written information being submitted to district for entry into system - increases risk of transcription errors and delays reporting times	Strategic Information: (13) Epidemiological and Health Data	4.6	Data entry at the site level - continued improvement in timeliness and completeness of submissions	1 year	Improvement in reporting by MOH and national data be PEPFAR	System has started roll out to site level during COP17
3	Timely (only 85%), complete, and accurate data resulting in lack of data use for program planning by MOH	Strategic Information: (13) Epidemiological and Health Data	4.6	On-time submission of data by 90% of supported sites (defined by meeting in-country reporting deadline each month); continued progress towards data alignment activity - improved data quality. 90% of PEPFAR and MOH data will match within 90% of sites supported by PEPFAR; data completeness - 95% of reported data will be complete	1 Year (Current SI COAG with extension to end Sept 30 2019. New CoAG expected to continue support.)	DATIM and DHIS2 reporting, MER indicators	Historical and current data from MOH
4	Not applicable	Strategic Information: (13) Epidemiological and Health Data	4.6	Completion of Lesotho VACS	2 years	Survey completion	Protocol is currrently entering into clearance
5	Not applicable	Strategic Information: (13) Epidemiological and Health Data	4.6	Completion of Lesotho PHIA	1 year	Survey completion	Data collection is done. Activities will be related to completing support activities. This is HQ funded and the overall PHIA CoAg is largely HQ driven

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
1	Deployment of system in HIV facilities throughout Lesotho.		Not applicable		Not applicable	
2	Site-level reporting by 90% of PEPFAR-supported sites. Data reported complete (>90% of indicators filled out with complete data) and on time (within one week of submission deadline)		Not applicable		Not applicable	
3	See column N. Measurable progress towards goals		Not applicable.		Not applicable	
4	VACS data collection will be completed. Final activities will be ongoing (final report writing and dissemination). Other appropriate post-VACs activities, such as a data to action workshop, will be provided.		Data disseminated		Not applicable	
5	Completion of all LePHIA related activities.		Not applicable		Not applicable	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
6	HHS/CDC	Strengthening Tuberculosis and HIV Response in Lesotho (STAR-L)	C&T	Implementation and evaluation of differentiated HIV care and treatment for people with advanced HIV disease in Lesotho	Assessments, evaluation, operation research	Implementation and evaluation of differentiated HIV care and treatment for people with advanced HIV disease in Lesotho
7	HHS/CDC	ICAP Global Technical Assistance	C&T	PROvide MIner-friendly SErvices for Integrated TB/HIV Care (PROMISE)	Assessments, evaluation, operation research	PROvide MIner-friendly SErvices for Integrated TB/HIV Care (PROMISE)
8	HHS/CDC	ICAP Global Technical Assistance	HSS	HIV Dr Resistance Survey	Surveys and surveillance	Develop a national HIVDR surveillance plan; conduct nationwide adult pre-treatment and acquired drug resistance survey.
9	HHS/CDC	Support Laboratory Diagnosis and Monitoring to Scale up and Improve HIV/AIDS Care and Treatment Services in the Kingdom of Lesotho under the President's Emergency Plan for AIDS Relief (PEPFAR)	C&T	Expanded and improved laboratory diagnosis and monitoring services that are integrated and coordinated with HIV services	Laboratory sample referral/ transportation systems	Strengthen the local referral networks through tiered lab services: national, district and health levels
10	HHS/CDC	Support Laboratory Diagnosis and Monitoring to Scale up and Improve HIV/AIDS Care and Treatment Services in the Kingdom of Lesotho under the President's Emergency Plan for AIDS Relief (PEPFAR)	HSS	Services decentralized and ongoing supportive and QMS assessments conducted at POCT facilities	Laboratory quality improvement and accreditation	Support Laboratory Quality system and Biosafety: Continuous Quality Improvement (CQI) and Proficiency Testing (PT) program

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
6	Not applicable	National Health System and Service Delivery: (1) Service Delivery	6.06	The primary objective of this project is to strengthen the program for people living with HIV (PLHIV) with advanced disease in Lesotho by implementing a differentiated care model and training clinical providers and laboratory staff on the recommended package of care for PLHIV with advanced disease.	2 years	Study Completion	Protocol cleared
7	Not applicable	National Health System and Service Delivery: (1) Service Delivery	6.06	Improve health outcomes among migrant miners and their families, a hard-to-reach population that represents a hotspot of TB/HIV transmission, in Lesotho and in PEPFAR programs more broadly; and 2) strengthen the implementation science research capacity of national and local institutions.	2 years	Study Completion	Protocol cleared
8	No national drug surveillance system	Strategic Information: (13) Epidemiological and Health Data	4.6	Population-level data on HIVDR available for program-level decision making	1 year	Adult pre-treatment and acquired drug resistance survey conducted	N/A
9	Limited infrastructure in decentralization of diagnostic and monitoring tests	National Health System and Service Delivery: (10) Laboratory	3.75	Local capacity developed and effective sample transport and referral network established; Functional sample tracking and reporting system in place where samples are tracked and results accessed at facility and reference laboratory levels: 1. Turnaround time for sample collection and results delivery within 2 - 3 weeks. 2. Sample rejection rate reduced to <5%.	2 years	Number of samples collected from sites; number of test results returned; reduction in turnaround time (TAT) from sample collection to results delivery; sample rejection rate reduction to less than 5%	Sample Transport Tracking (STT) system implementation strengthened. Tracking and e-reporting of test results are implemented.
10	Limited capacity in providing quality assured tiered lab services.	National Health System and Service Delivery: (10) Laboratory	3.75	Standardized and quality assured laboratory and POC testing are provided.	3 years	LAB_PTCQI Indicator; enrollment of labs in CQI; rate of PT participation and passing scores; number of laboratories accredited.	All 18 hospital labs enrolled in CQI 295 HIV rapid testing sites enrolled in EQA/PT scheme

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
6	Data collection completed		Data disseminated		Not applicable	
7	Data collection completed		Data disseminated		Not applicable	
8	Survey completed and results disseminated		Not applicable		Not applicable	
9	Less than 5% of samples rejected for referral testing services; 95% of TB suspects and HIV exposed infants access referral testing services; 95% all PLHIV on ART access VL monitoring.		Less than 5% of samples rejected for referral testing services; 95% of TB suspects and HIV exposed infants access referral testing services; 95% all PLHIV on ART access VL monitoring.		Not applicable	
10	All 18 hospital labs enrolled in SLMTA and 5 of them accredited by ASLM; 95% of 18 clincal labs and 295 POCT enolled in PT program successfully passed.		All 18 hospital labs enrolled in CQI/SLMTA; 295 HIV rapid testing sites enrolled in EQA/PT scheme		All 18 hospital labs enrolled in CQI/SLMTA; 295 HIV rapid testing sites enrolled in EQA/PT scheme	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
11	HHS/CDC	Support Ministry of Health to Strengthen Health Systems and Coordinate HIV/AIDS Prevention, Care and Treatment Programs in the Kingdom of Lesotho under the President's Emergency Plan for AIDS Relief (PEPFAR)	HSS	Strengthen referral testing services	Laboratory quality improvement and accreditation	Support Laboratory Quality system and Biosafety: Continuous Quality Improvement (CQI) and Proficiency Testing (PT) program
12	HHS/CDC	Support Ministry of Health to Strengthen Health Systems and Coordinate HIV/AIDS Prevention, Care and Treatment Programs in the Kingdom of Lesotho under the President's Emergency Plan for AIDS Relief (PEPFAR)	HSS	Strengthen referral testing services	Equipment procurement and maintenance	Make an inventory of standardized equipment platform; develop and/or revise guidelines and SOPs for maintenance services for major lab equipment; implement preventive and routine maintenance; development and enforcement of service contract with manufacturers for major lab instrument.
13	USAID	Global Health Supply Chain Management	HSS	Developing a supply -chain TA model to improve efficiency and effectiveness, and transfer skills to Government of Lesotho counterparts.	Supply chain systems	Support the SCCU to implement quantification, forecasting and supply planning for HIV and AIDS including ARVs and laboratory commodities.
14	USAID	Global Health Supply Chain Management	HSS	Developing a supply -chain TA model to improve efficiency and effectiveness, and transfer skills to Government of Lesotho counterparts.	Supply chain systems	Appropriate warehousing and inventory control for all HIV and AIDS commodities
15	USAID	Global Health Supply Chain Management	HSS	Developing a supply -chain TA model to improve efficiency and effectiveness, and transfer skills to Government of Lesotho counterparts.	Supply chain systems	Integrate a functional eLMIS for HIV and AIDS commodities to the DHIS system

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
11	Limited capacity in providing quality assured referral testing services.	National Health System and Service Delivery: (10) Laboratory	3.75	Standardized and quality assured referral testing services provided. LIS strengthened and quality data generated and used for planning and decision making.	3 years	LAB_PTCQI Indicator; number of laboratories accredited; laboratory test and patient based data generated monthly and quarterly for VL, EID and TB referral testing services.	Reference labs enrolled in CQI and PT program
12	Poor equipment management and maintenance system	National Health System and Service Delivery: (10) Laboratory	3.75	Lab mapping excercise completed. National equipment management and maintenance system in place: complete guidelines and SOPs for maintenance services and service contracts with manufactureres for major lab equipment in place.	2 years	Number of laboratories with no service interruptions due to equipment failure	Equipment maintenance and inventory system in place; equipment down time and service interruption reduced to less than 5 days.
13	Accurate and budgeted forecasting and supply plan for HIV & AIDS commodities	National Health System and Service Delivery: (8) Commodity Security and Supply Chain	3.56	Annual and bi-annual National HIV and AIDS commodities forecasting, quantification and supply plan and budget done.	1 year	National quantification, forecasting and supply plan (FASP) with 100% HIV and AIDS commoditities funded.	National quantification, forecasting and supply plan (FASP) with 75% HIV and AIDS commoditities funded.
14	Challenges with adhering to the prescribed Inventory Control System for HIV and AIDS commodities	National Health System and Service Delivery: (8) Commodity Security and Supply Chain	3.56	All HIV and AIDS commodities stocked according to the inventory control system plan for 12 months of the year.	1 year	MER Indicator SC_STOCK - The NDSO warehouse stocked according to plan 12 months of the year (100% commodity Security)	50% commodity security for HIV and AIDS commodities including ARVs, RTKs and laboratory commoditities
15	Lack of supply chain data visibility across all levels in the pipeline	National Health System and Service Delivery: (8) Commodity Security and Supply Chain	3.56	Data visibility for HIV and AIDS commodities improved at the CMS, SCCU, DHMTs and SDPs	1 year	National eLMIS functional at the CMS, SCCU and SDPs	WMS. Informed Push and Channel systems developed

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
11	Patient-based lab reports generated from National Reference Lab (NRL). Summary and disaggregated data reported timely. NRL connected with district labs and TAT improved in transmission of reports.		Standardized and quality assured referral testing services provided; lab and patient data generated for monitoring and decision making.		National reference lab accredited.	
12	Equipment maintenance and inventory system in place; equipment down time and service interruption reduced to less than 5 days.		Equipment maintenance and inventory system in place; equipment down time less than 2 days and no service interruption		Not applicable	
13	National quantification, forecasting and supply plan (FASP) with 100% HIV and AIDS commoditities funded.		Not applicable		Not applicable	
14	100% commodity security for HIV and AIDS commodities including ARVs, RTKs and laboratory commoditities.		Not applicable		Not applicable	
15	WMS, Informed Push and Channels systems integrated to DHIS2. 100% SDPs using the eLMIS for HIV and AIDS commodity requisitions, reporting and dispensing		Not applicable		Not applicable	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
16	USAID	Global Health Supply Chain Management	HSS	Developing a supply -chain TA model to improve efficiency and effectiveness, and transfer skills to Government of Lesotho counterparts.	Supply chain systems	In-service training and mentorship for health workers to the revised SCM SOPs for efficient procurement of HIV and AIDS commodities for Test and Start.
17	USAID	EQUIP	C&T	To strengthen the Lesotho HIV/AIDS response through providing documented and tested alternative service delivery models and services in order to to attain 90-90-90 by 2020.	Assessments, evaluation, operation research	The study measures the impact on retention and viral load suppression of a cohort of PLHIV, who receive ARVs every three or six months at facility and community level.
18	HHS/CDC	CDC HMIS support to the MOH	HSS	Establish HIV Incidence Surveillance System amiong People Newly Diagnosed with HIV using the HIV rapid-recency assay.	Surveys and surveillance	Develop a national HIV incidence surveillance system capturing people newly diagnosed with HIV using the HIV rapid-receny assay

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
16	Outdated supply chain standard operational procedures (SOPs) to ensure commodity security	National Health System and Service Delivery: (8) Commodity Security and Supply Chain	3.56	100% health workers trained in the new SCM SOPs.	1 year	100% health workers trained in the new SOPs.	None
17	To reach epidemic control (including high viral load suppression rates) a key area is achieving and maintaining high levels of retention, which requires strong facility and community support systems for improving adherence.	National Health System and Service Delivery: (1) Service Delivery	6.06	Final report provides evidence for identifying the most impactful models for multi-month dispensing of ARVs	3 years	Final evaluation Report submitted and approved	Data collection is on-going and expected to be completed by 9/30/2019
18	No system currently in place; lack of unique identifier to track patients along cascade	Strategic Information: (13) Epidemiological and Health Data	4.6	Results from recency testing will inform the identification of social networks correlating demographic and social risk factors related to recent infections. Test results will also provide HIV incidence rates within groups targeted for HIV testing.	3 years	Completion of surveillance system	None

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
16	100% staff trained in the new SOPs.		Not applicable		Not applicable	
17	Data collection and mid-term report		Data Collection completed		Data dissemination	
18	Initial deployment of surveillance system in 24 HIV facilities throughout Leribe district		Scale up of system in additional 48 sites -72 in two additional districts in Lesotho		Implementation of system in remaining districts throughout Lesotho	